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UNIVERSITY OF SOUTHAMPTON

FACULTY OF MEDICINE

Human Development and Health

Volume 1 of 1

Why hospitalised older people are inactive and how volunteers can help. A qualitative study

by

Alicja Magdalena Baczynska

Thesis for the degree of Master of Philosophy

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ABSTRACT

FACULTY OF MEDICINE

Human Development and Health

Thesis for the degree of Master of Philosophy

WHY HOSPITALISED OLDER PEOPLE ARE INACTIVE AND HOW VOLUNTEERS CAN HELP.

A QUALITATIVE STUDY

by Alicja Magdalena Baczynska

Excessive bed rest and sedentary behaviour in older inpatients are well recognised problems within the NHS which can contribute to a range of negative effects such as infections, thrombosis, pressure damage to skin, urinary incontinence, constipation, mental health issues, loss of muscle and deconditioning. Due to ever increasing time pressures on nursing staff in the NHS, other aspects of care (such as medical treatments, washing and feeding) take priority over frequent daily mobilisation of patients. Volunteers have been used in some hospitals worldwide to assist with mobilisation in older people with promising results.

This qualitative study aimed to gain views and perceptions of patients, caregivers, staff and volunteers with regards to volunteer-led mobilisation of older patients on acute medical wards. The study also investigated perspectives on hospitalisation in general, barriers to mobilisation and suggestions for improvements in the care of older people.

20 patients, 7 family members, 27 staff and 3 mealtime volunteers participated in either individual interviews or focus groups which were audio recorded, transcribed, coded and analysed according to the Framework method.

The results of the study were grouped into five main topics:

1. The hospitalised older adult which includes the concept of institutionalisation and disempowerment of the frail patient, advantages and disadvantages of hospitalisation
2. Mobility of inpatients which includes description of mobilisation practice in hospital, views on importance of keeping active in older age and awareness of bed rest risks.
3. Barriers to mobilisation which were grouped into environmental, patient related, staff related and family related themes.

4. Volunteer-led walking programme with following areas to consider prior to implementation: patient selection, volunteer selection, environmental issues, staff related issues.
5. Proposed changes which could help improve mobility of older people and care in general.

There are many ways in which the hospital environment, staff and even family members can add to the disempowerment in older inpatients which in turn results in increased social care requirements- institutional, cultural and organisational factors are all contributive. Early mobilisation could become a good, simple way of empowerment. Close inspection of barriers to mobilisation and searching for ward or hospital specific solutions to overcome them could support the paradigm shift. In this context, training volunteers to assist with mobilisation would provide a strong message not only to patients and caregivers but also to all types and grades of hospital staff. This work provides a multi-layered insight into the care of older patients in a large NHS hospital. The ideas, reflections and inferences derived from this study mirror the current climate in the NHS and provide evidence that a shift in perception has already happened. My interviewees have created a story that I attempted to unveil and systematise so that at least parts of it can be translated into practical solutions in day-to-day clinical practice.

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Declaration of authorship

I, Alicja Magdalena Baczynska

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Why hospitalised older people are inactive and how volunteers can help.
A qualitative study

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as:
   The use of volunteers to help older medical patients mobilise in hospital: a systematic review, J Clin Nurs. 2016 Nov;25(21-22):3102-3112.doi: 10.1111/jocn.13317

Signed: ....

Date: ....

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I would also like to acknowledge Dr Kinda Ibrahim for acting as the second researcher coding the data to ensure reliability and for her enduring friendship.

I am most grateful to all patients, family members, hospital staff and volunteers who took part in this study and helped me to accomplish this work.

Dedication

To my wonderful family, Tomasz, Jan and Elena for all their love, patience and sacrifices

Definitions and Abbreviations

Definitions:

Physical activity- any bodily movement produced by skeletal muscles that requires energy expenditure and may relate to any of usual activities such as work, household chores, travel and leisure.

Exercise- structured, regular physical activity which aims at improving fitness levels.

Mobility- the ability to move or be moved freely and easily and is often used in clinical literature when relating to physical activity of patients on the wards.

Mobilisation- the action of making something moveable or capable of movement for example as in joint mobilisation after injury. It is also used in the context of helping patients restart physical activity after a period of bed rest (frequently called early mobilisation) and may include passive bed-based movements or sitting out in a chair progressing to active movements, standing and walking with or without aids.

Ambulation- promotion and assistance with walking to maintain or restore autonomic and voluntary body functions during treatment and recovery from illness or injury

Abbreviations:

RN – registered nurse
SMAS- Southampton Mealtime Assistance Study
HELP- The Hospital Elder Life Program
The ACTIVe Program- Aged Care Therapeutic interventions by Volunteers
MOVE ON- Mobilisation of Vulnerable Elders in Ontario
WHO- World Health Organisation
AMTS- Abbreviated Mental Test Score
OPP- Older Peoples' Practitioner
CT- computed tomography
MOT- Ministry of Transport
CMH- Community Mental Health

Chapter 1: Introduction

1.1 Hospitalisation of older people

1.1.1 Sedentary behaviour in hospital

> Look at a patient lying long in bed. What a pathetic picture he makes! The blood clotting in his veins, the lime draining from his bones, the scybala stacking up his colon, the flesh rotting from his seat, the urine leaking from his distended bladder, and the spirit evaporating from his soul.
>
> **R. Asher, The dangers of going to bed, British Medical Journal 1947**

This accurate depiction of a bed bound patient was published 70 years ago and is still relevant today. The risks and complications of bed rest among patients such as thromboembolism, hospital acquired infections, pressure damage of skin, urinary incontinence, constipation, mental health issues and physical deconditioning are well recognised and described in wider literature. In particular, physical activity levels are low among older people and sedentary behaviour in those admitted to hospital is even more extensive than the 18 hours per day reported for community dwelling older people (1). Around 30-60% of inpatients will develop functional decline during hospitalisation, which may be defined as a new dependence or deterioration in self-care activities (2). A USA, accelerometer based study demonstrated that 45 previously independent older medical male inpatients (mean age 74 years) typically spent only 43 minutes per day in an upright position i.e. standing or walking (3). In the UK, 16 accelerometer wearing older female inpatients (mean age 85 years) spent upright only 25 minutes per day (between 9 and 5 pm)(4). In a USA observation study 15 nurses looking after 47 patients were shadowed over an 8 hour period to establish frequency and duration of patient mobilisation (5). Most frequent mobility activity was standing and transferring while mean duration of ambulation was only 2 minutes. More than 30% of patient were not mobilised at all during this period.

Importantly, sedentary behaviour among older people in hospital is associated with an increased risk of physical and cognitive decline and loss of social independence (6)(7). It is also associated with sarcopenia (8). An American study of 11 healthy older adults who underwent 10 days voluntary bed rest demonstrated a significant reduction in lower limb strength (13%), and power (14%) (9) with a loss of almost 1 kg of lean tissue from their legs (10). Given that the average length of stay in the UK hospitals is 7.7 days (11 days for the over 85's) (11), it is not surprising that many older people become seriously deconditioned and require increased support at home, a period of rehabilitation or even institutionalisation on discharge.

1.1.2 Challenges within the NHS

In the UK typically there are relatively low staff to patient ratios and more dilute skill mix on most wards for older people than other wards in hospitals. A Royal College of Nursing report states that there are 9.1 to 10.3 patients per registered nurse (RN) on older people's ward whereas there are 6.7 and 4.2 patients per RN on medical/surgical and paediatric wards respectively. This means that on an average 28-bed ward there are 3 registered nurses and 6 staff members in total (including healthcare assistants) (12). In fact, most older inpatients require at least some assistance with their care and those with severe behavioural issues may be in need of 1:1 special nursing. It is possible that inadequate staffing levels may result in poorer care of this vulnerable group of patients. In comparison, medical/surgical wards tend to have less dependent patients, whereas paediatric units are supported by parents actively involved in the care of their children.

To be able to provide basic safe care the Royal College of Nursing recommends at least four or more RN's and eight or more staff members in total per ward. The safe/ideal number of staff required will vary from day to day depending on the specific case mix of patients. The aspects of care reported to be most frequently neglected due to time pressures according to nurses are talking/comforting patients, promoting mobility and self-care. Given the current financial climate in the NHS it is unlikely that this situation will change in the near future. Therefore, other ways of engaging older patients in purposeful activity need to be explored and introduced in clinical areas.

1.2 Physical activity in hospital

> Lack of activity destroys the good condition of every human being while movement and methodical physical exercise save it and preserve it
>
> **Plato**

1.2.1 Definitions

Physical activity is characterised by any bodily movement produced by skeletal muscles that requires energy expenditure and may relate to any of usual activities such as work, household chores, travel and leisure (13).

Exercise is structured, regular physical activity which aims at improving fitness levels (13).

Mobility is defined as the ability to move or be moved freely and easily (Oxford Dictionary online) and is often used in clinical literature when relating to physical activity of patients on the wards. Mobilisation is normally defined as the action of making something moveable or capable of movement (Oxford dictionary online) for example as in joint mobilisation after injury. However, it is also used in the context of helping patients restart physical activity after a period of bed rest (frequently called early mobilisation) and may include passive bed-based movements or sitting out in a chair progressing to active movements, standing and walking with or without aids.

Ambulation is defined as promotion and assistance with walking to maintain or restore autonomic and voluntary body functions during treatment and recovery from illness or injury (14).

1.2.2 Evidence base for in-hospital exercise and mobilisation

There is silver (Cochrane Musculoskeletal Group grading of levels of evidence) level evidence from the 2009 Cochrane systematic review that targeted exercise intervention may be beneficial (increased proportion of patients discharged home and reduced length and cost of hospital stay). All the studies included in the review were conducted outside the UK and were based on employment of additional, trained staff members to deliver the intervention (15). The additional cost of implementing such a programme by hospitals is clearly a deterrent in the current financial climate, especially with a lack of clear evidence from well designed trials.

With regards to early mobilisation most studies relate to specific situations such as: in critical care, post myocardial infarction, post stroke, in treatment of deep vein thrombosis and fractures or to specific procedures such as: lumbar puncture or spinal anaesthesia (16). Two studies have investigated the benefit of targeted early mobilisation protocols as opposed to usual care (as ambulation is an essential nursing intervention) (17)(18). These showed that by introducing mobilisation programmes/protocols in hospital, the level of mobility and various health outcomes including length of stay can be improved.

1.2.3 Barriers and facilitators of in-hospital physical activity

In order to introduce a successful in-hospital mobilisation programme it is crucial to acquire knowledge about a particular environment, the attitudes of relevant stakeholders and any barriers or facilitators of physical activity that may need to be considered a priori.

Factors contributing to the sedentary behaviour of inpatients include acute illness, staff availability and patient beliefs. An American qualitative study explored perceived barriers to increased mobility among 10 patients, 10 nurses and 9 resident doctors on medical wards at a university hospital. The barriers most commonly described by all three groups of participants involved symptoms of weakness, pain and fatigue, presence of urinary catheters or intravenous lines and concern about falls. Lack of staff to assist with mobility was a major obstacle. Although doctors and nurses pointed towards lack of motivation this view was not reflected by patients themselves who in turn commented on the staff’s apparent lack of interest in promoting mobility. Absence of ambulatory devices or appropriate clothing were also concerns (19).

Another qualitative study reported that for most patients exercise in hospital meant walking. Motivating factors included avoiding negative effects of bed rest (such as boredom, functional decline or pain and fatigue), improved sense of well-being, promotion of functional recovery as well as recommendation of exercise by health professionals (20). While only 27% of respondents recalled being encouraged to exercise by hospital staff, most (85%) felt that such encouragement would be a good motivation to undertake exercise while in hospital.

In a UK study a structured, face-to-face questionnaire was administered to 44 inpatients at an urban hospital exploring the views around participation in physical activity (21). Over a half of the participants believed that their normal level of activity was adequate. However, the reported activity and frailty levels did not correspond with these beliefs. The reported barriers to increased activity were related to symptoms (‘breathing’ and leg’ problems). Only 11% recalled that they received advice from healthcare providers to stay physically active. There is a scope to increase the awareness of the benefits of regular exercise among older patients and to challenge the misconception that they should ‘rest and relax in their spare time’.

1.2.4 Evidence for falls

Despite fear of falling being a potential obstacle there is no current evidence that increased mobility results in more falls (18). It is thought that falls are more likely to be associated with cognitive and environmental factors rather than the level of mobility itself (22). Providing safe systems to mobilise for cognitively impaired inpatients and preventing delirium may reduce both falls and low mobility leading to huge cost savings.

1.3 Volunteers

> Support for a strong and vibrant voluntary and community sector is an essential component of our vision for the future of health and social care services and for the wider government agenda, which is about promoting social inclusion and building sustainable communities. Volunteering encourages and supports community capacity-building at a local level, and creates opportunities for all citizens to contribute to society.
>
> **M. Restall, S. Hawkins. Volunteers across the NHS: improving the patient experience and creating a patient-led service, 2006**

1.3.1 Volunteers in the UK

In the UK, volunteering (i.e. performing an unpaid activity for the benefit of people other than close relatives) is regarded as an integral and essential part of most aspects of life. It is estimated that in England, there are currently 3 million volunteers contributing in health and social care which is the same number as combined paid staff in both settings (23). However, detailed information about the number and extent of the roles is often lacking and some hospitals do not know the exact number of volunteers engaged on their premises (23). Volunteering England (2012) produced a list of more than 100 roles that volunteers are taking on in different health and social care settings. These roles range from community based support of vulnerable groups, lifestyle coaching, advocacy, teaching and training, through providing help and support for people at home and care homes, to major contributions in various healthcare settings such as mental health, palliative care and acute hospital care settings.

Supporting and expanding volunteer services is often on the agendas of the political parties. One of the pre-election promises from the Conservatives in 2015 was about enabling employees of the Public Sector (those companies with over 250 employees) to take 3 days of paid leave to volunteer (24). The aim of this new strategy was to empower local people and communities and to build a more motivated and stronger workforce. The consultations on the policy were to begin in 2017 however the plan has not been upheld in the current Prime Minister's manifesto.

Volunteering was also identified by Robert Francis in his Mid-Staffordshire report as a way of introducing more compassion, transparency and public involvement in NHS hospitals (25). The volunteers have time to listen, to provide impartial support and advocacy especially to those most vulnerable; they can offer a unique perspective often based on their own experience of healthcare, the idea of a ‘gift relationship’ as opposed to contractual one is greatly valued by patients (23).

1.3.2 Volunteers in palliative care

Volunteering is particularly well established in palliative care. A recent survey (26) reported that there are more than 100.000 hospice volunteers in the UK reducing the costs by around 23%. Volunteers are most commonly involved in day care and bereavement services and least commonly in home care. Their roles include serving meals and drinks, creative/diversional therapies, emotional care for patients and their families, driving, giving advice and information, providing physical care (turning, lifting, bathing) as well as offering professional skills such as complementary therapies, beauty therapies, hairdressing and spiritual care. Another important role identified is accompanying the dying patients in the last hours of their lives. Some of the services are entirely run by volunteers (e.g. complementary/alternative therapies or pastoral care).

1.3.3 Volunteers in the NHS acute hospital care

A survey was commissioned by the Department of Health (27) to explore the scale and value of volunteering in hospitals. 99 out of 166 (60%) trusts responded. There were on average 471 volunteers in every acute trust (360 recruited by the trust itself and 111 recruited by external organisations equating to 78000 volunteers across all acute trusts in England excluding general practice, mental health care and governance) (27). However, the information about the scale and value of their input is often not systematically collected or disseminated. There exists a great variety in the number of volunteers between the trusts which only weakly correlates with the number of employed staff. Thus, some smaller hospitals have a relatively large number of volunteers (e.g. 1200 volunteers versus 2000 staff) while other bigger hospitals do not match a similar ratio (e.g. less than 600 volunteers versus 13000 staff).

The five main areas where volunteers are engaged include: 1. befriending/visiting, 2. signposting, 3. hospitality/activities support (drink trolley, mealtime helper, play assistant), 4. entertainment (hospital radio, library) and 5. administrative support. There is a strong feeling that the volunteers enhance patient experience and add other forms of value e.g. linking with the community and listening to the public.

In spite of a financial assessment being controversial as contradicting the very idea of volunteering being unpaid, it does provide a way of judging whether the trust’s investment in training volunteers pays off in the long term. It is estimated that for every £1 invested the trust receives £11 in return (27). Clearly, apart from the obvious financial benefits volunteers enhance patient experience and quality of care so new ways of measuring this crucial impact need to be established. Noticeably, in most hospitals the roles of the volunteers do not include provision of fundamental care to older patients (i.e. feeding, mobilisation, personal care). These roles raise the issue of accountability and clashes with the roles of paid staff as well as acceptability among patients and their caregivers.

There are several challenges related to volunteering in hospitals. Relationships with paid staff can sometimes be tense especially if volunteers are performing tasks traditionally attributable to paid staff such as feeding. Also, the staff may not fully understand the role of the particular volunteer and ask them to perform other duties which are beyond their competence. Another issue lies within the recruitment procedures which involve lengthy Disclosure and Barring Service (DBS) checks and costly compulsory immunisations that need to be paid for by the trust. Finally, the funding of the volunteer services (resources required for formal training, supervision, uniforms, ID badges, travel expenses etc.) often proves to be a major obstacle resulting in long waiting lists for volunteer training in some hospitals.

1.3.4 Southampton Mealtime Assistance

The Southampton Mealtime Assistance Study (SMAS) was the first large study to evaluate the impact of trained volunteers to assist with mealtimes on two female medicine for older people wards (8). It showed that volunteers can be successfully trained and integrated into ward healthcare teams to provide mealtime assistance in a safe and sustainable way. The volunteers were greatly appreciated by patients, their families and staff (28). Currently the programme is being rolled out across other wards (29). The potential candidates receive a half day training and after completing a successful competency check the volunteers take on the role of a mealtime assistant, usually 1-2 times per week. They help to prepare the patients by tidying the trolleys, wiping patients' hands, opening the packets/cutlery and if necessary they feed patients identified by a staff member.

1.3.5 Mobility assistance

The idea of using volunteers to assist older patients in hospital with their mobility is little explored. I undertook a systematic review to evaluate the existing literature and to refine my research question.

1.4 The use of volunteers to help older medical patients mobilise in hospital: systematic review

1.4.1 The aim

My aim was to provide a systematic review of studies describing the involvement of volunteers in mobilising older patients in acute medical wards.

1.4.2 Methods

A systematic review of the literature was undertaken according to the criteria of the Centre for Reviews and Dissemination from University of York (Centre for Reviews and Dissemination 2008). The study was registered with Prospero (registration number: CRD42014010388) and has been published (30).

Study criteria

The review included hospital based studies, projects or programmes in which volunteers assisted in the mobilisation of general medical inpatients aged 65 years and over. Multi – intervention trials were included if mobilisation was part of the protocol. I did not exclude non-English publications and I did not use publication year limits. Studies were excluded if they were conducted in non-acute healthcare settings, in non-medical wards, or were limited to specific neurological conditions such as stroke as I was interested in the use of volunteers on general medical wards for older people.

1.4.2.1 Search strategy

Search criteria were created using a combination of subject headings (where available) and free terms. The terms were divided into three groups: terms related to the setting (Hospital and Aged), terms related to the intervention (Exercise/Mobility + Delirium + Falls) and volunteer terms. The possibility of delirium and fall prevention programmes including volunteers as part of the intervention was reflected in the search terms. Boolean operators 'AND' and 'OR' were used to combine the searches. The electronic databases Ovid MEDLINE(R) 1946 to August Week 2 2015**,** Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations August 19, 2015, Embase Classic + Embase (1947 – 2015 August 19), Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Amed Allied and Complementary Medicine were accessed via EBSCOhost and Ovid SP. The Cochrane Library was searched using the terms: mobility, walking, older people, volunteers. In order to minimise publication bias the grey literature was reviewed. Google Scholar, Web of Science, Current

Contents Connect, BIOSIS Citation Index, BIOSIS Previews and Zetoc were searched using a combination of terms: mobility, walking, project, volunteer, hospital, elderly, older, patients. Google was searched using broad terms: walking, hospital, older people, and volunteers: the first twenty pages were screened. Reference lists in retrieved articles were hand searched for relevant articles. The searches were performed in August 2014 and repeated in August 2015. The search strategy undertaken in Medline is presented in Table 1.

Table 1 - Search strategy for: Ovid Medline (R) + Non-indexed (1947 – August 2015) 20-08-15

	Terms related to the setting
1	exp Inpatients/ or (inpatient* or in-patient* or hospitali#ed or ward*).ti,ab.
2	exp Aged/ or exp Ageing/ or exp Geriatrics/ or ((geriatr* or elder* or old*) or (6#year* or 7#year* or 8#year*)).ti,ab.
3	1 and 2
	Terms related to the intervention
4	exp Exercise/ or exp Exercise Therapy/ or exp Exercise Movement Techniques/ or exp animal assisted therapy/ or exp exercise movement techniques/ or exp musculoskeletal manipulations/ or exp Walking/ or exp Physical fitness/ or exp Rehabilitation/ or (rehabilit* or physical therapy or physiother* or (strength* adj 3 train*) or exercise* or walk* or ambulat*).ti,ab.
5	exp Delirium/ or exp Confusion/ or (delir* or confus*).ti,ab.
6	exp Accidental Falls/ or fall*.ti,ab.
7	4 or 5 or 6
8	3 and 7
	Volunteer terms
9	exp Voluntary Workers/ or exp Hospital Volunteers or (volunt* or unpaid or charit*).ti,ab.
10	8 and 9
11	exp stroke/ or (CVA or stroke or cerebrovascular accident).ti,ab.
12	10 not 11

1.4.2.2 Article selection and analysis

Titles and abstracts of all potentially relevant studies were assessed against the inclusion criteria by myself and one co-author (Dr Helen Roberts) working independently and any disagreements were resolved by discussion. Full texts of those articles selected by either author were retrieved and reviewed independently by both reviewers again to confirm that they met the inclusion criteria. Data were extracted from the articles included in the review by the two researchers working independently and using a pre-defined data extraction form. Information was extracted on study design, participants, training and intervention delivered by the volunteers, comparators used, analysis methods and reported outcomes.

1.4.2.3 Quality of studies

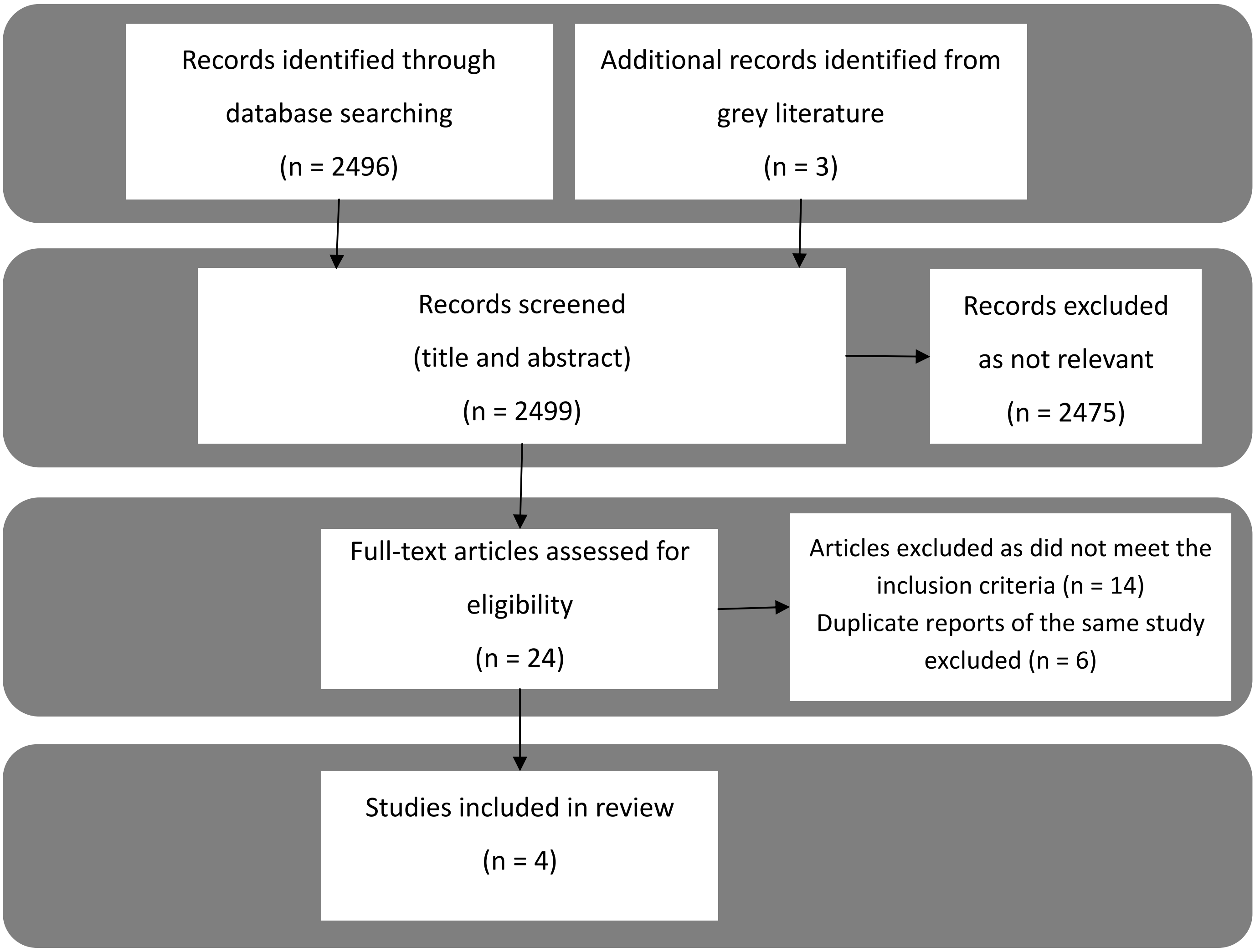
Studies included in the review were assessed for methodological quality by myself and the co-author (Dr Helen Roberts) working independently using published criteria with a maximum score of 27 points (Downs & Black 1998).

1.4.3 Results

1.4.3.1 Search results

The total number of articles arising from the electronic database searches was 2496 (See Figure 1). The Google internet search additionally identified three reports of quality improvement initiatives (the Footprints Walking Program, the ACTIVe Program, and Mobility is Medicine). Review of the titles and abstracts identified 24 articles which met the review inclusion criteria. After full text review, only twelve papers were still relevant, seven of which related to the Hospital Elder Life Program (HELP), and two related to the MOVE ON (Mobilisation of Vulnerable Elders in Ontario) study. Although MOVE ON was included in the initial review, at the time of writing this thesis the results are published (31) and do not include any reference to volunteers. Therefore, this study was excluded. References cited in articles that met the inclusion criteria were screened but yielded no new results. No relevant non-English papers were identified from screening of English titles.

Figure 1 - Flow diagram of search reslts (Adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA



1.4.3.2 Quality of studies

Of the four studies evaluated by two researchers only one (HELP) received a high score of 22. The remaining 3 studies scored low: Footprints at 3, ACTIVe at 2 and Mobility is Medicine at 5.

1.4.3.3 The Hospital Elder Life Programme (HELP)

The Hospital Elder Life Programme (HELP) (www.hospitalelderlifeprogram.org) is a model of care designed to prevent delirium and functional decline among hospitalised older patients (32)(33)(34). The programme aims to involve multidisciplinary staff and trained volunteers in the delivery of protocols addressing six risk factors for delirium; orientation, therapeutic activities, early mobilisation, vision and hearing protocols, oral volume repletion and sleep enhancement. The programme has been demonstrated to be effective in preventing and managing delirium and functional decline in sites in the USA and Australia (35). It has been disseminated to over 60 acute and community hospitals in the US (36), Australia (37), Taiwan (38) and Canada (39).

The early mobilisation protocol comprises ambulation or active range-of-motion exercises performed three times daily, but it is reported to have been implemented less often and less completely than the other protocols (for example 84% for mobilisation protocol versus 96% for orientation protocol)(32). It is unclear to what extent volunteers (rather than other health professionals) delivered this protocol. Volunteers were involved with the basic and enhanced mobility protocols at the community teaching hospital linked with the original site but implementation of these protocols was delayed because of an initial shortage of volunteers (35). Replication of the HELP programme at another community hospital in New Jersey did not include the mobility intervention because of reported staffing limitations (40).

The HELP programme has been evaluated in the UK to aid the design of the Prevention of Delirium, a randomised controlled feasibility trial in eight NHS hospitals (16 geriatric and orthopaedic/trauma wards (41). The results of this trial are awaited; however, it is unclear how much input was provided by volunteers rather than staff members. An initial participatory research study (42) which examined current knowledge and practices relating to delirium and delirium prevention in three UK hospitals found that the current practice of volunteer employment on the wards was not consistent or reliable. The authors recommended that there should be a clear support system in place to enable volunteers' participation in care and better communication with staff members.

In the Netherlands, the HELP programme was also evaluated in a cluster randomized, stepped wedge trial in two hospitals over a period of 20 months and the volunteers were successfully trained to deliver the protocol (43). Unfortunately, due to unforeseen difficulties with recruitment of participants, consent process and the unreliability of data collection the researchers were not able to draw any conclusions on the effectiveness of HELP in this setting.

1.4.3.4 The Footprints Walking Program

The Footprints Walking Program was implemented as a clinical quality improvement initiative in one acute hospital in the US (44). The objectives of the project were to maintain mobility and prevent deconditioning during hospital stay, with the aim of reducing length of stay, prevent complications of bed rest and increase patient and staff satisfaction. Over 50 trained volunteers assisted adult inpatients in daily 15-minute walking sessions and 20-25% of the inpatients were reported to take part every day. The project outcomes reported were increased patient and staff satisfaction and reduced length of stay. However, this programme was just one of many hospital-wide clinical service improvements and as such the outcome cannot be attributed solely to the volunteer-assisted mobilisation scheme.

1.4.3.5 ACTIVe Program – Aged Care Therapeutic interventions by Volunteers

The ACTIVe Program - Aged Care Therapeutic interventions by Volunteers – was developed in one acute ward for older people at an Australian hospital (45). Twenty volunteers were trained to provide a range of interventions aimed at improving patients’ experience and preventing functional and cognitive decline. The interventions included meal assistance, mobility assistance, companionship and therapeutic activities. Within a few months of implementing the programme an exercise class was created to engage patients in regular activity twice a week. Reported outcomes of the programme included a decrease in the frequency of one-to-one nursing care required for the patients at risk of falls and those with delirium, greater family involvement in patient care while in hospital as well as increased patient and staff satisfaction.

1.4.3.6 Mobility is Medicine

The Mobility is Medicine pilot project was implemented in 2011 on two acute care medical nursing units in a hospital in the USA (46). The aim of the programme was to increase the frequency of patient mobilisation, to improve communication around mobilisation and to increase the accuracy of nursing documentation. Six college student volunteers were recruited and received 3 hours of training with a physiotherapist and several hours of supervised practice. They delivered 200 mobility encounters during a period of three months, mainly walking the patients in the hallway. The intervention was not formally evaluated but the authors reported improvements in nursing documentation of patient mobilisation, patient reported mobilisation, and observed discussion of patient mobilisation by nursing staff in handover meetings as well as positive patient and staff perceptions of the programme.

1.4.4 Discussion

This systematic review has identified a lack of trials specifically designed to study volunteer-assisted mobilisation in older acute medical inpatients. The best current evidence comes from HELP, a well-designed and evaluated clinical controlled trial that included volunteers. However, the aim of this programme was to prevent delirium, and so the primary outcomes did not include mobility or functional level. Furthermore, the mobility protocol appears to have been one of the more difficult to implement in several different settings and it is unclear to what extent volunteers rather than clinical staff were involved with this protocol. Three small quality improvement initiatives, the Footprints Walking Program and Mobility is Medicine in the US and the ACTIVe Program in Australia, involved trained volunteers in mobilising patients and were reported to be acceptable and regarded as useful by patients their families and staff but were not otherwise formally evaluated.

The review identified only one study which was assessed as being of high quality (the HELP programme). The three quality improvement initiatives were assessed as being of low quality, although including them helped reduce potential publication bias. It is possible that other examples of small scale quality improvement initiatives were not identified.

Many hospitals have an established volunteer workforce, whose tasks are typically centred on talking to patients, helping with refreshments for patients and staff, conducting patient surveys and administrative support for clinical staff. The benefits of early mobilisation of adult inpatients are well recognised and include physical effects (improved physical function, fewer medical complications), psychological effects (less anxiety, depression and emotional distress), social effects (improved quality of life and independence) and organisational outcomes (reduced length of stay and cost)(47). Trained volunteers could help maintain older patients' mobility during hospital admission and support time-pressured staff but further research is required to evaluate this extension of the volunteers' traditional role.

1.5 Qualitative studies relating to volunteer-led mobility

Prior to implementation of any innovation in hospital it is crucial to present the stakeholders with the idea and gather their opinion about it. I have not come across any papers that specifically explore the views and perceptions of older patients, their families and different staff groups with regards to volunteer-led mobilisation. Given the relative novelty of this idea with all the potential risks and concerns, it would be sensible to devise a study that addresses this knowledge gap.

1.6 Rationale for method selected

The literature review identified a lack of research that specifically applies to inpatient volunteer-led mobility programmes. WHO recommends that all relevant parties are consulted prior to implementation of national healthcare policies and strategies (48). These views are essential to develop a deeper understanding of a particular area of interest, to find out about the issues and concerns of the stakeholders that may not be always apparent, to ensure that the strategy is fit for purpose in the specific environment, to anticipate any potential problems, to promote discussion and exchange of ideas. In the UK, there is a requirement by the Department of Health to involve service users in all stages of research (49). Thus, this study is in line with general recommendations because it aims to gather the opinions and views of all relevant parties concerning a new mobility enhancing strategy.

1.7 The purpose of the study

1.7.1 The aim of the thesis

The aim of my thesis was to explore stakeholders' views and perceptions surrounding the mobility of acutely hospitalised older people and the acceptability of using volunteers to assist with early mobilisation.

1.7.2 The research objectives

1. To conduct semi-structured interviews with patients, family members, staff and volunteers on wards for older people.

2. To identify barriers to mobilisation on acute wards for older people.
3. To create a recommendation for other researchers and stakeholders which they could use to address sedentary behaviour in hospitals and to implement volunteer-led mobilisation programmes.

Chapter 2: Methodology

2.1 Study design

> Neither quantitative nor qualitative methodology is in any ultimate sense superior to the other. The two approaches exist along a continuum on which neither pole is more 'scientific' or more suited to … knowledge development.
>
> **Williams et al 2011**

2.1.1 Qualitative versus quantitative methods

In order to choose the most appropriate method for my research I considered the differences between quantitative and qualitative methodology. These are summarised in Table 2.

Table 2 - Comparison of quantitative and qualitative research – adapted from multiple online sources

Quantitative research		Qualitative research
To test a hypothesis	Purpose	To generate hypothesis or develop ideas
To measure and test	Approach	To observe and interpret
What? Who? Where? When?	Questions answered	How? Why?
Large and random	Sampling	Small and purposive
Surveys, experiments	Methods	Interviews, focus groups, observations
Artificial	Setting	Natural
Numerical Hard, reliable	Type of data	Non-numerical Rich, deep
Strongly structured Confirmative Generalizable	Data collection	Unstructured or semi-structured Explorative Non-generalizable
Statistical	Analysis	Interactive (non-statistical)
Distant	Researcher	Close
Objective	Results	Subjective

The purpose of my research was to explore beliefs and opinions about a certain topic rather than to test a particular hypothesis. My research question was: what are stakeholders' views and perceptions surrounding the mobility of acutely hospitalised older people and the acceptability of using volunteers to assist with early mobilisation? I wanted to know how patients and their relatives perceive the hospital environment, what they think and observe about physical activity on the wards and whether they see a potential in volunteers increasing mobility of patients. These questions call for a qualitative design which enables the participants to express their unique views, which creates a time and space where new meanings can be developed and which allows for the data to be rich and diverse without the need to fit into predetermined criteria. I did not think that a survey would be appropriate in this context as it would be too restrictive, preventing a free flow of ideas and impressions which are often crucial to understanding of a complex subject. My aim was to explore rather than confirm, to listen rather than measure and to interpret rather than test. Instead of looking for objective measurements in a large sample, I was interested in subjective beliefs of a relatively small sample. Thus, qualitative methods lent themselves better to gather in-depth data coloured by participants' unique personalities and experiences which after thorough analysis serve to develop a complete, real-life depiction of the examined phenomena.

2.1.2 Types of qualitative research

There exist five common qualitative approaches which differ in their goals, data collection and analyses. These include: narrative research, phenomenology, ethnography, grounded theory and case study. They are usually associated with a specific discipline and underpinned by certain philosophical ideas which shape the process of analysis. Narrative research comes from anthropology and literature and aims to develop a narrative about a story of an individual; phenomenology is derived from philosophy and describes shared experiences of individuals; grounded theory is a sociological method that by analysing interviews through coding generates a theory illustrated in a diagram. Ethnography comes from anthropology and involves complete immersion in the culture or situation for example by becoming part of the studied population (in a school, workplace or prison). A case study refers to an in-depth, rich and varied analysis of a single person, group of people or organisation and aims to explore how a complex set of circumstances result in a particular manifestation (50).

Another qualitative method, The Framework approach, was developed in the 1980's by social policy researchers (51) and has since been widely adopted for use in health research. It acts rather like a flexible tool and is not connected to any particular philosophy. Framework is a type of thematic (qualitative content) analysis and it can be used in many different qualitative approaches which generate themes (52). It can be used with both deductive (starting with a theory and working to confirm it) and inductive methods (starting with an open mind, generalising towards creating a new theory). Although the former method is often associated with quantitative research and the other with qualitative research there are no set rules and any particular piece of research could be placed somewhere on the inductive-deductive spectrum and combine both approaches according to the need. This method is commonly used to analyse semi-structured interviews, but could be adapted for other types of textual data such as diaries or field notes from observations.

2.1.3 Rationale for method selected

In qualitative research different tools can be used to gather data: interviews, observations, documents, artefacts or video and audio records (53). Interviews are used most commonly and include verbal exchange between the researcher and the participant, who can use their own words to express their view (54). There are several types of interviews including face-to-face interviews, focus groups, telephone interviews and video conferencing. Individual interviews can be used to allow for confidentiality and privacy, when the topic is sensitive, to gain a wide range of different views in order to understand a complex phenomenon and where little is known about the subject of interest. In contrast, focus groups are used to promote discussion and exchange of thoughts among a group of people guided by the researcher. They are used in order to explore 'the shared wisdom' of the group, where there may be a range of views and the disagreements among the participants are of interest to the researcher or to find a consensus on how to best achieve a certain goal (54).

The interviews can be structured, semi-structured or unstructured (54). The structured interviews contain a set of predetermined questions and a selection of answers. This allows for high reliability and validity of the collected data, makes the analysis straightforward and akin to quantitative methods but is limited in depth. Semi-structured interviews contain some closed and open-ended questions allowing the researcher to gain answers to specific questions as well as to flexibly probe the respondent to elaborate on a particular topic or follow a new line of inquiry. Unstructured interviews allow for free flow of conversation and more flexibility in asking questions; they allow the participant to speak for themselves, they can be used where there is a diversity of respondents who may express different worldviews and where the focus is on subjective human experience. They are more time-consuming than other forms of interviews to analyse but provide a much more in-depth understanding of the examined phenomena.

In my research I used semi-structured interviews because I wanted to answer specific questions while allowing for some flexibility in probing new ideas. I also used focus groups for staff to initiate useful discussions and thought exchange among those who would be directly affected by the volunteer-led mobilisation. I conducted all of these face-to-face as it was the most feasible and natural option given the fact that many of my participants were older inpatients based at a university hospital.

As a method of analysis I decided to use the Framework which provides a clear structure and suitable tools for analysing focussed healthcare related data.

In the next paragraph I will explain the rules about applying the Framework.

2.1.4 The Framework method

The Framework method starts with transcription of the interviews (stage 1) which can be either done by the researcher (which allows for immersion in the data and pre-analytic reflection) or can be delegated to save time (it usually takes about four hours to transcribe one hour of an interview and longer to transcribe a focus group) (52). The next step (stage 2) is to become familiar with the transcript, to 'immerse yourself in the data' followed by a careful reading of the transcripts line by line and application of interpretive labels or 'codes' (i.e. indexing) (stage 3). This stage is described as open coding if no particular framework is used prior to the process; if it is more deductive, the codes will be pre-defined, based upon previously researched areas of interest. This is ideally performed by two researchers. After coding of a few transcripts, the researchers should meet to compare their work and create higher level categories in order to develop a working analytical framework upon which subsequent analysis can be based (stage 4). This framework should be applied to analyse the rest of the transcripts (stage 5) but will likely need to be revised a few times until a final most suitable version is established after coding the last interview. Stage 6 involves charting of the data into the matrix of the framework, usually using a spreadsheet. This is performed by summarizing the data by category and linking it with an example quote. Interpreting of the data (stage 7) may involve identifying commonalities and differences within the data sets, mapping out connections, generating typologies and examining prior or new concepts. This process could lead to explanation of certain phenomena, clarification of subjects' responses and reactions to a situation or identification of important issues within a system and ways of dealing with them. See Table 3 for a summary of these steps.

Table 3 - The Framework method stages

adapted from Gale et al. BMC Medical Research Methodology 2013 13:17 (52)

Stage	Explanation
Stage 1 Transcription	Transcription of the interviews or focus groups by the researcher or a trained transcriber
Stage 2 Familiarisation	A process in which the researcher becomes familiarised or immersed in the transcripts
Stage 3 Indexing	Applying labels ('codes') to parts of text
Stage 4 Development of a working analytical framework	Based on the first few transcripts a framework is developed to aid the analysis of subsequent transcripts
Stage 5 Application of the framework	The framework is applied during further analysis and revised in the light of new data emerging
Stage 6 Charting	The indexed data is charted into the framework
Stage 7 Interpretation	Analysis of the key characteristics as laid out in the charts, aimed to provide a schematic diagram of the phenomena to guide the interpretation

2.1.5 Ethical considerations

This study required ethical approval which I gained from the Newcastle and North Tyneside 2 Committee Health Research Authority (LREC number: 13/NE/0276 – Appendix 1). I present Research and Development approval in Appendix 2 and the study protocol in Appendix 3. Firstly, I considered the risks involved in participation which included possible distress or unease as a result of the interview questions. Should a situation like this occur, the interview would be stopped and support offered to the participant. Depending on the participant's view, the interview would then be either concluded or if possible, rescheduled to another time. All potential candidates were be provided with an information sheet and given at least 24 hours to make a decision about whether to participate or not. Written consent was gained prior to the interview with explicit consent to audio recording. Confidentiality was ensured by identifying the participant by a study number only, anonymising the transcripts and keeping the personal details (names on consent forms) in a study site file located in a locked office for the required period of time. The participants were informed that they may withdraw from the study at any point without their care being compromised.

2.2 Study materials

2.2.1 The interview guides

I designed semi-structured interview guides which contained open and closed questions. On one hand, this was to enable the interviewee to express their own opinion and allow an unrestricted flow of thought. On the other hand, given the time constraints of the participants in a busy clinical environment I had to involve specific questions to guide the conversation in the right direction. I created three different interview schedules: for patients, for family members and for staff (see Appendices 4, 5, 6).

In the patient interview schedule I started with general questions about how they were feeling while in hospital. This aimed to establish a rapport with the participant and explore their general attitude, mood and any important experiences. In the family schedules, I probed their feelings with regards to their relative being on the ward. This question opened up the conversation and guided me with regards to the participant's frame of mind.

In the staff/volunteer schedule I first asked about how they visualise an older person in hospital. I was interested in what would be their main associations and whether they would be similar between the different groups of staff. In an attempt to gauge their opinion about the level of care provided on the wards, I used another visualisation: of their own relative being admitted into the ward they work on. I then explored advantages and disadvantages of hospitalisation, patient's normal and current activity level as well as views on physical activity in older age in general and in hospital. I specifically asked about the awareness of the risks of bed rest in all participants to identify any educational needs in this respect. In the staff/volunteer schedule I also asked about the current mobilisation practice, about how the responsibility of mobilising patients is shared among staff, what their opinion is about current and ideal levels of activity. Following these background questions, I then focussed on barriers to mobilisation, views on volunteers in general and the concept of volunteer-led mobilisation. I also asked what changes would be most imperative for the participant if they had the right resources to introduce them.

In addition to the above, in the patient schedule I included a question about coping with mobility limitations to gain some insight into how older people manage and adjust to reducing mobility.

The last question pertained to family participation in care. I wanted to find out how families are viewed by staff, whether they get involved in the care of relative in hospital, which aspects in particular and possible reasons for not doing so. This question also explored patient acceptability of family providing care in addition to paid staff. I aimed to interview staff from different cultural backgrounds (such as other European/Asian/African origin) as their opinions and experiences of different healthcare systems could vary significantly.

2.2.2 Information sheets and consent forms

In addition to the interview guides I prepared information sheets for patients and staff in accordance with Research Ethics Committee (REC) guidelines. These were separate for patients, family members and staff/volunteers (see Appendices 7, 8). They were composed of two parts. The first part contained: general information such as the purpose of the study, why they were chosen to take part, an assertion that they do not have to participate and information on what will happen next if they agree to participate and what could be the potential risks and benefits of taking part. In the more detailed second part I clarified confidentiality arrangements, the right to withdraw from the study at any time, arrangements regarding a potential concern or complaint, details of ethical approval and funding source, plans for dissemination of results and contact details for myself and the Principal Investigator. The information sheets for patients and family members were printed in a larger font 16 to account for any visual problems.

Informed consent is a crucial element of research and there are specific requirements about its structure from the REC. I prepared two types of consent forms: one for patients and one for staff and family members (Appendices 9, 10). There were five sections on the form which had to be signed by the participants: confirmation that the appropriate version of consent form was read and understood, confirmation that they are aware they can withdraw from the study at any time, consent to audiotaping, consent to further contact by research team and finally consent to participation in this study. I assigned a study number to each participant which contained a letter and a subsequent number (in order of interviewing).

2.2.3 Setting and participants

The study was conducted at a university hospital between 06-01-2014 and 12-10-2016. This is a large teaching hospital with about 1400 beds and 10000 of staff. There are five wards for acute medical patients aged over 80, with a total of 130 beds.

I recruited participants using purposive sampling, which is defined as 'deliberate selection of specific individuals, events or settings because of the crucial information they can provide, which cannot be obtained as adequately through other channels' (55). Therefore, I decided to interview older patients hospitalised on the five wards, family members of older patients and a range of healthcare professionals including doctors, nurses, physiotherapists case managers and also volunteers. I chose to interview patients and family members separately for confidentiality and feasibility reasons. I was aiming to conduct focus groups with various staff groups selected by profession and grade but had to adjust my plan according to staff availability (especially so for nursing staff and the consultant geriatrician). Focus groups were preferable because of the group dynamics and creation of a space where ideas can be developed, shared and questioned.

2.2.3.1 Patients

I systematically screened the five Medicine for Older People wards to find patients who fitted a set of predetermined criteria. I used the following eligibility criteria: stable medical condition, Abbreviated Mental Test Score (AMTS) 9-10, hospitalised for at least 1 week and likely not to be discharged within 2 days, ambulatory 2 weeks prior to admission with or without aids, able and willing to be interviewed. Patients who were unwell, dysphasic, confused, cognitively impaired or unable to mobilise 2 weeks prior to admission were excluded. These criteria were presented to a senior member of the nursing staff who identified those eligible and asked them if they would be happy to speak to me. After this initial verbal consent I spoke to the patient, offered them information about my study and left the information sheet with them. I would then agree with them that I would return the next day to see if they were interested in taking part.

As the sampling technique was purposive I used a set of three criteria to select a diverse sample of patients: age (younger and older than 75 years), men and women and those living alone or with others. Later during recruitment I found that I had to recruit any eligible and agreeable patients as the choice of different characteristics was limited.

I used a log to record all patients approached, their age, Abbreviated Mental Test Score (AMTS) and accommodation, whether agreed or refused to read the information sheet, reasons for exclusion and whether consented or not.

2.2.3.2 Family caregivers

Family members were chosen on the basis of being a regular visitor to a patient and being willing to take part in an interview. I was aiming to recruit a selection of older and younger females and males. Similarly to patient recruitment, I first asked the ward staff about any family caregivers who visit a patient on a regular basis. After initial consent obtained by the staff member I would then approach the family caregiver with the information sheet and make an appointment to meet them after more than 24 hours to see if they would agree to take part. It was much more difficult to recruit family members than patients as they came in to hospital at different times, often during the weekends or evenings only. Many of them did not have a chance to observe the ward long enough to form particular opinions about patient mobility.

2.2.3.3 Doctors

I aimed to recruit different grades of doctors and group them by level of seniority into focus groups. Firstly, I approached the doctors at a lunchtime meeting to inform them about the study and to distribute information sheets. I received two replies and arranged for a focus group to involve those two doctors. One of them could not attend but the other doctor (a senior house officer SHO) came with an interested Foundation Year 1 doctor. I approached Specialist Registrars directly on the wards and agreed a date for focus groups to suit their clinical schedule. I also interviewed one Medicine for Older People Consultant.

2.2.3.4 Nursing staff

My aim was to recruit a variety of nursing staff from different study wards and from all levels of seniority. Initially, I attended handover meetings to distribute the information sheets. However, nobody volunteered to participate. Thus, I decided to approach the nurses on the wards. By that time, I was able to offer a shopping voucher as an incentive (this was financed from my academic bursary in agreement with my Supervisor) which aided my recruitment. I arranged three interviews with staff nurses and a healthcare assistant, which took place on their ward, one focus group involving healthcare assistants and a student nurse and one focus group with three ward sisters (one contacted me via e-mail and the other two were encouraged by her colleague to attend).

2.2.3.5 Case managers

I contacted case managers (now called Older People’s Practitioners –OPP’s), who come from different backgrounds (e.g. nursing or therapy) and whose role is to create individualised plans for new patients and act as coordinators of patients’ journey in hospital. I spoke to one of them directly in their office and asked to find a date that is suitable to arrange a focus group.

2.2.3.6 Therapy staff

I met with the head physiotherapist and explained the details of the study leaving several information sheets with her. The interest among the physiotherapists was strong and two focus groups were arranged. Six physiotherapists and one occupational therapist participated.

2.2.3.7 Volunteers

I contacted the mealtime volunteers via their e-mails and received three responses. The interviews were arranged to suit their timetable.

2.3 Data collection

I collected data using either individual interviews or focus groups. All participants were formally consented and the consent forms were held in the study site file in a closed office.

2.3.1 Patients

All patients were interviewed at their bed space on the wards. This was the most feasible way as most of them had mobility limitations and there was no suitable room that I could use on the wards. Prior to starting an interview I always ensured that the patient was comfortable and checked with their nurse, so that I would not interfere with their clinical care. In case the interview clashed with any aspects of care, visits or mealtimes, I would either reschedule or return later to continue. Altogether, I interviewed 20 patients. The characteristics are displayed in Table 4.

Table 4 - Patient characteristics

Female (in bold)/male	lives alone	care home/lives with family
Younger (<75 years)		P03
Older (>75 years)	**P01**, **P02**, P04, **P06**, P07, **P11**, **P13**, **P16**, P19	**P05**, P08, **P09**, P10, P12, **P14**, **P15**, P17, P18, P20

2.3.2 Family members

For family members I booked a private space using either one of the seminar rooms next to the wards or one of the research offices. This ensured privacy and allowed the caregivers to be honest when talking about care received by their relatives. I interviewed seven family members whose characteristics are shown in Table 5.

Table 5 - Caregivers characteristics

	Female	Male
Younger (<75)	F02 F03 F05	F04 F06 F07 F01
Older (>75)		

2.3.3 Staff members

Nursing staff were either interviewed separately in a staff room on their wards (after agreement with the ward manager) or focus groups were arranged in the research seminar room. Doctors were interviewed in their offices or in the research seminar room. Therapy staff and case managers participated in focus groups in the research seminar room. In total, I conducted nine interviews and eight focus groups with 28 staff members.

2.3.4 Volunteers

The three interviews with the volunteers were conducted in the academic offices available at the time. The characteristics of staff members and volunteers are displayed in Table 6.

Table 6 - Staff and volunteer characteristics

Participant code	Role	Gender
D01	GP trainee	F
D02	Foundation Year 1	F
D03	Specialist Registrar	F
D04	Specialist Registrar	M
D05	Specialist Registrar	F
D06	Consultant Geriatrician	F
N01	Ward manager	F
N02	Ward manager	F
N03	Ward manager	F
N04	Healthcare assistant	F
N05	Staff nurse	F
N06	Healthcare assistant	M
N07	Staff nurse	F
N08	Healthcare assistant	F
N09	Healthcare assistant	F
N10	Student nurse	F
N11	Healthcare assistant	M
N12	Healthcare assistant	M
PH01	Physiotherapist	F
PH02	Physiotherapist	M
PH03	Physiotherapist	F
PH04	Physiotherapist	F
PH05	Physiotherapist	M
PH06	Physiotherapist	F
OT01	Occupational therapist	F
C01	Case manager	M
C02	Case manager	F
C03	Case manager	F
V01	Mealtime volunteer	F
V02	Mealtime volunteer	F
V03	Mealtime volunteer	F

2.3.5 Consideration of the researcher’s background

When interviewing patients, I have not informed them of my clinical background (Specialist Registrar in Care of Older People), but instead introduced myself as a researcher working for the University. When recruiting staff members, I could not conceal my qualifications because I have previously worked in this hospital as a Specialist Registrar and knew many of the respondents. Despite the possibility of bias, my personal experience of the issues on the wards has helped me to empathise with my respondents, create an atmosphere of mutual understanding and guide the conversation accordingly to elicit relevant information.

2.3.6 Transcription formalities

All the interviews were audiotaped on a digital recorder, each participant was assigned with a code and no personal details were used in the transcript. The recordings were sent via a safe system to a university approved transcriber who transcribed them verbatim. The data were anonymised using participant's code. The transcripts were of very good quality with only occasional misspelling of words that I was able to correct when reading or by listening to the recording.

2.3.7 Data analysis

I analysed the data using the Framework approach and Microsoft Word. Initially, I read through all patient transcripts to gain a general view and immerse myself in the data (stage 2). I used the interview schedule as the initial framework for analysing the patient data using codes. I re-read the first three transcripts and assigned each piece of data with the most suitable code (stage 3); I ordered the codes by attributing to them higher level categories – see table 6 and 7, (e.g. a code 'lack of space' would be attributed to the broader category of 'environmental barrier') and so creating a working analytical framework (stage 4). Next, the working framework was applied to the first ten interviews by myself and the second coder simultaneously (stage 5). We met to compare the analyses and to adjust the framework according to the emerging new categories. This was achieved by going through each transcript and comparing how we coded the data. We would discuss any disagreements among ourselves and also with my academic supervisor. We followed the agreed framework for the remaining patient transcripts adjusting it during subsequent meetings. Any pieces of data that did not fit into the framework would be placed under the miscellaneous section to be reviewed at a later stage. The final framework was reapplied to all transcripts (stage 5). A similar process was followed separately for family members, staff and volunteers. The detailed coding system is displayed in Table 7 and 8. Stage 6 (charting) of the analysis was performed by pasting the appropriate quotes into the created framework. I created separate tables for patients, family caregivers, different staff groups and volunteers using the final frameworks to systematise the quotes. In Appendix 8 I give an example of the barriers to mobilisation theme with quotes from all doctors. The interpretation of the data (stage 7) involved analysis of the key characteristics, identifying similarities and differences among different participants, systematising emerging ideas , finding associations and providing explanations.

Table 7 - Barriers to mobilisation. A list of codes and how they were grouped into categories

Code	Category of barriers to mobilisation
Lack of space No goal/lack of stimulation Location of facilities Infection spread Hospital routines/institutionalisation Inappropriate clothing Lack of equipment	Environmental/organisational
Lack/loss of motivation/low mood Anxiety/fear of falls Medical condition/treatments Confusion Pain Health and safety issues (patient related) Lack of knowledge/awareness of bed rest risks	Patient related
Anxiety/fear of falls Hands-off culture Lack of knowledge/awareness of bed rest risks	Family related
Staffing levels/Staff time Lack of encouragement/discouragement Staff education/confidence issues Health and safety issues (staff related)	Staff related

Table 8 - Volunteer-led walking programme. A list of codes and how they were grouped into categories

Code	Category
Suitable patients Identification system Recognition of unwell patient Patient motivation	Patient selection
Personal characteristics/background experience The role of a volunteer i. Mental stimulation ii. Patient interaction iii. Mobility maintenance iv. Falls class v. Chair exercises vi. Guiding/accompanying Legal responsibility Direct supervision Education and training Competency checks	Volunteer selection
Timing Space Hospital routines Health status of other patients	Environment
Professional clashes Extra work for nurses Education of staff re volunteer role Potential miscommunication	Staff related

The main five themes which emerged from the analysis were:

The hospitalised older person

Mobility in hospital

Barriers to mobilisation

Volunteer-led walking programme

Proposed changes

2.4 Summary

In this chapter I presented my rationale for the selected qualitative method which includes data collection using semi-structured interviews and focus groups and the Framework as the analytical tool. I described how it fits with the objectives of my research and how I applied it to analyse my data. I also described the study procedures including development of the study materials and recruitment of participants. The process of coding and categorising is presented and examples of thematic framework are displayed in the tables. In chapter 3 I will present the five main themes derived from the analysis.

Chapter 3: The hospitalised older person

In this Chapter, I present views of the respondents around hospitalisation of older people in general, further enlarging upon particular advantages and disadvantages of being in hospital according to the various groups of interviewees.

3.1 Patients' and relatives' general perception of hospital

Patients recognised that they needed to be in hospital and appreciated the care they received. Often, their general impression of hospital was very positive, they stressed the quality of medical and nursing care, kindness of staff, and high level of cleanliness. Although noise or lights at night prevented them from having a good night's sleep they accepted that tolerating this constitutes part of a patient's life in a busy hospital:

> Well you can't really complain. They are all doing their best. I have never had any complaints about the NHS, and it's not their fault that I can't sleep at night because of noise or lights or anything else like that. P13

They regarded themselves as 'lucky' when comparing this hospital to other hospitals but understood that differences are unavoidable as in any other area of human life:

> I think we're lucky with this hospital here. I mean there are some, obviously some hospitals that aren't as good as others, but then that's life. It's the same whatever it is, some businesses are better than others, and so that's human nature and that's life as it is, so you've got to be a bit philosophical about it. P08

An overt discontent about hospitalisation was usually balanced by the understanding that current circumstances required them to be here:

> I don't like being in hospital, but I realise that it's essential to be here and I must say that people are very kind. I feel that there is a benefit in it. P02

Patients' family members recognised the need for admission to hospital and that certain treatments had to be provided in the acute setting. Hospitalisation was often the final outcome of a gradual deterioration at home and provided a relief for the worried family.

> (…) He's in the best place. He's responding very well to treatment, so I can't fault the nursing staff. F04

However, some of the caregivers expressed a negative opinion of the hospital. They felt that their relative was not receiving the right support and was declining gradually, becoming more and more dependent. Two of the relatives wanted to take their parent out of hospital as soon as possible. I describe this in more detail in the disadvantages of hospitalisation section.

> He seems to have been here a long time, and I don't think he's improved very much. In fact he's gone downhill, from his mobility point of view. So we are a bit disappointed and we're looking forward to getting him home. F03

3.2 Staff and volunteers' perception of the hospitalised older person

The three case managers painted a picture of a frail, confused and dependent patient whose admission to the hospital was often a result of a 'crisis'. Typically, the hospitalisation was only the culmination of a progressive decline and the underlying additional diagnoses and complex needs had to be unveiled during careful multidisciplinary assessments.

> I feel that they come in with one reason, but actually that you have to look at the holistic, you have to look at the whole person, because actually they've got a lot of co-morbidities to go alongside with it. C02

The doctors' vision of a patient on a geriatric ward was that of an older confused lady, lying in her bed, with visual impairment, whose tray with glass of water was out of reach, but who was too shy to ask for help from a staff member. The view was also that patients were part of the generation who often saw themselves as 'a burden' and 'a trouble' and would not like to 'hassle people' (D03) with addressing their needs.

Two of the junior doctors noticed the particularly strong emphasis on safety of confused patients with increased level of supervision and mattresses being put next to patients' beds to prevent fall-related injuries.

> And there are things in place to, I mean you see on the wards floor mattresses to make sure they don't fall out of bed and hurt themselves, so there are lot more safety precautions in place in hospital that they may not have in their own homes. D01

One of them also expressed her sympathy towards the patients she encountered.

> I feel quite sorry for them and I think I like old people, so I feel quite a lot of sadness for them sometimes. I think when they come into hospital they're usually not coping and they're unwell, so we don't ever really see them at their best. D02

Similarly, the volunteers' empathy was clearly displayed in their ability to identify with the patients they look after. They noticed how being 'out of their usual environment' (V02) could make vulnerable people feel frightened and how they often simply needed to be listened to. They also noted that patients were very ill and therefore dependent on people caring for them.

> You know they're frail, and they need your help. You know, so, and understanding you know and being listened to, because you know I've found since I've been doing the MTA, sometimes they just need you to talk to them or you know just listen to them and things like that. V03

A senior doctor highlighted the huge difference between a fitter person with a single medical problem and a frail person with a range of co-morbidities and a complex social background.

> So the older person that comes into hospital tends to have multiple problems, they tend to be frailer. The ones who are fitter and have a single system problem tend to be turned about quicker, so the ones that are long stayers tend to be multiple comorbidities, chronic disease, often very complex social situations, but there's a large variety within that… D06

The therapy staff stressed in particular the fact that the patient was taken out of their familiar 'micro' environment which in itself could cause multiple problems and destabilise an older person (in contrast to a younger one) who would otherwise function reasonably well in their own home.

> I think it affects them more profoundly than it would any other age group (…) older people that are coming out of sometimes micro environments that they've been in for a significant amount of time, that when they're put into a situation like a hospital environment where there's so many different environmental factors for them to be looking and coping with and taking in, that that then has quite a profound effect on their cognition. PH05

One ward manager questioned whether a particular patient in front of her needed to be in hospital or whether they would be better looked after in the community.

> So probably the first thing is not, is actually is it the right place for them to be. And that's quite, that's at the forefront of our minds, in terms of should they be here or should they be in their homes or in a nursing home, or somewhere else. N01

For another senior nurse the first thought related to a geriatric ward is simply of ’an older patient lying in bed’ (N02) which in itself says a lot about the general context of immobility in hospital and could be used to sum up the general impression of an older person in hospital: lying in bed rather than walking.

3.3 Advantages of hospitalisation

3.3.1 Medical and nursing care

Patients accepted the fact that they were recovering from serious illnesses thanks to the care they were receiving from doctors and nurses. This was stressed at multiple points during the interviews.

> And they organised the admission and they organised the ambulance. I got here about three o’clock in the morning. They looked after me pretty well. They examined me on arrival (…) Anyhow, they treated me perfectly well. P07

Similarly, the family members appreciated the quality of care received by their relative. They showed great insight into how the wards worked and how much input an older patient required from the constantly time-pressured staff. They also admired the dedication of the nurses and the way they approached the patients who might sometimes display challenging behaviour.

> Well the only thing I can say is the nursing staff have been absolutely fantastic. But you know, I really do admire them because I couldn’t do it. Not the amount of hours they do, and they’re literally here, there and everywhere. You know as soon as a buzzer goes they are off again. It’s, they’ve got a really difficult job and some patients haven’t got any patience (...) F04

One relative appreciated the geriatric expertise in managing patients with dementia not only on wards for older people but also in other parts of hospital. He compared how previously nurses would ‘just let them shout’ and would ‘zone it out and carry on with their job’. Whereas now, ‘they do one-on-one with them’ (F02) showing ‘enormous’ understanding of the needs of patients with dementia.

Likewise, all staff groups described the hospital as a source of expert medical and nursing care which would be otherwise inaccessible from the community. The older patient was often very complex and the teams involved needed to have the required skills and knowledge to be able to deal with this complexity.

> A lot of our patients need to be in hospital. I don't think you can, you shouldn't view hospital admission as a failure. Some people actually really need to be here and to get the care they need to make them better. D04

> One of the ward managers expressed the hope that as a result of this 'picking up on things and sorting out' patients would have 'a better quality of life for longer' (N02).

3.3.2 Level of hygiene

The level of hygiene was mentioned by patients on a few occasions. This seemed an important issue to them, possibly due to previous experiences:

> I was in hospital during the war, with a head injury and I always remember the pillow had blood on it. And I left a week later and the pillow with the blood on it was still there. I didn't think anything of it, because we didn't expect any else… (P02)

The interviewees had a lot of time to observe the cleaners performing their daily tasks and appreciated that nowadays the standards of hygiene were much higher.

3.3.3 Attention

Patients often felt confident and hopeful about the recovery process due to the fact that the staff attended to them and were proactive in meeting their care needs. Some patients who lived on their own or did not socialise regularly enjoyed the 'reassuring' (N01) attention of nurses and other staff while hospitalised.

> (…) I think they like someone to talk to. The number of ladies that say that at home there's no-one to talk to and they just like the company; that's quite sad isn't it to say, but we do get that. N01

One patient (P14) remarked that she is being 'spoilt' as many aspects of care were being done for her. This could be viewed as positive from the patient's perspective, but at the same time it contradicted the idea of early mobilisation and facilitating independence.

3.3.4 Communication

One family member praised the level of communication he received from the medical team and the way doctors engaged with his mother. He pointed out that ‘doctors are very good at communicating, because it’s quite a skill’ (F02).

3.3.5 Place of safety

Doctors and a volunteer also described the hospital as a place of safety for patients who were not copying at home. This applied in particular to patients who lived on their own and had no social support, therefore provision of 24 hour care for them was sometimes the only way to ensure their safety at this point of time.

> Well if they’re living alone they’re safer. V02

3.3.6 Safe discharge

According to staff nurses, once the patient had recovered, the discharge process commenced and included assessment of the multidisciplinary team (MDT) regarding their particular needs to be addressed. A safe discharge was a priority, but often could be complex and prolonged, causing frustration to all involved – I describe this later in this chapter.

> I think the main advantage is that the hospital doesn’t like discharge them if they are not going to have a really good support at home. N05

3.3.7 Multidisciplinary team (MDT) assessment and investigations

According to staff, all the necessary assessments, investigations, treatments and planning happened more easily and smoothly in hospital, during a relatively short period of time in comparison to the community as ‘most of the team are here’ (D05). The patient who had been resistant to help for a long time might finally come to realisation that they required some level of support. Other patients might have not been aware of services available to them and thus hospitalisation initiated the necessary support. While they were an inpatient, it would also be easier to perform investigations which for one reason or another might have been not feasible in the community. A case manager highlighted that patients are often seen ‘at crisis point’ (C01) and MDT ‘can put the things in place to properly manage them’ (C01).

3.4 Disadvantages of hospitalisation

3.4.1 Insufficient staffing levels

Low staffing levels were mentioned by all respondents as the main problem on the wards and the cause of substandard care. Nursing staff often had to prioritise the basic care (washing, changing, turning in bed, administering medication) over other care needs. For example, according to therapy staff it was sometimes easier to bring a commode to a patient than assist them with walking to the toilet. Nevertheless, patients often displayed a great level of understanding and patience towards the overstretched nurses.

> Sometimes you're perhaps on the commode a bit too long, but you can't help that because of the staff shortage you know and they come when they can and that's it. P15

> I mean they haven't got enough staff have they, this is the problem. It's all down to staff, and then they do their best. P16

Due to staff shortages some aspects of care were taken over by family:

> Luckily, we were there with mum every day and she was really poorly and we did need to feed her; had we not been there to feed her I think she would have perhaps not done quite so well. (F05)

However, there seemed to be little guidance as to what they were allowed to do especially with regards to helping other patients:

> I stepped in to try and help feed somebody because her relative asked if I would do that, and so I did, but because he didn't clear it with the ward sister there was a bit of a… and she didn't like it and they wouldn't let me do it. (F05)

There was a sense of frustration among the family caregivers associated with unnecessarily prolonged hospitalisation of their relatives which they viewed as a failure of financial planning in the NHS:

> There doesn't seem to be enough staff to be encouraging, I think. I mean what intrigues me is the Health Service says we haven't got the money to do this, and yet because they haven't done that, he's here two and a half months. Now that must be costing them more

> than having the additional people to do the other bits. You know it just, I just find it's they're so short-sighted it's untrue. F03

This also applied to social services who often relied on locum staff to help with discharging patients from across the hospital. 'They just don't have enough of them and enough resources', commented one case manager (C01).

The healthcare assistants described their day-to-day jobs where rushing and not being able to attend to a patient immediately was a norm, where they could not spend quality time 'just' talking to patients due to time pressures.

> Yeah we find it hard when they want to sit and talk to us but we know that we've got so much to do on the ward. Like sometimes we don't have that twenty minutes were we could actually sit down and talk (…) N08

One of them admitted that staff often have to prioritise one task over another and if 'you need to hoist someone out to sit out for the day or a few hours, it's not always going to happen' (N04).

3.4.2 Shortening of life expectancy

One of the case managers pointed to the statistical data which showed that hospitalisation shortened patients' life expectancy.

> Well I mean there are statistics that actually say you know for every day, week, you have in hospital as an inpatient, for that particular client group, it actually shortens your life expectancy, so that's the most, you know the most obvious one. C03

3.4.3 Hospital routines

Being in hospital was associated with certain fixed routines and rules. Some patients who were accustomed to fairly independent living felt deprived of their liberty at times, 'not being able to do as they please and when they please' (P02)

> The disadvantage is I suppose is that being at home, your own environment and doing what you want to do when you want to do it you know, and not have to wait to go to the toilet, you know because sometimes you do wait a little while, other times they're quite good. P15

There was a particular emphasis on controlling movement of patients within the wards for older people due to potential vulnerability, dementia and falls risk. It was often a major undertaking on part of a cognitively intact patient to gain permission to leave the ward.

> Well I am confined to bed. I think this ward is a bit tight along wandering. When I wanted to go and buy a newspaper yesterday, there was a small explosion, but after a doctor intervened, they allowed me to go downstairs to buy a newspaper. P07

This particular patient displayed his autonomy by 'putting up a bit of a struggle' against urinary catheter insertion and in the end was 'allowed to be awkward'.

One person noted the constant rush and time limitations in the work of nurses, which were completely inappropriate for the older disabled patient.

> What I don't agree with is all this blinking time and motion turn out in hospitals. This time and motion, you're supposed to have five minutes for this and five minutes for that. Well nurses can't be timed to that extent with a patient. P01

Another interviewee mentioned the long waiting times for things to happen which was related to low staffing levels.

> All the sitting and waiting and, it's not that I really dislike it, it seems to me, unless I'm very ill, it seems to me a bit of a waste of time. P10

The Specialty Registrars and the Consultant also noted how being hospitalised forces the older person into the role of a dependent and incapable patient.

> You certainly have loss of autonomy, which is maybe partly due to condition you've got, but it's also partly due to the way things work… D04

Simple actions like going to the toilet, eating meals or drinking tea and taking regular medications were taken away from patient's realm of responsibility. Some medical treatments (e.g. intravenous drips, urinary catheters), although necessary, may have felt restricting to patients. Likewise, the visiting hours seemed to be quite strict. All these routines may have contributed to patients feeling out of control and therefore frightened and powerless.

3.4.4 Delayed discharges

Many respondents stated the delay in discharges as an issue often causing frustration to patients, caregivers and staff members alike. The focus group with case managers revealed the key issues which caused the delays. The case managers' main role was to expedite the discharge process, but they still found it challenging, pointing to poor communication between the services and short staffing among social workers. Patients who solely required a restarting of their already existing package of care were usually easy to discharge. The main issue was with the so called complex discharges, where patient's needs were extensive and multifaceted or where a new nursing home placement was required. In those cases, multiple assessments took place with delays in-between causing significant extension of the patient's stay.

> And just things aren't, I mean we'll try and pre-empt things and speed things up as much as possible when someone does become medically fit, but perhaps they have quite complex care needs. We know they're going to need a comprehensive package of care when they go home. We'll try and get a head start, so we'll get the ward to complete sort of dependency charts and nursing needs assessments and things, and you'd think would really help speed things up, so we'll do everything we can, and then you press the button to send all this information, and then that's it, you're just waiting. The discharge group often don't even receive the notification that this patient is ready until the following day, and then it may not get allocated for several days, and I just, I don't know, the communication's poor and things are lost in translation all the time. C01

One of the staff nurses explained how complicated the process of discharge could be and how every step needed to be organised and followed up if not happening as expected.

> (…) discharges are, for me are quite complicated. You need to get the doctors to do the HMR. Sometimes they do, but they don't sign, so you need to be to follow them. Yeah, and then pharmacy needs to do their medication, and then transport, you book for one time, but you never know when they are going to come (…) They can't go home if there is going to be anybody there to open the door for them. So discharge itself, quite difficult I think. N05

3.4.5 Hospital acquired infections

Four nurses displayed an awareness of the risk of hospital acquired infections and were concerned about patients staying longer than necessary.

> I mean there's always a chance in hospital for the older people, they're very frail, they're very vulnerable to picking things up, and whether it be winter vomiting bugs, whether it

> would be chest infections, they're just more vulnerable compared to you and I aren't they! N01

One family member described hospital acquired infections in his father (Norovirus and pneumonia) and seemed to be aware of this potentially very serious complication of hospital stay. In contrast, patients did not express similar fears.

3.4.6 Drug unavailability

One of the staff nurses pointed to the issue with drug supply on the wards: 'if you need IV paracetamol, (…) you never have it in the ward' (N05). Treatments were sometimes delayed due to medication not being available. Nurses had to go to other wards in search for the drug, wasting precious time that could be dedicated to caring for patients instead.

3.4.7 Lack of expertise

One physiotherapist noted that due to lack of beds some of the older patients had to be transferred to different, so called outlying wards. These wards did not have the same geriatric expertise and older people could be 'left behind' (PH06) among predominantly younger medical patients. A sister also pointed out that this expertise is often underrated and regarded as less 'trendy' than the expertise of other specialties. However, she pointed out that 'it's been a big problem for so long, that is clearly coming to the forefront now, particularly post the Francis report, and the fact that our population is ageing' (N03).

3.4.8 Lack of proactivity in staff

The doctors noticed that staff can at times lack the proactivity that is needed to keep patients comfortable, to support and to promote independence with daily tasks such as eating, drinking, dressing, toileting and walking. They also point that this proactivity is everybody's responsibility. If a member of staff saw that a patient is struggling they should stop and help rather than assume it was somebody else's task.

> They're kind of slumped over in bed, you know and people have just been walking past like however many times, and it's only when you kind of go and see them and you're like oh are you comfortable. D03

A volunteer, naturally having more time to spend, realised how important it was to encourage, reassure and maintain the positive spirit of patients.

> Maybe I think they probably could get out more, you know get up more, walk around more, (…) be encouraged more, because I think sometimes (…) if they fall asleep and they'll sort of say I don't want anything to eat (…) once you've started feeding them, then they'll, and quite often they say to me I feel better for having something to eat. V03

3.4.9 Adverse incidents

Adverse incidents taking place on the wards can be very stressful to family and patients:

> Unfortunately she suffered a fall, which I haven't, I haven't followed up. I haven't made any complaint or anything like that. Yes. But I'm not very happy that she fell in hospital. I mean you don't come to hospital to fall. I feel that, I feel that something is not right there. F06

Another caregiver vividly described a string of adverse events which occurred during his wife's admission undermining his trust in the safety of hospitals.

> I mean in the first four days my wife was in she had a fall. The second day she disappeared off the ward. She managed to get out. Somebody else brought her back. And the third day she was locked in the toilet for twenty minutes. She locked herself in, and they don't have anything to open the toilet door with. There's no key or anything to open the toilet door. F01

Staff members mainly highlighted falls as the result of being in an unfamiliar environment (see following paragraph), but they did not particularly mention other examples of adverse incidents.

3.4.10 Unfamiliar environment

All staff groups realised that the hospital was a strange and disorientating place, which might feel menacing to older patients who were used to their own 'micro environment' (PH05), their own routines. This was especially true for patients with dementia. As described before, this unfamiliarity contributed to increased confusion and falls in hospital. Moreover, patients might be transferred from one ward or department to another, several times during their admission, sometimes during the night hours which further added to the disorientation. They become 'ensconced within the sick role rather than their usual personality and their usual lifestyle' that is taken away from them (D06). The multidisciplinary team members possessed a good recognition of how the hospital influenced an older person's cognition or self-dependence and accounted for that in their assessments.

3.4.11 Non-adherence to protocols

One caregiver was quite specific about the hospital protocols adherence due to his professional background. He noted that there were protocols in place which were not being followed and for that reason patient's safety may have been compromised. He mentioned one protocol about preparation of patients' tables prior to having a meal and another relating to providing appropriate footwear to prevent falls. According to his observations neither of these protocols were being followed.

> The guys, the people that dump the food they don't tidy the tray. The food may be out of reach, they may not be able to take the. The covers off. They're not given hand-wipes. That protocol is not in place. F06

3.4.12 Inconvenience

The inconvenience of being in hospital was related to sharing the room with other people who may have required treatments during the night or were behaving loudly due to physical illness or delirium:

> I don't know what time it was, I was awake anyway, because I haven't been sleeping very well because she coughs all the time. P11

One patient was surprised in the middle of the night to be 'suddenly bundled out of bed and taken down for an X-ray' (P13).

Similar insight into sleep deprivation in hospital was provided by a volunteer:

> Sometimes people talk about the noise at night. Say if somebody's in a room with somebody else whose got dementia. And they can get a bit noisy and a bit active at night, so it stops them getting much sleep. V02

One patient complained about starched sheets:

> The only thing I don't like are the starched sheets. I don't think they should put starch in the sheets. They look good, but they don't feel good. That's just a practical thing. P02

In addition, losing belongings or personal items such as bags, dentures or glasses was a source of distress for both patient and their caregiver.

3.4.13 Isolation

Several patients felt strongly that they are being isolated from the outside world. They often missed their spouses, friends or neighbours. The feeling of isolation was increased if the person with normal cognitive function was sharing the same bay with confused patients.

> So I'm not put with people of my own intelligence level, I'm put with people who are gaga, and so I can't speak to anybody. I can't converse with them. It's like being in solitary confinement. P03

This issue was also remarked on by one of the Specialty Registrars.

> I think a lot of people get lonely don't they, well not, lonely is maybe not the right word, because there're people around, but. Isolated maybe. Yeah, especially if they don't have family that live nearby who can come and visit them. D03

Being placed in isolation for infection reasons could prove to be 'quite a lonely place as well' (N12).

The sisters commented on how important human contact was for their patients, how it improved their mood and morale. They witnessed very lively reactions of older patients towards little children and the Pat Dog. They also appreciated the work volunteers do and welcomed entertainment provided by volunteer services on the wards for older people.

3.4.14 Lack of privacy

For one of the volunteers being in a side room would be a better option than being in a bay with others due to her strong sense of privacy.

> And I suppose maybe when the doctors come in and the curtains are pulled round the bed it doesn't really cut out the voices, so maybe a bit sort of general lack of privacy. Though of course I know some people have a side room to themselves, so they're lucky. V02

3.4.15 Boredom/lack of stimulation

For some patients it was the inactivity and boredom rather than feeling of isolation which was difficult to bear. They mentioned lack of any entertainment, stimulation, lack of television.

> The worst things, are just the sitting around, well basically waiting you know. The boredom. Boredom. Yeah, I would say I'm bored to tears. P19

Inactivity and lack of stimulation was noted by a family member as a barrier to recovery for a relative with dementia. The ward was depicted as a place where nothing interesting happens and even TV is not readily available to patients (‘she’s just sat in the chair staring into space, so I don’t think she’s getting better in that sense’ F06). He also compared the UK hospitals with other European hospitals (as he worked in Spain), where there were fewer patients per bay and where television and telephone were available at each bedside.

Nursing and medical staff also recognised boredom as a problem which was difficult to deal with.

> A lot of the patients are just, they just want to get out of hospital as soon as possible because they get so fed up. D01

> We have nothing really. We’ve got a few TVs that don’t get a signal, and we’ve got like a computer that plays music and radios and that’s about it. N09

The therapists discussed the issue of lack of stimulation at length. An unmotivated, bored patient either refused to commence a therapy session or after initial consent would have little enthusiasm to fully participate. The reason for lack of access to facilities like TV or newspapers could be infection control or lack of money. Visitors often provided diversion in the form of puzzles or IPad, but not all patients received visits regularly.

The volunteers also noticed that patients were longing for interaction and were pleased to find a person willing to listen to them. They recognised that their role often involved keeping company in addition to formal mealtime assistance.

> I just think they’re so bored in hospital. I mean Olive, that I’m with, I mean all she’s doing I think all the time is sleeping because there’s nothing else, you know, and when I get there she’s, she’s chattering away. I can’t always hear what she’s saying because she talks very quietly, but I try to make, you know I try to nod in the right places, but she talks rather than eats. V01

3.4.16 Inability to help/emotional distress

Some female respondents showed lots of empathy toward other, less fortunate patients and rather than complaining about the noise, they felt distress triggered by inability to help.

> And you sit here and think wish you could help, but of course you can’t. P05

> Poor Nancy over there, she calls and calls and calls and perhaps it's ages before they go, and I try to say Nancy wants you, but I shouldn't really interfere, but I don't like to see her getting upset… P15

3.4.17 Disempowerment/loss of independence/institutionalisation

All staff groups agreed on the fact that hospitalisation often resulted in patients losing their self-dependence and becoming institutionalised. The Consultant emphasised that 'some patients as soon as they set foot in hospital actually stop caring for themselves completely' (D06). Equally, a staff nurse commented that the care the nurses were providing might lead patients into losing ability to care for themselves. The therapists noted a high number of patients wearing pyjamas in hospital which often depended on how busy the nurses were with other, higher priority tasks. They felt that it was 'often quicker for people to just do things for them' (PH06) and it was easier to fit the patient into the usual hospital routines rather than to constantly promote their independence or respecting their right to be in control.

> I think that's when we get a lot of non-compliances, when actually people are resisting fitting in with your regime, and it's seen as non-compliance rather than actually they just want to be in control. PH03

Institutionalisation became obvious when patients were referred to therapists for assessment and they were found to be unable to complete activities essential for independent life at home.

> I haven't been having to wash and dress by myself for the last few weeks because the nurses have been doing it for me, and so obviously I'm not able to do it as I did before, or my exercise tolerance is low because I'm always brought a commode. PH06

A relative seemed to also be aware of the importance of keeping patients active on the ward and retaining their 'self-control'.

> Not enough stimulation, not enough activity, not enough self-control. F02

3.4.18 Low mood

The case managers noted that low mood is a problem in medically fit patients who are awaiting social input on discharge.

> And the minute we make someone medically fit, then it's a waiting game to get them out of the hospital with package of care or, it's not a flow, a good flow at the moment. So they're

> sat here and actually yeah they've could become low in mood, they might have been a chirpy person on their way in. C02

3.4.19 Loss of function

Loss of function, clearly evident from staff interviews, was also noticed by family members. In contrast, patients did not specifically mention this as a problem on the wards. Two caregivers expressed their serious concern about how their relative had gradually deteriorated during hospitalisation to the point when they were either bedridden or requiring assistance with all mobility.

> I personally think that if he's been in hospital for nearly two and a half months and if they'd kept him mobile all the time, he'd have been out after a week, and not two and a half months. And now he'll come home and he'll be practically bedridden.F03

3.5 Opinions about hospital food

Although not directly asked about food the patient interviewees often voiced their opinion about hospital meals.

Some of them praised the improvement in quality of food:

> but it's much better now; nice menu. I've enjoyed my meals actually. I think I need to go home because I'll be putting on weight! P15

However, many complained about the quality of food, probably depending on what they were used to eating at home:

> It's not very tasty, and then you do for something like roast beef or pork, but the made up stuff is messy. It's the sort of stuff you would buy at Tesco, and get a meal for about one pound fifty I would say. It's probably less in the bulk, but nothing much to write home about. P07

Patients admitted that some meals were better than others and some people might have different opinion about the quality of food than they did:

> That it definitely microwaved, you can tell that, yeah. But there's nothing like cooked on site is there really? Yeah. But then again I'm a little bit fussy with my food, I mean because I cook my own and I know how I like it like you know. And nobody cooks like your mother or yourself do they? P19

Other issues were the erratic timing of the meals, misguiding information about the menu, no choice of plain food or too large portions. It seemed that food was a big part of an inpatient's life and the opinion about it varied considerably between the respondents. Mealtime volunteers at Southampton General Hospital were trained to specifically address the issue of malnutrition among older patients. When interviewed, the volunteers were very keen to describe their experiences of and insights about mealtime assistance. They noted that the food did not always look appetising or appropriate for the particular person. Yet, by being sensitive to patient's individual needs and preferences they could help them increase their calorie intake for example by offering an alternative meal (such as a mug of soup).

3.6 Positive staff perceptions

Without any particular prompting patients liked to describe their experience of the NHS staff. They often praised their kindness, patience and caring attitude.

> I think they are angels (about nurses) P01

> Excellent. (care) You can't say, if that's the highest word for them, it's excellent plus. Honestly you wouldn't believe how marvellous they are, and even the men, they don't, they've got it all, you know well there must be this dedication. Marvellous! P14

Patients had the opportunity to observe the ward life very closely and they concluded that nursing staff were hardworking, reliable and dedicated.

> As soon as I came in here, it's nurse, nurse, nurse, it's these nurses all the time. I've never known anything like it. Honestly, you know they're doing, well they're seeing to me, doing this, doing that, they're going round washing some of you, well you know, but it's all these nurses. And when I can see them, they're doing ten things when they should be doing five; that's the best I can put it, or even fifteen. P14

Medical staff were regarded as knowledgeable, approachable and striving to maintain high levels of hygiene in comparison to past experiences.

> But consultants then were quite different from now. No-one came in to a room and said I'm Charlie. P02

3.7 Negative staff perceptions

Poor staffing levels were mentioned at multiple points in almost every interview. Increasing the staffing levels was often proposed as the one single improvement that would make a huge change in the NHS. Patients noticed that the needs of an older person were complex and time-consuming.

> Not enough of staff: You know which I have found this in other hospitals as well, but there's not the staff to go round to do things.P15

Other issues that surfaced in the discussions included inadequate training levels of the more junior staff.

> And there was another young, she was a young girl, and like learning all…, and she went to do somebody's pressure, she really pushed her, bless her. P14

Other problems that were mentioned included indecisiveness of staff and inability to receive a second opinion, not following doctor's advice or issues with professionalism and no insight into own practice.

The communication between family and staff was regarded as poor by two relatives due to substandard handover of information among the staff: 'you ask a few questions, you pass the information to one nurse and it doesn't seem to get passed round' (F01). Equally, communication of staff with a patient who was hard of hearing was also seen as problematic:

> Well he's very deaf, so he's found it incredibly confusing. There are lots of different people coming in to see him, through from the nursing staff and the caring staff, and they all seem to be different, and they've all got different accents. And I think he's just found it really difficult to understand what's being said to him' F03

3.8 Summary

In this chapter I have presented patients' and relatives' perception of hospitalisation followed by staff and volunteers' perception of a hospitalised older person. From these findings (relayed mainly by staff members and relatives) emerges an image of the frail and vulnerable patient in a disorientating and often frightening environment who slowly becomes institutionalised and functionally impaired due to the disempowering effect of restrictive routines, constantly time-pressured staff and lack of stimulation. However, the story told by the patient interviewees is different and more positive: they are resilient individuals, keen to maintain their physical and mental independence, able to empathise with those who are unwell and appreciative of hospital staff for their enormous work and dedication.

Chapter 4: Mobility of inpatients

In this chapter I present the views of respondents around the importance of exercise, mobility in hospital and awareness of bed rest risks among patients and relatives.

4.1 Importance of keeping active in older age

All patients and relatives were aware that exercise was beneficial in older age and displayed positive attitude to the idea of keeping active in older age. Many of them, however, were rather vague about explaining the reasons behind their opinion (‘Well there must be mustn’t there?’ P11). They mentioned ‘health’ in general or preventing of stiffness but did not comment on any precise benefits.

> Well you’ve got to keep moving, that’s why I keep moving, because otherwise I’d seize up, and you won’t move will you. P01

> Oh I think it’s important. You know I think, you know the one thing you risk is as you get older you tend to stagnate. If you don’t do anything you will stagnate. Whereas even though I’ve got a problem with my ankle, I still go out and kick a ball with my thirteen year-old grandson. You know I go out and do things. I walk the dog. You know I try and keep reasonably active. F04

Another relative listed several benefits of exercise such as ‘keeping more mobile not seizing up’, losing weight, mental stimulation and meeting other people (F05).

There were patients who expressed themselves more strongly e.g.: ‘If you don’t exercise you die.’ (P03) or ‘Oh it’s vital, yeah, no question about it.’ (P13)

P08 noticed how exercise helped him to solve certain problems in life by taking his mind off the matter and allowing him to gain a new perspective:

> Because your mind switches off from the sort of problem and goes on to another problem, a golfing problem, a gardening problem. And then that you know, and then all of a sudden you might sit down and then you think, oh yes, because your mind, whether your mind rests, I don’t know. P08

One of the volunteers also admitted that exercise was beneficial for her, even with the limiting effect of pain:

> You’ve got to keep going, whether you’ve got bad knees or what have you. I mean my knee’s playing me up at the moment, but I still make sure I go out and walk, but yeah. Yeah, no you’ve got to exercise. And I do Pilates as well. I might look silly doing it, but I do it. V01

Staff members unanimously praised the benefit of exercise in older age pointing to the significant differences between active and inactive patients which they observed daily in their clinical practice.

> It’s lovely when you get people that come in, they have a medical problem, but normally do so many rounds of golf, or can garden, can get themselves to the shop, and all you do is, you know fiddle with their medication, get them home again, and you know that’s great, but I think as a society, we need to change culture now in terms of exercise. C03

One of the doctors pointed out how patients with a similar disease burden could differ greatly in their level of fitness, attitudes and social situation depending on how active they were in the community.

> I think it’s really important. I think that the people that we see who are surviving with a good quality of life are those who have tended to be physically active throughout their lives and who tend to keep that going into older age as well. So even with the same multiple medical problems, if you compare someone who’s sedentary to someone who’s been active, their coping mechanisms tend to be better as well, they tend to be, from what I can see, tend to have a much more positive outlook on life as well if they have a variety of activities within their life as opposed to being sedentary and with being sedentary comes loneliness as well, and I think the people who are more active tend to be more sociable. D06

A therapist noted how those patients who walked their dog regularly stood out (‘you can always tell the walkers’) by having exceptional motivation to mobilise during the hospital admission.

> The people who’ve got dogs, because they want to be doing, they want to engage with us, and they tend to progress quicker, and the mindset is entirely different. OT01

A senior doctor observed that although some patients had ‘an awareness that it would be better for them to go out and do things and to be more active, but actually they feel that they can’t, it’s not in their lifestyle, it’s not within their grasp’(D06). She concluded that ‘it’s very hard to convince someone at this stage of their life to take up activity if they’ve not been active previously’.

4.2 Mobilisation practice in hospital

According to staff, mobilisation of patients was closely combined with the discharge process rather than solely aimed at improving fitness level.

> Well, all the mobilising we do on the ward is with regards to a discharge plan and getting them home, not just for exercise. N03

One of the junior doctors noted how infrequently patients were seen walking outside their ward in order to get some exercise. If they did, staff would perceive them as being lost and confused ('wandering') rather than trying to keep active. Also, patients would rarely 'walk down the corridor all the way to the other end and walk back just to get the exercise' (D01).

> Realistically I think that the patients that you see walking around geriatric wards are the people who are wandering and generally not those that, and I think if you see a patient, I had a patient a few weeks ago who was over on one of the F or D wards, an outlier, and when I found on this side of the hospital, I presume that he was lost and confused, just because he'd walked such a long way. And he was completely fine, he knew exactly where he was, he was just going for a walk, and we really don't see that. D01

The suggested reason for this might be that patients were not certain about what they were allowed to do in hospital without direct nursing input.

> But when they're told they need to buzz if they need the toilet or buzz if they want anything, I think that, I don't know, but I can see how you would think oh can I just get up, I mean if they're able to, can I just get up and go for a walk, because they seem to want to know when I'm doing everything, kind of thing. D03

The therapy staff described what their routine practice with regards to mobilisation was and commented on how and why it differed from nursing practice. The first step was to enquire about baseline mobility; then they would work with the patient towards achieving this level of mobility before discharging them from therapy and making recommendations to the nursing staff.

> After we've seen them, we put a sign above the bed, saying how they mobilise and if, what bit of equipment that they use. And then I always hand over to the nursing staff, so it would be the case of if they're able to mobilise out to the toilet, then we need to make sure that we're doing that every time they need the toilet and not bringing them a commode, because obviously that's going to make them deteriorate. PH02

The therapist noted however that the nurses would often not follow that recommendation because they felt 'it's quicker to bring them a commode and then they'll deteriorate from a kind of physical point of view, and then they'll get referred and then I have to pick them back up again and get them back to that point' (PH02).

This problem was also noted by nursing staff themselves, especially with those patients who needed a lot of assistance:

> I wouldn't say, the ones that need a lot of, quite a lot, well assistance, they don't really, they don't really go for walks. Like they are mobilised from bed to chair, maybe bed to the toilet, so obviously they will do a bit, but it's not probably enough. It's not going to keep them really you know on their feet. N04

The therapists stressed the importance of maintaining patient's other functional movements apart from mobility 'because when they go home they're going to have to reach up for things, so simple reaching, you know the turn of the hand is a massively functional movement that they're going to need to use when they're outside of the hospital' (PH05). In hospital, that movement might be lost very quickly **'**through quickness and through staff shortages, it's quicker to get on and do it for the patient, and not allow them to use the functional skills they may have' (PH05).

Patients received exercise sheets from therapists to help recovery of function, but they often required encouragement and reminding to performing them regularly:

> So sometimes you will see a patient and they'll be sat in the chair, and it's almost like a learned response, and they see you and they just start marching in the chair. PH02

The senior nurses stressed the importance of being active as a means to fighting boredom 'as the only sport that they do is watch the nurses' (N03).

> And that's the only entertainment that's there is nurse-spotting, so I think just to start with, like give them a reason to get out of bed, give them something to do. Because it must be boring lying there! N02

For a similar reason, a family member was supportive of increasing exercise levels in hospital:

> I think it would be nice if there was more. You know she's just, I mean I don't know what happens in the morning, but between three and eight when I come, nothing's happening. F06

4.3 Awareness of bed rest risks

Not all patients were aware of particular risks associated with being in bed. They often felt happy and comfortable just resting and not having anything to do.

> I think I'm sort of resting all the time really; I'm sitting here, so I can't think of anything. I only know that I'm quite happy. P05

> I think it has some healing power really, because you're giving your body a bit of a holiday aren't you? P02

This coincided with reports from staff that many patients preferred staying in bed than mobilising.

> I don't know if the patients are aware of, a lot of them say, oh I'll be fine when I get home, I'll be fine when I get home, I don't need to see any physio, and I don't think they have much insight into the longer-term implications of it. C01

One of the relatives also supported the idea of staying in bed:

> It's a wonderful thing isn't it! I mean yes, yeah if they need to be in bed they need to be in bed. F06

However, most patients and family members were mindful of at least one or two risks of immobility such as pressure sores, thrombosis, infection, muscle weakness.

> So that, and in my case I suppose it's, perhaps it's more relevant because I had, I've had pneumonia. And when I'm standing up, I feel so much better. When you're sort of slumped in a chair or a bed it's not good for your chest and things, and I think it would have cleared a lot quicker you know had I been up and standing a lot more. It's just my own opinion. P13

> Well of course, of course, bed sores, you've got the problems of bed sores, you've got the problems of DVTs, you know. F01

One patient seemed to be supportive of having a choice with the emphasis on the benefits of moving over resting:

> Well I think if a person needs to lay there at rest, let them do it, but if they want to get up and move about, move about, because moving about is better than laying in there. P09

P11 observed that bed rest was often the only method of treatment 'in the old days':

> I think these days, for people of my age, if you're in hospital you're in bed, and I think we have to sort of educate them that, I think anyway, that it's not always the best thing to be in bed. P11

This statement was rather unusual as according to a senior doctor 'a lot of our patients are from an era where if you were ill, that's what you did, took to your bed' (D04):

> And the doctor prescribed strict bed rest, so they're always very surprised when they're basically hoiked out of bed and told to get moving. D04

Therapy staff reported that although the knowledge of bed rest risks was not common (except pressure sores), patients and family were often open to change their views when educated appropriately.

> I've been told several times by families, oh they're not ready yet, and I'm like it's kind of my job and the doctors jobs to decide if they are ready to get up to be honest, but, so if you explain the risks, I find that a lot of family members are then more than amenable. So one of the patients that I was mentioning earlier, who I've discharged and then they've been re-referred, her family are now taking her out to the toilet, or if she's saying she needs a commode her family are like no, you're going to the toilet, and they will walk her out to the toilet, so from that point of view that's good because obviously then she's getting more input and she probably does more here than she does at home. PH02

4.4 Summary

In this chapter I reported opinions of respondents with regards to keeping active in older age, I described the current mobilisation practice in hospital as well as patients' and relatives' awareness of bed rest risks.

Chapter 5: Barriers to mobilisation

In this chapter I present the theme barriers to mobilisation which I divided into four main categories: environmental, patient related, family related and staff related.

5.1 Environmental barriers

Participants identified inherent barriers to mobilisation which were directly related to how the wards were organised.

5.1.1 Lack of space/mechanical obstacles

Patients and nurses noted that there was not enough space for mobilisation on the wards given the amount of equipment required such as beds, chairs, drip stands or Zimmer frames as well as drug trolleys at several times in the day.

> I think we have issues with storing kit. Most of our patients need a Zimmer-frame and we haven't got space, and then it becomes a falls risk if we have a Zimmer-frame per patient in the bay, that's six Zimmer-frames, where do you put those! Because we've got to have a chair, a bed, a drip-stand, you name it, you know, so in an acute setting. N01

If most of the patients decided to have a walk that would have caused crowding and could have contributed to falls risk.

> I mean people like me and people like them over there, we're all in each other's way aren't we? I mean the only way we could walk around the ward is when it's empty. I mean if you get three or four people in there, all a bit weak on their feet or whatever, then somebody's going to give way. P04

Two of the family members also noticed the constantly crowded space and vividly described it as 'an obstacle course' (F01, F06). They thought that staff should be more conscientious at putting the equipment away after they finished using it.

One nurse mentioned a specific issue that could potentially be easily remediable. She found that the toilet doors in the bay opened inwards obstructing the space and making it almost impossible for patients to manoeuvre their Zimmer frames in the toilet. She suggested that the problem could be solved by altering the door so that it opened outwards rather than inwards.

A physiotherapist talked about the corridors where patients could potentially go for a longer walk, but where haphazard pieces of equipment were often placed.

> And the corridors are such hustle and bustle with beds and all sorts of obstructions, it's probably not terribly safe. You would have to be very confident that the person really was able to make an assessment of obstructions and obstacles. PH04

5.1.2 Location of facilities

Relatively distant location of facilities like bathrooms was an issue from therapists' and nurses' perspectives. Many patients were not able to walk 30 metres to a toilet located at the end of the ward, so often a commode was brought to them instead. However, this issue was addressed proactively by nurses who found time to wheel the patient half-way so they could walk a shorter distance. In addition, therapy staff suggested that fitter patients could be placed in the more distant bays; although this may not always be possible. Ideally, each bay should have a toilet, which could present patients with an achievable mobilisation goal.

5.1.3 Lack of equipment

Lack of equipment such as frames, walking sticks or wheelchairs was a major hurdle for patients who could be mobilising independently and for staff who would like to promote mobility. The physiotherapists emphasised that the frame needed to be of appropriate height for the individual patient and it should be only within the reach of those who can mobilise independently - otherwise it may represent a falls hazard. This could be achieved by educating the nursing staff.

> It's meant to be handy for the patient to be able to reach if they want to mobilise. Well you need to make a judgement on whether the patient is safe to up and go on their own, but some of the patients who are able to mobilise safely, the frames get tidied up and put into the corner of the room. PH04

Other crucial pieces of equipment which helped patients to sit out were the hoist and Sara Steady (a standing aid). There was only one of each for all five wards which according to the healthcare assistants was not sufficient.

A patient suggested that if there were grab rails next to his chair, he would be able to get up and walk on his own.

A family member also made a point about the inaccessibility of walking aids:

> But if people want them you've got to, so you know presumably all the old people there are mobile and need the frames, but they're not there, and they're not there where they can reach them, which seems a bit odd to me. What's the point of having a frame at the other side of the ward! F06

5.1.4 Inappropriate clothing

One of the physiotherapists pointed out that if a patient was wearing a hospital gown, staff had to ensure that their dignity was maintained during mobilisation.

5.1.5 Hospital routines/institutionalisation

There were apparent rules that applied to medicine for older people wards but not necessarily to other medical wards. The most obvious was the high level of security in order to prevent confused patients leaving the ward. When this rule was applied to every patient without much consideration it naturally caused frustration in those who were cognitively intact and wished to go for a walk. Those patients often needed formal consent from the doctor or senior nurse to be able to maintain their freedom while in hospital.

> Yes, this is a very odd ward. This isn't geriatric, it is actually a mental ward. The security here is totally different from the security on the surgical wards. On the surgical if you can walk you walk, you don't need permission. In fact they encourage you to go for walks. Even outside the building. P07

> I was going, trying to get down to the lift. All I wanted to do was to go down, I wasn't going anywhere, but I wanted to go down to the lift, and where are you going, where are you going? I said I just want to go. P08

The great variety and unpredictability of hospital routines also created a barrier to mobilisation. Patients were not sure when exactly the next drug round, treatment or meal would take place and hence preferred to stay at the bedside so as not to miss anything.

> Well as soon as I get a chance you know, as soon as I've done one thing, you sit down and then they come and you've got another thing, something else to do as well. Don't get much of a break (to do her usual exercises). P05

> Well there's nothing stops me in my mobility, other than the fact that I don't know when the food is coming, which could be within an hour or an hour and a half. It's so erratic it's unbelievable. P03

This fact was also noted by a physiotherapist:

> There was also something about trying to convince patients to go off the wards, because they are worried about missing visitors or they might miss the doctors or they might miss their medications.(PH0?)

On the other hand, all the routines may also interfere with therapy sessions. There was no correlation of nursing interventions such as sitting the patient out in a chair or personal care with therapists' mobilisation planning. This meant that patients were often too tired to participate in physiotherapy.

> I think the Turnaround can be an issue, because they get all their patients out of bed immediately after wash, they're then out for two hours, they're then back in bed, because they have to for protection of pressure areas, but certainly from the point of view of timing it with therapy, then they go, oh well I've just got comfortable in bed, I don't want to get out again. And you can have, particularly in the afternoons you can have that for almost every patient. PH03

The Specialty Registrars also commented on how rarely they saw patients going out for a walk with relative's assistance. Once the patient became medically fit for discharge and had no clinical reasons to leave the ward (e.g. for an X-ray), 'they just sat there' (D04), sometimes for many weeks in the same bay.

5.1.6 No goal/lack of stimulation

If there was no particular goal to aim for, patients would have little motivation to walk or even to get out of bed. This problem was brought up by a patient, a sister and a therapist.

> I was trying to get out just to go down, I only wanted some exercise, because I don't like sitting around a lot, and hopefully I shall get home, but you see, there's nowhere to go, there's nowhere interesting to go. P08

> And again there's not very, I mean where would we go to take, like to the lifts and back, well like how exciting is that! N03

> And so when they do say no thanks I'm okay, I'll stay in bed, it may well be due to the fact that it's boring just sitting and stare into space all day. PH06

The staff members suggested that a dayroom would be very useful to fulfil the stimulation role but in the current circumstances of limited space in hospital this would not be a priority investment.

> I think that's a tricky one (reinstitution of dayrooms). I think staff-wise, it would be harder in some ways, but it probably would be feasible in some wards, but I think the more potent factor is the bed space that would be lost in order to create these spaces, and I think that's why there's resistance to having dayrooms back again. D06

There was a subgroup of 'wandering' confused patients who spent their time walking constantly. The nursing staff noted that 'they are trapped in an L-shaped environment' and providing them with an opportunity to do 'laps' would work better and possibly reduce the confusion. I address this idea further in my analysis.

5.1.7 Infection control

Inevitably, in every hospital there would be a particular group of patients who were prohibited from walking around the ward and hospital in order to avoid spreading infection. Examples included isolation due to MRSA colonisation or bay/ward closures during outbreaks of diarrhoea. According to one of the healthcare assistants, this limitation of movement was particularly 'disturbing' for patients with delirium, as they felt they were 'being imprisoned' (N12)

5.2 Patient related barriers

These were the barriers which were directly related to the patient's attitude or character, their physical and mental state and general knowledge about risks of bed rest.

5.2.1 Loss of motivation/low mood

Patients' lack of motivation to work with a 'bunch of strangers' (D06) to increase mobility was seen as a major hurdle by staff members. Being unwell, isolated from family and friends, forced into unfamiliar environment and routines for a prolonged period of time may have understandably led to low mood and disheartenment.

This sense of 'losing the will' was also noted by a family caregiver:

> Yes, when I saw it (the bed exercises), I would say to him right, come on then, let's do these. But as time got on, he'd, oh I've done that today. Yeah, but you've got to keep on doing it. No, I've done that today. So I think he, part of it is him. He's decided. He's lost the will. That he can't walk. He's lost the will to walk. Mind you I think I would. F03

Some patients seemed to have an inherently negative attitude toward mobility promotion often giving the reason of 'old age' as a justification for non-compliance: 'well I'm ninety-two, what do you expect from me now and I'm quite happy sitting here' (PH04). When staying in hospital, they might also have felt that they 'had kind of carte blanche to lie in bed, because they were ill, and did not need to get up if they did not feel like it' (D06).

The nurses and physiotherapists often found it difficult to 'just get people out of bed' (N01); they had to provide constant encouragement and prompting for patients to do their exercises as 'some people had to be prodded to move' (P04). The case managers recognised that this intensive level of patient motivation was not sustainable due to the time pressures experienced by nursing staff. Coming back 'later' to support a demotivated patient might be impossible: 'later is a long time in a nurses world, because then you'll go on to your next patient or to the next wash, then it's medicines, and then it's lunchtime…' (C02).

Some patients were used to a sedentary lifestyle at home and consequently continued to be immobile in hospital: 'they just want to lay there because that's what they're used to at home' (N04).

Family members accepted that motivating their relative to mobilise can be challenging.

> and then again I understand that if he says no I don't want to, they can't force him. F03

To help the patient staff used a variety of psychological methods tailored to individual needs such as humour, sense of competition and visualisation of the rewards (eg. favourite pastimes or going back to their treasured home). A case manager gave a comparison of a highly motivated person with somebody who had given up on life altogether. If a patient resisted therapy consistently and strongly, their choice needed to be respected.

> I think if it's someone who's desperate to get home, and you say well you know we need to get you back to baseline before that's safe, this is a way that we can do it then they're more likely to engage. Some people get to the stage where they actually want to go into a rest home or a nursing home; quite often they do think actually they've had enough; I've worked all my life, and I just want to be looked after now. C03

The rather negative attitude to those who choose not to mobilise was evident among two patient interviewees.

> I know people that would sit there all day, if they were left. P01

> Some people won't walk if they can help it. They don't walk at all. P03

5.2.2 Anxiety/fear of falls

A level of anxiety about mobilising existed among patients, especially among those who had fallen in the past. This was noted by nursing staff who also realised that this fear needed to be targeted within mobility promotion:

> Some of them are really like scared as well, especially if they've come in from having a fall, they're too scared to try. N04

5.2.3 Medical condition/treatments/symptoms

The fact that patients were often very ill and therefore bedbound was an obvious barrier to mobilisation and unless it was safe to do so from the medical point of view the therapy staff would not try and mobilise them. Patients and relatives recognised that a serious medical condition, co-existing ailments like a frozen shoulder/incontinence/unsteadiness following a stroke or symptoms like dizziness could all prevent mobilisation.

> We're all a bit, I can't think of the words now, we've all got something wrong with us. P10

Incontinence was portrayed by case managers firstly as a disincentive to mobilisation from nursing point of view – an incontinent patient did not require mobilisation to the toilet 'because what they'll do is they'd stand him up, give him a wash, change his pad, and he'll sit back down again' (C02). Secondly, it could be a source of embarrassment 'because people are quite sedentary and their bowels don't move when they're still, as soon as they get up and start walking, that's when things start happening' (C01).

The symptom of pain, especially in the legs was very common and reported as significantly disabling in many patients. Doctors often prescribed painkillers with advice to administer them prior to mobilising the patient to aid participation in the therapy session.

> It's, the only thing is this right hip gives out now and again, but I've got no pain anywhere else. P09

In older adults, there was usually a combination of conditions and symptoms that would contribute to their immobility, while certain treatments like intravenous drips or urinary catheters added further impediment.

> I think you're ninety and you're stiff and your bones ache, and everything is hard, then you know add on top of that a UTI or a chest infection that makes you feel rough anyway, and why would you want to get out of bed with that awful physio. N01

5.2.4 Confusion

Patients with dementia represented a separate problem in many different ways. For instance, their motivation was hindered by limited insight and ability to retain information or use it appropriately.

> Some of our patients, you know you stand them up to do some mobility practice, by the time they've stood up they don't know why they're stood up anymore, so it's really difficult. PH05

These patients would not follow any recommendations due to loss of short and medium term memory, so they had to be constantly reminded to do their exercises. They were also at risk of walking out of the ward and getting lost in hospital which was noted by one of the family caregivers whose spouse had dementia.

> The other problems would be if they sort of started to wander off, if they were not really sure of you know their faculties completely. They might be confused and might just simply wander off mightn't they? F05

5.2.5 Health and safety issues (patient related)

Often, nursing staff worried that, increased mobility could be associated with falls and therefore patients were best kept in beds and chairs in order to minimise this risk.

> I guess with mobility, there's always that they could fall over and break their hip, and there's that kind of I'd rather step back and not do it than take a chance. D03

The doctors especially noted that if they requested some investigations, other staff members interpreted this as a sign of medical instability and therefore a contraindication to mobilising i.e. in the case of ordering a head CT:

> No-one will move them, and then you have to come along and feel like it's like a battle, and you have to write, oh my goodness, you can move this patient, this is ridiculous. It's like you can't order anything anymore. D04

The 'risk averse' (D03) culture became apparent in how patients, especially confused ones were discouraged by staff from walking about. I also mention this in the staff attitude subcategory (4.4.3) later in this chapter.

> And you hear a lot of, oh sit down, sit down, sit down, on the wards, rather than actually saying actually if I was to get that patient up and walk with them, walk them back, they'd then be tired, they'd then settle. Yeah there is lot of people being told to sit down. PH03

5.2.6 Lack of awareness of bed rest risks

Patients were generally thought to be unaware of risks associated with staying in bed. They seemed to follow the 'olden days tradition': 'you're ill, go to bed, stay there until you're better again' (PH05). In particular, the occupational therapist mentioned the unawareness of immobility causing pressure sores, even after multiple explanations from the nursing staff.

> I was on the Turnaround project, I can think of patients who refused to be turned, although it's been explained to them, they still don't want to, and they certainly wouldn't initiate it themselves, those that can. OT01

5.3 Family related barriers

All groups of staff noted that family influenced patients' mood and behaviour to a great extent inadvertently creating barriers to their mobilisation.

5.3.1 Anxiety/fear of falls

All staff groups remarked upon families actively discouraging their relative from walking for fear of them sustaining a fall. One daughter was regarded as 'very caring but wanted to have mum in bed all the time as if it was a sign that she was still being looked after cosy and safe' (D01). One nurse observed that families might have 'put their worry onto patients' (N04) keeping them in bed. A physiotherapist thought that although staying in bed might be regarded as 'safe' by family, 'it can actually be more dangerous' (PH03) as they were becoming deconditioned or willing to climb out of bed unsupervised.

5.3.2 Hands-off culture

Another matter raised by nursing staff was the perception that most relatives were not actively engaged in the care of patients. Instead of helping out with basic care like feeding and walking, ‘they were constantly grabbing attention for something really small’, expecting that the nurses would carry out every single task immediately. The sense of frustration was noticeable among the healthcare assistants:

> There’s buzzers going, and they just, they want you in that room twenty-four seven with their mum, and it’s sometimes you can’t do that. N09

Although sometimes nurses asked the relatives to contribute to care, they were generally cautious so as not to make a bad impression. They thought they might be seen to ’just trying to get out of another task’ (N10).

> I think they also relate it a lot to bad care. If you were to ask them to do something, I think they would actually think well why aren’t they doing it. N10

Very rarely, there were families who would take over nursing tasks on a regular basis, but rather than waiting for any guidance or arrangements ‘the ones that do, do it’ (N01). Such ‘hands-on’ families might ‘make the nurses feel uncomfortable, because it’s not the norm’ (N01).

5.3.3 Lack of awareness of bed rest risks

Similarly to patients, their relatives often did not possess the knowledge about the risks of staying in bed and would think ’oh they’re in hospital they need to be resting’ (N04). However, the therapy staff showed a positive attitude towards educating families about the benefits of mobilisation and gave examples of constructive change that led to enhancing patient’s mobility level.

5.4 Staff related barriers

Barriers to mobilisation may be inadvertently generated by staff members in hospitals and I report these complexities in this last section of the chapter.

5.4.1 Staffing levels/Staff time

All groups of interviewees thought that lack of sufficient numbers of staff was a huge barrier to increasing patient mobility. Moreover, several patients reported that lack of assistance was the main barrier for them to mobilise in hospital.

> Patients shall we say, would get a lot better quicker if they had more opportunity to see a physio every day. Now I see one, one day, and they say see you tomorrow, but no, it was three days actually, it was the next time. P13

Every family member commented on the lack of exercise in hospital which led to functional decline in their relative. The rising bureaucracy was pointed out by one family member as a hindrance to spending more time with patients:

> I can remember the times when I did nursing, we would spend twenty minutes with the patient and five minutes writing it, writing about it. Today you spend five minutes with the patient and then writing for twenty minutes about. It's not necessary, because you're repeating it quite a lot, all the time. F01

Another relative revealed irritation with the limited number of therapy sessions that her mother was receiving, stating that 'the physios come around once a day, if you're lucky' (F02). F03 described the serious consequence of being immobile in hospital by using blunt language: she felt that her father 'lost his mobility and was scared stiff to stand up'. Meanwhile, F06 pointed out that nurses were 'overworked' and that they were 'probably doing a very good job in very difficult situations'. F07 stressed that with the low nurse to patient ratio you couldn't regularly do 'one-to-one care' which was needed for supporting patients' mobilisation.

Similarly, a junior doctor expressed an opinion that 'if there was a lot more physios and a lot more nurses and lot more doctors I think we would have a bit more time to encourage them (the patients)' (D01). From the accounts of nursing staff, there seemed to never be enough time to provide the optimal level of mobilisation. Often, two or three nurses were required to safely mobilise a patient with a high risk of falls. This was illustrated with a real life example by one of the ward managers and confirmed by the others:

> She was really unsteady. So she'd go from one side to the other, so it took one either side and then somebody following up at the rear with a chair, (…) but it took one behind to walk with her, just in case she was to buckle and then we needed to sit her straight down. N01

> That’s half your workforce. N03 Yeah, on one person. N02 To have three just walking one person. N01

Therapy staff explained in detail the reasons for why patients, having been discharged from their care would be at greater risk of losing their functional ability:

> I have discharged patients before, who can say they only walk five or ten metres and that’s their baseline. With supervision if they’re doing that to the bathroom with the nursing staff every time then that will keep them at their baseline. (…) Sometimes, depending on the nursing staff, they will feel it’s quicker to bring them a commode and then they’ll deteriorate from a kind of physical point of view, and then they’ll get referred and then I have to pick them back up again and get them back to that point. PH02

Staff shortages did not allow the nurses to encourage independent functional skills as it was ‘quicker to get on and do it for the patient’ (PH05). The case managers also confirmed that ‘the priority is to make sure everyone’s clean and dry’ (C01) and that transfers to toilet to retain patient’s mobility rarely took place. The final result was that a patient who was mobile on admission, after a prolonged hospitalisation required ‘nursing home or doubled up packages of care, because all they can do now is just transfer’ (C01).

One of the volunteers recalled her husband’s admission to hospital and the inadequate time he had spent with physiotherapists:

> He got maybe a five, ten minute session a day and it just wasn’t enough to get him up and going. V01

5.4.2 Lack of encouragement/discouragement

I created this separate category on the basis of patient and family responses. However, I also realise that from staff’s perspective the lack of encouragement would be partially dependent on the number of staff available.

The mobility promoting culture of a cardiology ward was contrasted with the mobility discouraging climate of a geriatric ward in this patient’s quote:

> I think the heart unit here is excellent, and the amount of staff there is unbelievable. They encourage you to move, to walk, the same way as they discourage you to walk here, but of course they are different cases. P07

Another patient had a more positive interpretation of what happened on the ward:

> The staff are very good, but of course they are so good you don't have to move about, they do it all for us. P10

One of the family members and a volunteer highlighted the issue with doing bed/chair exercises recommended by physiotherapists. They felt that their relative was not sufficiently encouraged by staff to perform the exercises: 'It was just put down in front of him and said you try and do that' (F03). The volunteer also commented that despite her efforts she was not able to help her hospitalised husband in that respect: 'he needed someone there to tell him to do them, and that wasn't me, because he wouldn't listen to me' (V01).

5.4.3 Staff attitudes

In addition to staffing shortages, the lack of shared responsibility for patients' mobilisation came to light as an important concern in the focus group with Specialty Registrars. D03 thought it should be 'everyone's job' to mobilise patients.

> Everyone thinks it's the physiotherapist's job, which I think is probably the wrong attitude. So there's not enough physiotherapists to come in and do, (…) I think you might need a therapist doing an initial assessment and telling you what they should be achieving, but I don't see why we shouldn't all be able to get that patient up. D03

However, waiting for therapy assessment might lead to a considerable delay in patient mobilisation: 'and then three days later they're still sat in bed' (D03). As previously mentioned, the 'risk averse' attitude (D05) was especially pronounced in case of patients with dementia who liked to wander about the ward. Those patients would be often stopped by members of staff and told to sit down or go back to their bedside. D04 felt that 'in a safe environment' they could 'just let them do their own thing without having to chase them'.

One patient who was particularly mobile commented:

> I would like it if you were allowed to walk. But if you go too far they start sending out search parties for you. P19

5.4.4 Staff education/confidence issues

In therapy staff focus groups, it was pointed out that 'physiotherapists develop therapeutic handling manoeuvres and skills that make the patient more able to follow instructions and facilitate their movements' in comparison to nurses. PH03 also noted that in general one did not learn 'anything about elderly care when you were at university, you did not really cover dementia'. The attendees provided significant insight into how lack of appropriate manual handling skills and confidence among nursing staff frequently hindered early mobilisation of older patients. They reported that the nurses were keen to be trained in this area; however there were some restricting professional considerations to be taken into account:

> We were told we could do joint treatment sessions with them, but we couldn't teach them, because it makes us vulnerable from a registration point of view. PH03

In addition, the high rate of staff turnover and the country of their original training (as opposed to the UK) needed to be recognised as factors contributing to reduced confidence in manual handling among nursing staff.

Combining rehabilitation with essential nursing and medical care 'from day one' rather than separating these processes was imperative 'to help maintain and build function back up' (PH01).

In spite of these deficiencies, according to the Consultant, 'geriatric wards had more specialised nurses who were educated in the needs of older frail patients when compared with other medical specialties' (D06). Still, there were wide differences among the various outlying wards which cared for older patients:

> And often they have actually approached the patient and the patient has declined, and it's been left at that, whereas on other speciality wards where there's more awareness of the needs of elderly patients the staff would work much harder to try and persuade that patient to get up rather than taking their word for it. D06

5.4.5 Health and safety issues (staff related)

One Specialty Registrar discussed the problem of maintaining one's own as well as patient's health and safety while attempting a handling manoeuvre.

> The amount of sick days and absenteeism that the public sector has to bear means that it's just not worth someone being laid off for weeks with a back injury. D04

Usually, doctors did not receive sufficiently in-depth training to perform these manoeuvres independently and therefore did not engage in mobilisation of patients routinely.

5.5 Summary

In this chapter I presented the second theme – barriers for mobilisation- enlarging on the wide range of obstacles discussed by the respondents. Within this theme, I have described four main concepts:

- environmental barriers which included lack of space or equipment, distant location of facilities, restricting hospital routines, lack of goals, infection spreading and inappropriate clothing;
- patient related which included their lack of motivation, fear of falls, medical conditions or symptoms, confusion, health and safety issues and lack of knowledge with regards to bed rest risks;
- family related which included anxiety about falls, hands-off culture and also lack of awareness of bed rest risks;
- staff related which included limited staffing levels, staff attitude, lack of patient encouragement and staffing education issues.

In the following chapter I will present the views of the respondents with regards to whether the volunteers could help improve patients' mobility in hospital and how to best approach this matter.

Chapter 6: Volunteer-led walking programme

In this chapter I present the theme volunteer-led walking programme focussing on four categories of considerations that need to be taken into account prior to implementation.

6.1 Patients' and relatives' views

Patients generally expressed a positive attitude when presented with the idea of volunteers assisting with mobility.

> Oh I think it would be beneficial, yes. P02

> That's what's needed. P14

They would not mind who exactly helped them with mobilisation if they needed support.

> Yeah, so if I needed help, I wouldn't care who it was. P01

P10 thought that assisted mobilisation could instil hope into patients and suggested that the hospital had 'huge grounds' which could be utilised for outdoor walks. Due to the fact that they were often fairly independent, several respondents commented that they would not need such service themselves. P07 said he had no opinion at all.

> If a person needed help, then that's fair enough. But I feel at the moment I'm perfectly able to, you know get about. P09

Only two patients had a strong negative opinion about mobility volunteers:

> I don't think in a hospital you can have a lot of people all walking about exercising. It'd be chaos. And everybody's so busy, as you know. P10

The other person was particularly dismissive stating that 'you get do-gooders coming into the medical service, full of the joys of spring and health, but they haven't got a clue what the bloody hell they're talking about' (P04). Yet, it is important to note that this interviewee was generally frustrated with his hospitalisation and expressed a multitude of sceptical opinions.

Most family interviewees were affirmative and accepting, pointing out that contact with volunteers would provide not only physical but also mental stimulation (F01, F06).

> Anything that you can get a patient, that'll motivate the patient to walk, and I again emphasise that the communication etcetera, if you get them walking along and talk to each other, you know, and that's all beneficial. F01

F07 thought 'they would possibly fill in when I'm not here, and then (…) the nurses would be free to carry on with their normal work' (F07). F05 expressed a regret that one needed 'to go down the voluntary sector' to provide basic care for patients while appreciating that 'it would be a good idea'. Only one person had reservations saying that it was 'a responsibility too far', stating later however that 'if you asked me in a week's time I might have changed my mind, because I've never thought about it before' (F02).

> My gut reaction is this is an unacceptable pressure and there's too much risk and there's too much liability and the whole thing is just going to go wrong, so I would say volunteers shouldn't do that. F02

In comparison to staff responses around this topic, neither patients nor families enlarged upon the potential issues that would need to be addressed. This is the only quote in which a family member considers potential matters of importance:

> But they'd have to have adequate footwear and supervision you know and a place to do it. F06

6.2 Staff and volunteers' views

The idea of a volunteer-led walking programme was well received among all groups of staff as well as among the mealtime assistants:

> It's going help us a lot to do our job better, as a healthcare assistant. N06

> Yes. I should think, because the nurses are quite busy, so that'll be a good thing for volunteers to do. V02

> I've had some contact with the mealtime volunteers and I think they've all been really enthusiastic, sort of universally have been really enthusiastic and obviously they are people who are motivated to volunteer, so I think they're a really good group of people to advocate for our patients as well, so kind of a good middle ground between the clinical staff and the patients. And actually they're seen by patients I think in a slightly different

> light as well meaning volunteers rather than clinical staff, so I think they're a really useful asset and I think they're under-used and I think we could make a lot more use of the volunteers. D06

One of the volunteers was concerned about the cost of such an initiative but noted that 'a lot of people do want to be volunteers, so the idea of having volunteers in to help people walk about if they want to, that does seem a good idea' (V02). Another volunteer would be keen to take on this role herself as she observed directly how it could be beneficial on the ward:

> If I could do it on those two, those two days on G9, I'd be more than happy, because I know how sometimes the nurses try and get the patients up to try and walk with them, but they've got other things to do. And they're sort of saying X where're you going? They've got to stop what they're doing and go and help you know and things like that, so yeah I'd be more than happy to do that. V03

One doctor suggested that a mobility session could provide an escape from boredom for patients:

> I think psychologically he feels like he's doing some exercise, he's been given a task to do. Like it must be so boring sitting in hospital as well, and actually if you think like to take ten minutes out of the day to do, to focus on something. D3

6.3 Patient selection

This first category relates to the process of patient selection. First of all, it would be essential to establish which patient is most suitable to be mobilised by a volunteer. Secondly, there would have to be a way of identifying those patients. Thirdly, the patients' potential to deteriorate rapidly should be accounted for. Patient motivation to mobilise would also influence the outcomes of the mobility session.

6.3.1 Patient suitability

All staff groups were concerned that the number of patients suitable to be mobilised by a volunteer would be quite small, possibly only one to three per ward. These patients (relatively independent, medically stable, not confused or at high risk of falls) were described by one physiotherapist as 'the cream tea of patients' (PH03).

> I think one of the problems is that only a very, very small percentage of patients who would that criteria, and I think there's a larger percentage of patients really do fluctuate

> from, even from a treatment session with us, and we will adapt the treatment session, only perhaps a small, in a small way, with verbal prompts to push up from the chair and lean shoulders forward for a stand, PH04

The patients would have to be identified by a therapist and meet stringent criteria to qualify, namely: to be able to walk independently (with or without an aid), not be of high risk of falls or confused (N02). A potential issue with nurses choosing the patients was raised by PH06:

> But then if you say that they're ones that the nursing staff would give them a list, a lot of time the list that we get as a handover in the morning, is inappropriate, and so I mean even that I mean is an issue within itself that potentially they need further education, the nursing staff, on what is an appropriate referral and what isn't, and so it's fine when they've referred to us, because then we can go and assess and say look this person is not appropriate, not safe, whatever, but if they then referred to a volunteer that hasn't had that education and training, would they be able to make that decision. PH06

There were particular concerns from the therapists and nursing staff regarding patients who were assessed as being high risk of falls:

> They are high fall risk, and I don't think it would be fair to put a volunteer in the situation. N10

In contrast, the Consultant suggested that 'there are quite a few patients who are very stable and who are waiting here for other social reasons' (D06); they would qualify to take part in the programme which could help 'keep their motivation up and keep their spirits up' (D06). Similarly, a case manager (C03) felt positive about the idea provided that specific training, clear guidelines and good communication with the nurse in charge regarding the suitability of patients would be in place. One HCA mentioned that walking the patient to toilet would not be an appropriate task for a volunteer, but she pointed out: 'that's like most of our patients, if they're going to walk, they're going to walk to the toilet' (N09).

6.3.2 Identification system

The physiotherapists laid emphasis on having a safe and practical system in place to identify suitable patients to volunteers using e.g. patient journey boards, stickers or wristbands.

> It's finding a way to identify them to the volunteers wouldn't it, so it might be say, I don't know, maybe like the patient journey boards, there was for the sake argument, like a

> Zimmer-frame next to people that the volunteers could come and mobilise, and that would need to be reviewed on a daily basis by the kind of the medical professionals on the ward. PH01

This issue was also highlighted by the case managers who thought that identifying the patients during the morning ‘board round’ by the nurse in charge could be feasible.

6.3.3 Recognition of unwell patients

According to therapy staff and case managers, after selecting the right patient and identifying them to the volunteers the next step would be to ensure that any deterioration in a patient’s condition is recognised. This is important especially in older people as ‘even the ones that are medically fit, fluctuate greatly’ (PH06).

> I think they’re a group that if they get the slightest bit of a urine infection or something very slightly changes, it really reduces their mobility and alters it and I think that fluctuation would make it, you know makes it quite difficult to manage. And even from the morning to the afternoon, someone could change, so you could sort of feel that someone was a safe person for someone to walk, and then I would be concerned that that could change drastically. PH04

PH06 gave an example of a patient who was fit for therapy in the morning but suffered a stroke in the afternoon, therefore a degree of vigilance was necessary. Doing an ‘on the spot assessment there and then’ (PH04) was one way physiotherapists dealt with that uncertainty on a daily basis. Meanwhile, the nurses would check patient’s vital signs to ascertain their condition before mobilisation e.g. to make sure their blood pressure is normal (PH01).

> I guess for me then it’s about recognising signs of potential deterioration would be my concern, more if for instance you know nursing staff will know to check obs and stuff like that before someone’s getting up, and I think if someone doesn’t have that knowledge, I think that might be the barrier for me, that’s what I’d be worried about. PH02

A case manager suggested that volunteers would need to communicate with either the nurse in charge or ‘even better, talk to the nurse that’s in that bay at that time, because something could have suddenly happened’ (C02).

6.3.4 Patient motivation

A further issue highlighted by nurses in charge was patients' lack of motivation to mobilise. This might limit volunteers' scope of practice.

> I think it would be better one-on-one, just watching, so the volunteer that comes up and asks if anybody wants to just go for a walk in his wheelchair, just to get out the ward and go see the shops downstairs, and I would think that people snapped at his hand. I struggle to find him one person that wants to go. By the time I actually ask the patients who wants to go, just down to the shops just for a bit of fresh air. Nobody! And I'm like oh, because you'd think it would be so popular. And I always think okay, if we said to the ladies who wants to go do a bit of exercise, I imagine the same thing would probably happen. N01

There were clearly some patients motivated to be mobile on the wards, but many preferred to stay in their bed or chair despite being able to walk. Instead of trying to reach the toilet they would request a bedpan or a commode (N02).

> It does really depend on the patient, because some are so keen to see the physio and go for walks and things and want physio every single hour of the day. Others are like, no, I'll just sit here dear. N03

N01 accentuated: 'that's the pickle, just to get people out of bed sometimes'.

6.4 Volunteer selection

This category contains themes specifically related to the volunteers: their character and previous experience, their potentially various roles, their training, competency checks, supervision and legal implications of this role.

6.4.1 Personal characteristics/experience

One senior doctor and the therapy staff considered how a volunteer's current and previous work experience would impact on their role. On questioning, the doctor affirmed that recruiting medical students would have a positive influence on their holistic education and give them a valuable insight into a patient's hospital journey.

> I think certainly it would be useful for each one of those students at some point in their student career to have been a volunteer for a while. I think it gives them a really useful insight into the other side of the picture that they will be participating in as they qualify. D06

However, the doctor also stressed that it would have to be ‘a constant training programme and constantly replenishing a group of volunteers as they move on, and also cutting into their educational time’. The physiotherapists discussed the idea of therapy students taking on the role of a mobility volunteer. They admitted that not every student would be appropriate for this role:

> It’s very patient-person specific, person specific, because some students are better than others, and yeah, some like the elderly, some don’t have the patience for the elderly. You need to be a certain breed of person to work with the elderly. PH06

PH04 explained that the physiotherapists ‘develop a sort of relationship with the staff that we work with, which actually incorporates a huge amount of time’ and also ‘trust’ (added by PH06). When seeing a patient with a therapy assistant there was ‘a lot of ongoing discussion and reflection’ and this level of rapport could be difficult to build up with a volunteer.

A volunteer (V03) commented that the physical characteristics and abilities of a mobility assistant would play a role in a scenario where a patient started to fall and required some saving manoeuvres to protect from injury.

6.4.2 The role of a volunteer

A number of potentially useful roles were mentioned by the respondents.

6.4.2.1 Mobility maintenance

During the focus group with the Specialty Registrars it became apparent that volunteers could be utilised to maintain the mobility of those patients who were discharged from therapy but were still awaiting social arrangements.

> There’s probably a lot of people who are medically fit but not function maybe as good as they were, that we still might send home. D05

Those patients were often left to sit in chair for long periods of time which resulted in deconditioning and the need for re-referral to therapy staff. Frequently, there were family complaints about this functional decline as well as issues with discharge arrangements:

> And the rest home would come in a week later to assess them and they're like well they're not transferring now. D03

The therapy staff admitted that they did not have time to maintain patient's mobility once they reached their baseline and relied on nurses to continue this task. Sometimes, just minimal prompting and support would be enough to facilitate mobilisation:

> So it would be perhaps just the sort of prompts and sort of opening a door or moving a table. PH04

6.4.2.2 Guiding/accompanying

In many cases, simple guidance and anticipation of potential barriers could be all that was needed to enable a person walk as PH01 indicated:

> I mean there's some people who for example they might just need somebody with them because they're visually impaired and they just can't physically see what's going on in the unusual ward environment, they may be relatively steady, so they could just literally have somebody there to say oh no, mind the box on your left and we need to turn right through the door. I mean things like that, I think anybody should be able to do that really. PH01

A case manager also pointed out that providing 'a specific aid to walk' with verbal prompts would be an easy way to increase mobility of inpatients (C01).

6.4.2.3 Falls class

Another idea brought up by PH01 was for the volunteers to help in a falls class for inpatients. This would be organised by therapy staff but the volunteers could assist patients in travelling to and from the class as well as in exercises performed during the class.

6.4.2.4 Chair exercises

Another role proposed by the nurses, therapists and one volunteer was chair based exercise classes. This would be less risky in comparison to walking assistance and would be potentially appropriate for a greater number of patients.

> If they are more able and they're just waiting for their relatives to come in, in the afternoon, I think they would be quite happy to do that, especially if it's going to help them with their discharge and things and going home. N10

Such classes could not only improve muscle strength but also increase patients' well-being and motivation. These sessions could work on a one-to-one basis or involve two or more patients in the same bay; they could be useful not only for those who needed maintenance of their mobility but also for those who were having ongoing therapy but were be able to tolerate 'a double session' (i.e. physiotherapy plus chair –based exercises).

> Because even if we've already seen them, say we get someone up, we do a bit of an assessment and a treatment session, if we finish and do some more chair exercises or whatever needs be, they're then going to get another session on top of that aren't they, so it's not necessarily just for the patients that we can't maintain, but it would also be good for the ones that are good enough to have a double session. PH02

V03 proposed that by doing the chair exercises together with the patient she might provide more encouragement for them to participate.

6.4.2.5 Patient interaction

Therapists also suggested that volunteers might be able to encourage interaction among patients but admitted that it would depend on their preferences:

> Because that has been a challenge, as much as they go there's no stimulation and you then offer them, so with the reminiscence group we tried before, and with the exercises groups, actually saying can we go and do an exercise programme together, to second you mention doing it in front of someone else it's a no, no, no I'm fine, I'll do them in my own time by my bed. PH03

6.4.2.6 Mental stimulation/improving morale

All staff groups appreciated that volunteers would not only contribute to patient mobility but provide equally important mental stimulation. By devoting few minutes of quality time they could increase patients' 'confidence and morale' (C03).

> I think it would have quite a lot of benefits, not just for their mobility, but like you say, psychologically and stuff, and having, and then it's also about having someone to have a conversation with as well then if you're cognitively with it. D03

PH02 noted that many patients did not receive visitors regularly, so would benefit from company; it could 'brighten them up'.

> And anything that benefits that they get a little bit extra, more time as a one-to-one must be good. If you count up how many minutes that they actually are being talked to or being someone's sitting next to them or, it's not much in a twenty-four hour day. C02

A volunteer suggested that organising group sessions could allow for more patient interaction and socialising. Whereas a staff nurse reported that although not many patients would be appropriate to be mobilised by a volunteer, many more would be keen' to just have a chat' N05.

6.4.3 Legal responsibility

All staff groups raised the issue of liability in case any incidents might arise during a mobility session (especially falls).

> I think there would be probably some anxiety about falls and falls risks, and which I think would be a big hurdle to overcome, but not all of our patients that are not mobilising are very high falls risks. And in the community, if they came across these people in a social setting we probably wouldn't think twice about walking with them, but I think in hospital there's a much higher fear of safety breaches. D06

N01 compared the situation to mealtime volunteers who could only feed those patients who were on a standard diet without any swallowing problems. With regards to mobility, the ward manager admitted that 'ninety-percent of my patients probably are a falls risk' and 'would be uncomfortable' with volunteers undertaking the task of mobilisation. Therapy staff made it clear that there would have to be a thorough plan, 'a legal framework' (PH04) with regards to handling a falling patient (which might have consequences on both patient and the assistant in terms of injury). In addition, therapists questioned if a volunteer would be allowed to take patients for walks outside the ward areas.

> In case if they collapsed mid-corridor, and I mean these patients are elderly, so potentially they could have a fall halfway down the corridor, then what would they then do, would they be able to assess that situation and know how to deal with it appropriately. PH06

Similarly, a volunteer was not certain about acceptability of such an initiative due to concerns about patients' safety.

> It's a bit of difficult one that. I don't know. I can see it would help, if you got more people being able to help, but on the other hand I'm thinking how would I feel if it was a relative of mine being helped by volunteers. V01

6.4.4 Education and training

Nursing and therapy staff emphasised the need for a 'careful selection' (N03) and a comprehensive training to enable the volunteers practice safely. One staff nurse made a comparison to the mealtime assistants:

> They really, even though they're volunteers, they need to be trained you know, but most of them will ask. (…) They're not going to do anything without your consent, and ask a nurse in charge, you know. Before they do something they will ask you, which is good, because you're not putting the risk of the patient, especially mobilising just in case they fall, you know they're going on the floor and then. N07

Physiotherapists showed most concern with regards to educating volunteers explaining how they routinely check patient's medical notes and observation charts to ensure safety prior to each therapy session.

> And obviously things like checking the medical notes before. We do it second nature and we know that if someone's had a fall or we know if someone's awaiting a Doppler scan for a DVT and we know not to mobile them until they've had it; do volunteers know that? PH02

There was a need for considerable time investment if 'you were going to reap the rewards for it' (OT01). Case managers were appreciative of the idea as long as 'there was specific training and there were clear guidelines and there was good communication between the ward nurse in charge' (C03) and the volunteers. One of the mealtime assistants admitted that she would be interested to undertake the role of a mobility volunteer with the right amount of formal training.

> If I had the right sort of training to be able to sort of, because I sort of see like, there's one gentleman, he gets up and goes off and I can't do anything, because I'm not trained to do that, so I have to say the nurse, nurse so and so has gone sort of walkabout, do you know that? V03

6.4.5 Competency checks

The therapists highlighted that in addition to a formal training there would need to be a system to check the competencies of prospective volunteers.

> One of the things that we do when we've got any member of staff, is that we are sort of assessing their competencies. PH04 Continually. PH05 Yes, and highlighting any issues as they crop up, and that might be difficult to do. PH04

6.4.6 Direct supervision

The issue of supervision was regarded as a 'huge investment of time' (PH04) and raised some anxiety among the nursing staff with regards who would be the person responsible for this. PH04 was also sceptical about the ability to ascertain a candidate's proficiency in view of the complexity of teacher - trainee interactions.

> I think we almost don't realise how much sharing of information and teaching we do just because we quite often end up working in pairs, and so you often are discussing and reflecting, as I mentioned before, and I just feel you wouldn't have anywhere near the amount of time to feel you could confidently assess if someone was safe. PH04

Meanwhile, a staff nurse was more positive about facilitation of good quality supervision:

> I think if it was put that these volunteers were obviously with a trained, well like member of staff, a nurse or HCA, then I think yeah I don't see why it would cause any kind of issues if they're with someone else that is on the ward day-to-day. N04

6.5 Environment

While the previous subcategory was dominated by therapy staff quotes, the issues regarding environment were brought up solely by nursing staff.

6.5.1 Timing

The timing of mobility sessions would have to be considered carefully so as it would not interfere with other nursing care plans or medical interventions.

> It's the suitability of when they come as well. In the morning it's everyone's busy, you know half the curtains in the bay are closed and everyone's having a wash and using the commode. I don't know when the best time would be. N02

6.5.2 Space

Volunteers would have to find a suitable space where mobilisation would be possible and safe:

> You'd need to have somewhere to go to do it. N01

6.5.3 Hospital routines

Even though the mobility session might be planned at a relatively quiet period of time, the volunteers would have to be prepared to delay or postpone it if a clash with another intervention occurred.

> Because it's not suitable to be, so I'm thinking like in terms of having a wash. N01

6.5.4 Health status of other patients

If there are other patients in the same bay, who were unwell or dying, a mobility session might not be appropriate; therefore a volunteer would have to be prepared to adjust to unpredictable circumstances as required.

> If someone's poorly or dying you know in another bed. N02

6.6 Staff related

6.6.1 Professional clashes

Therapy staff considered the issue of undermining their authority (especially of less senior therapy assistants) if mobility volunteers were to take over part of their normal duties.

> So our band twos can mobilise patients but they can't progress patients, so that would be essentially if were to have volunteers to do it, that would be the level we would be working at. I would agree that it would undermine a vast group of our profession. PH03

There would have to be a clear instruction in place about volunteers' remit of practice, so as they would not exceed their competences.

> If they just did, say they were a Zimmer-frame and they just walked them with a Zimmer-frame, that might overcome that, so as long as they're not changing what is already in place by therapy. PH02

6.6.2 Extra work for nurses

N04 raised a concern regarding who would be responsible for guiding and supervising the volunteers given the fact that nurses were already over stretched.

> I mean if, is that another job for us to do, identifying, it’s another form to fill in isn’t it? N04

When expressing their opinion about volunteers, a number of nurses admitted that sometimes they may require a significant degree of support.

> It depends on the volunteer. Some are amazing; others, perhaps take up more of your time and end up being more of a hindrance than a help. N03

6.6.3 Education of staff re volunteer role

PH02 also thought that there would have to be a clear instruction to the nurses concerning the role of the volunteer and how it fitted with or differed from formal physiotherapy.

> I just, yeah as long as it is what it is and it’s not the case of well, because of lot of physiotherapy is, it’s not necessarily understood, so we do a lot about what we can offer as a profession and what my concern would be, we wouldn’t necessarily get the referrals or nursing staff may think you know just send them to the volunteers or whatever, and it maybe that they have something underlying that we’d pick up on and not necessarily someone else. PH02

6.6.4 Potential miscommunication

If the above concerns were not addressed there is a potential for miscommunication among the various groups of professionals within the wards for older people.

Chapter 7: Proposed changes

In this chapter I present respondents' suggestions that according to their view would lead to improvements in the care of older people.

7.1 Increasing staff numbers

As previously discussed, all respondents felt that there were not enough staff on the wards and therefore this problem would need to be at the forefront of any planning. 'The right amount of staff' rather than having extra numbers was required to ensure best care for the patients.

> And more staff, I think that's key isn't it. Well just the right amount of staff. N02

7.2 Day room

Access to a day room was mentioned by several staff members as a way to stimulate, motivate and engage patients in positive interactions and activities in an environment that resembles their own home. It would 'make the ward a much more social place and less of a clinical environment' (D06) and it would allow the patient to make a smooth transition between the hospital and the community.

> Because I think there's a big jump at the moment from being in a very clinical ward based environment to going home, and there's no kind of halfway house for a lot of our patients. They don't have, once they're feeling well, they're still in the bed space, they're still in the same chair, still doing exactly the same as they were doing when they were ill. I think there seems to be a sort of lack of progression before they go home. D06
>
> I think it's quite nice when they have like dining rooms, like an actual separate dining room. I think that would be quite nice, because they could even walk there. Even to put them in a wheelchair, even if they can't walk, to put them in a wheelchair and go and wheel them to the table so they can talk to other people. N10
>
> They don't feel they've got anything to look forward to, so having a dayroom where they can sit and chat, play games or whatever. D04

The staff realised that there might be not enough space in hospital to create such rooms, so also suggested that having a table in the middle of a bigger bay could be very beneficial.

> Having a dining table in the middle of a bay would be also beneficial. However, with both options, the implementation would require finding additional space.

> Dining room tables in all the bays, an area. It's not big enough, most of the bays. C02

For patients with dementia, such a separate, sociable area had already been shown to reduce their agitation and anxiety by creating 'some sense of normality within a ward' (D06).

> And there are a certain number of my patients who've really benefited from that, and you see them at their bed space and they're really agitated or you know just sort upset and not wanting to engage, and you see them sitting at a table with other people and they're immediately smiling and engaging, even if they can't speak to each other or have a conversation, just that very social aspect of sitting at a table, which is so normal in everyday life has been really beneficial. D06

7.3 More stimulation

The case managers felt strongly about the need for more stimulation in all inpatients.

> I think just more stimulation for patients on the ward. If, for example if a patient's in a bay, there's not much stimulation, if they're in a side room there's zero. And you see them go downhill with that lack of stimulation, and they just become sedentary and institutionalised and just lay there in bed… C01

One of the proposals was to re-introduce free bedside television:

> Well I find it easier when I first started, that the over-eighties used to have free TV. Because even though they don't, you know like my nan, well they chat all the way through Coronation Street or Emmerdale, or they're on the phone to someone, but there's background noise. It's just, it's just a routine that they have at home, that at seven o'clock that turns, or the radio, The Archers, and they've got routines, like you say it's routine again, that actually they know that they would normally sit and have their meal when the News, the Six O'clock News or, it's that type of thing. You just think actually you're taking everything away, while trying to charge the earth when actually the over-eighties should

> they, do they really need to be charged when they probably only will have it on two hours a day, but you end up paying five pound a day. C02

Although radios provided entertainment for some patients, the staff found it difficult to satisfy the preferences of all patients in the same bay:

> That sounds like a great, in the ideal world, but I know when I used to be in the purple bay in G8, I loved it. But then they get frustrated because they'd get fed, one didn't want that CD on, the other wanted it, so it all sounds lovely that they're all tapping, but I had two tapping and the other two were going no, argh, maybe I'll have to put Elvis on for that one. C02

The case managers spoke with enthusiasm about a modern technology ('a brilliant piece of kit' C01) that could provide a variety of stimulating therapies tailored to the needs and preferences of an individual patient. It would help to lift patients' mood, encourage mobility, prevent institutionalisation and 'that might be enough for everything else to click into place' (C01).

> You know they're trying to raise money at the moment for sort of an interactive, basically a huge TV that's interactive, a big screen and you know you can do exercise programmes on there, there's you know tailored care plans passports, there are reminiscence therapies on there, all sorts, and that, you know something like that actually having something to get people out of bed, that's what we need. (C1)

The doctors talked about volunteers or paid staff members who could engage patients by conversation, games or interaction with a pat dog as well as enabling them to go down to the shops and 'seeing that little bit of normal life', so 'they can come back to the ward and cope again' (D06).

> I think in some hospitals I've worked in they have more people coming round, kind of Friends of the hospital, like the League of Friends type people, coming round talking to them a lot more, sitting with them. I know they do have some things on the wards, so they have a man coming round with a dog to stroke and things like that, and I know that the patient is just so much smilier and happier and like more engaging after they've had that. D01

Taking patients outdoors was seen as particularly beneficial and strongly supported by the nursing staff.

> And maybe more volunteers. We have like a gentleman don't we, and he comes in with a wheelchair and he like takes them down to like Costa to get a coffee and out the front to get some fresh air, and they come back and they love it don't they? N08

This idea also appeared in focus groups with the nurses who were in favour of employing 'an activity organiser' (N10). There was however a potential downside of such an initiative.

> Like just someone who comes in and can organise something for them, but then obviously there's the risk of it becoming too much like a care home so that no-one would actually want to leave. N10

One relative was particularly supportive of mental stimulation drawing on his own professional experience in running a psychogeriatric ward.

> I'm sorry, I seem to be harping on communication, but I'm a great believer in it. Things we used to do, I think here we would put a word up on the board and they would work out how many words they could make out of that word. Six or seven words. And we used to sit and right, anybody else got one, and two of them would be sitting saying don't you think of a word, they would actually start to communicate with each other what should be up on the board. That was mental mobility though you know. That's the sort of thing I think we don't do enough of. F01

7.4 Promoting independence/empowerment

A case manager suggested that the moment a patient was regarded as medically fit they should 'start wearing their own clothes' and 'start getting into mentality of going home' (C03).

> And people were very much encouraged to get themselves and washed and dressed, then if they had a problem they would then ring their buzzer for the nursing staff, and that type of thing. So given that extra level of independence, which I know is very hard on Acute, but the own clothes thing is really quite simple. PH01

PH03 stressed that empowering patients should be incorporated into the normal ward routine rather than trying to control their each move.

> It's about trying to empower patients, or empower the patients whilst they're here to be in control. Because I think that's when we get a lot of non-compliance, when actually people

> are resisting fitting in with your regime, and it's seen as non-compliance rather than actually they just want to be in control. PH03

One family member proposed that the wards would need to change the attitude and become more patient-centred, allowing the patients to decide more about themselves in line with other cultural changes taking place in the society.

> Hospitals are viewed as passive places perhaps, where doctors do health to you and you just cope with it, so. And maybe this generation of elderly will cope with that, but the next generation, the baby-boomers, they won't accept passively in quite the same way. Well is it you see it changed with childcare, it changed with midwifery; women were in charge and in my mother's generation women were very passive. It's changed with diabetes and other physical diseases. So I cannot believe it won't change with elderly care. You just have to have quite a few stroppy seventy year-olds and it must change. F02

7.5 Allowing self-medication

The idea of self-medicating in certain patients e.g. those with Parkinson's disease was given as an example of empowerment and rehabilitation. One therapist described how in another hospital patients were allowed to keep a tablet in their pocket and take it at their usual times (which did not necessarily coincide with nursing drug rounds). Another respondent questioned whether drug delivery systems were sometimes overused in patients who would be actually able to self-medicate.

> I think another thing as well is simple things, like enabling patients to self-medicate, so actually a lot of time we say oh well they need a Nomad to go home, so the boxes, something like that, and actually we haven't assessed whether they have like the ability to self-medicate and that's taken off them when they're here. PH03

> Actually it's all part of that rehab and actually stimulating the mind to have to think about when you need your medication. PH03

7.6 Orientation

Further suggestion by the therapists (with the awareness of financial implications) was to orientate patients by placing clocks and calendars on their tables.

7.7 Exercise class/gym

Patients as well as relatives agreed that introducing a regular exercise class (either in a separate room or as a chair-based class in a bay) would be beneficial to many patients.

> You know maybe they could, if you like take them there so they can do a few exercises, if you had a physio room for example. You know, and let them go in there and try and get them to mobilise themselves. You know try and put the onus back a little bit on the patient. F04

7.8 Written instructions for patients

A doctor thought that patients should have a written instruction in front of them informing them about what they could or couldn't do without nursing supervision:

> Some of our patients are just not sure they're allowed to get up I think, so I think would be useful after a physiotherapy session, having that in front of them saying you are safe to do x, y, and z. D06

7.9 More equipment

The focus groups with healthcare assistants revealed their frustration with lack of basic items on the wards to enable proper care such as an observations machine, hoist or even a sufficient supply of hospital pyjamas.

7.10 Separation of confused patients

One patient had a strong opinion about separating those who were disruptive to others due to dementia or acute confusion.

> The people, that unfortunately for them, can't control themselves, should be in a separate place, away from people that control themselves. I said to the staff, you would not tolerate any of this on a bus, in a cinema, in a supermarket; you wouldn't tolerate it anywhere, why should sick people have to tolerate it. It's outrageous. P03

7.11 Education of staff, patients and relatives

The physiotherapists thought it was necessary to educate everybody with regards to the importance of early mobilisation.

> It's sort of trying to encourage rehabilitation for admission really, and that's, I think that's the key is it's so often some people, especially if they haven't really had much exposure in Elderly Care, they will look at this patient's really unwell and they'll look at that very separately to the overall rehabilitation process. But actually we need to be starting from day one, trying to help maintain and build these peoples' function back up, because it is the old use it or lose it essentially, at the end of the day (PH01)
>
> I think it's all about education from nursing staff and the twenty-four approach to care, so that actually it's not just a therapy session in a day, it's every aspect of the patients care is deemed therapy. PH03

Patients expressed the opinion that some of the staff required more training with regards to how to perform their daily tasks:

> I think some of the supportive staff, you know the people who do the domestic, I think some of their training could be a little more detailed. For example, a jug is put, of water is put way out there and you're up here. I've heard it happened and we've all known it's happened, but I thought it might have improved, but it still doesn't. P02

A relative also pointed to this issue, highlighting the need for better communication.

> I mean they come in with a cup of tea and they pop it down and then they walk off. They bring her meal and put it down and don't say a word to her. Just put it down in front of her and walk away again. They don't say hi love, enjoy your meal or something, you know there's no communication that way. F01

7.12 Family involvement

The relatives interviewed were generally in favour of their greater involvement in patient care as they realised the crucial role they played in the recovery process. They thought it would have to be more formalised as often relatives did not know what they were allowed or not allowed to do. F02 questioned why families 'were reduced to just talking to patients'.

> And actually if you've got an eighty-odd year old parent, there's nothing you need to say to them. There is no talking desperately you need to do. You know, so in actual fact they would probably appreciate being given a task, can you encourage your mother to eat this, can you encourage your mother to stand here, can you encourage your mother to do this?

She compared current care of older people with paediatric care years ago:

> In the old days children used to go into hospital and their parents would come and collect them after four or five days. And then the parents would visit maybe for visiting times. But now we have a system where parents are the primary carers of, within hospital situations it's normal. I have no idea why that's not the same for the elderly. F02

F01 proposed that the family could be educated with regards to mobilising their relative as currently they did not seem to contribute to that aspect of care but would help with e.g. feeding.

> And like say to them, your mum is a wee bit unsteady, but we need her to exercise a bit, how would you like to walk her up and down the corridor for a five minutes and bring her back again, and give her that wee bit of exercise, then walk with her this way or hold her this way and go for a walk. Yes, I would. Oh yeah, yeah, and give them a, don't throw in the deep end as I say. Get them to start off with a five minute walk down the corridor and a five minute walk back. They're here for to see their mum anyway, so if they're going to be able to help mum or dad, then let them do it. F01

7.13 Better location of the department

The ward managers discussed the upper floor location of Medicine for older People which hinders mobilisation of patients outside the wards. They complained about the long waits to get a lift.

> And also, so I went to CMH (Community Mental Health), and I was so jealous, in terms of a lot of patients are medically fit, and we're stuck on the top floor, so in terms of a purpose somewhere to go, oh let's go water the flowers, let's go sit on the bench outside and enjoy the sunshine, and you can do that at rest homes and nursing homes, but we're stuck on the top floor, And I can't even go see the Christmas tree; I'd love to take my patients to go see the Christmas tree at the moment and it's such a long way to go. N01

A ground floor location with an access to a garden would be ideal.

> Stick us on the ground floor with doors that open onto the gardens, and I'll have a purpose. I don't need a day room then. So we'll go outside to water the flowers. I think that needs to be thought about in terms of if we're going to do elderly care properly, because a lot of the older generation like gardening, they like outside, they like fresh air. N01

7.14 Summary

In this chapter I reported suggestions of the interviewees that they felt could improve the current situation on the wards for older people. Most of these proposals were pertinent to mobility promotion: increasing the number of staff, providing day rooms and stimulation, promoting independence, exercise classes, written instructions for patients, providing sufficient amount of equipment, education of staff, family and patients, family involvement in care and better location of the wards. Other suggestions were related to more general well-being of inpatients: allowing self-medication, orientation of patients to time and date, separation of confused patients.

Chapter 8: Discussion

In this chapter I summarize and interpret the main findings from my study, make a comparison to current literature, discuss the strengths and weaknesses of the study as well as its clinical and research implications.

8.1 Study findings and interpretation

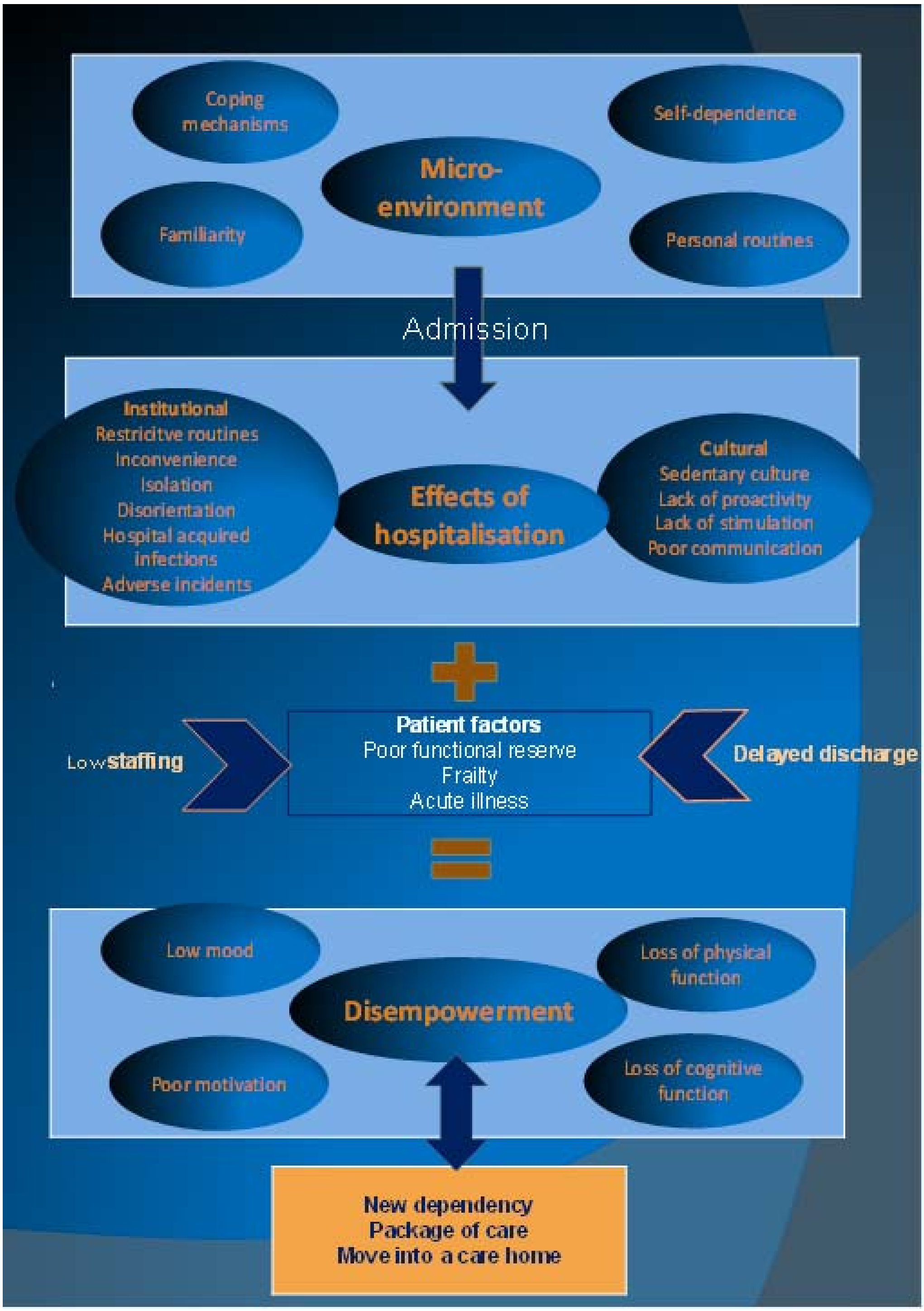
> ‘Not enough stimulation, not enough activity, not enough self-control.’
>
> **Relative (F02)**

8.1.1 The characteristics of a hospitalised older person and the hospital environment

8.1.1.1 The image of an older patient

The general vision of an older person in hospital bears certain similarities among different groups of staff. The overwhelming impression is that of an older patient lying in bed who is unwell, frail, confused, fearful and undemanding, vulnerable, complex socially and in terms of medical co-morbidity, dependent and requiring a high level of supervision. This image fits well within the existing nursing literature (56) which highlights the complexity and vulnerability of the older patients who now make up 65% of all hospital admissions (57). There is however, a spectrum of patients who at the other extreme are fit for their age, have less co-morbidity and therefore tend to recover faster from an acute illness and spend less time in hospital. We can get a glimpse of this sort of patients when reading the transcripts of patient interviewees: they do not seem particularly frail or vulnerable, in spite of suffering from ailments and having been treated for an acute illness; they often voice strong opinions and exhibit a need to stay in control rather than succumbing to the role of the sick. Nevertheless, the latter description appears to refer to a patient who is an exception rather than an average hospitalised older person. What follows in this chapter pertains mainly to those frail and vulnerable patients who are at greater risk of complications, who are often not able to speak for themselves (e.g. they did not participate in this study mainly due to being medically unwell, severely frail/immobile or lacking capacity to consent to the study), but who comprise the main business of geriatric care in hospital. The main ideas surrounding the journey of a hospitalised older person are summarised in Figure 2.

Figure 2 - The journey of a hospitalised older person



8.1.1.2 Effects of hospitalisation

It is worth noting that there are many positive aspects of hospitalisation appreciated by all respondents. First of all, being in hospital allows for timely diagnoses and management plans with regards to acute issues; the nurses provide compassionate and expert care in constantly time-pressured circumstances and attention which is most appreciated by those who live alone;

communication within the teams and with patients is improved from what it used to be according to patients and relatives. Furthermore, thorough multidisciplinary assessments of function and social situation enable the patient safe return to their home environment. The hospital is also regarded as a ‘place of safety’ especially for those who live on their own. Finally, the understanding of older person’s needs is much better than in the past which is particularly evident in the care provided for those with dementia. The combination of these interventions creates a so-called holistic approach which lies at the centre of care for an older person. In nursing literature, the essence of caring has been defined as a practice of addressing the specific needs of the person being cared for (58). Understanding the individual needs and responding to them in a sensitive and caring way are parts of the healing process which is more than just appropriate medical attention and use of technology. Kirkevold (59) conceptualised two forms of nursing actions that underpin the value of caring: ‘alleviating’ and ‘enabling’. The initial phase of reducing the burden and stress of patients admitted with a medical condition (in this case a chronic skin disease) was ‘alleviating’; followed by a phase of ‘enabling’ in which the nurses shared their knowledge and skills of managing the condition with the recovering patient and finally offered supervision only in aid of self-management. This is an excellent example of empowering care which contrasts with the concept of disempowerment in the care of older people (see paragraph 8.1.1.7). Yet, it is important to remember that with the older frailer patients’ multi-morbidity ‘enabling’ care offers much greater challenges for healthcare professionals.

Despite the increasing efficiency and understanding of the care for an older adult the interviews revealed many negative aspects of hospitalisation. Some are inherent to being in an institution, but others could potentially be alleviated by changes in either logistics or attitudes of hospital staff.

Inevitably, patients are taken out of their micro environments where they use their own routines and individual coping mechanisms, where they make their own choices and look after themselves in their own way – all of this may not be perfect according to hospital standards but may just be good enough for that particular person to be able to function at home.

From an older patient’s point of view, the hospital can be characterised by an unfamiliar environment with loss of typical home routines. Instead, they are replaced with restrictive hospital rules which occur at certain times independent of patient’s preferences and habits or sometimes unpredictably (such as mealtimes, tea/coffee rounds, drug administration, visiting hours, ward rounds, personal care). Typically, restrictive rules are associated with being in an institution and to compound this picture there are further characteristics that contribute towards the negative impact on patient:

- Multiple ward/bay moves which result in disorientation in time and place
- Inconvenience of staying in the same bay with five other people involves lack of privacy (except for curtains that can be drawn around the bed) as well as noise due to other patients being confused or undergoing medical treatments
- Isolation in a single room due to infection
- Hospital acquired infections (these may include pneumonia, urinary tract infection, Clostridium difficile diarrhoea, spread of norovirus and flu)
- Adverse incidents (including falls, patients escaping, lost belongings, medication errors or equipment failures)

Older patients are not protected from falling in hospital. They still have the same risk factors as when they live in the community, now compounded by the unfamiliarity of the hospital environment. This fact is not necessarily known to the families, who certainly do not expect their loved ones to have a fall while an inpatient and regard the hospital to be a place of safety. In such circumstances, an adverse incident can cause distress and loss of confidence in staff and their professionalism.

8.1.1.3 The concept of 'total institution'

The term 'total institution' was popularised by Erving Goffman, an American sociologist in the 1960's (60). Although the author focused mainly on mental hospitals/asylums as an example of a total institution, other comparisons have been made since, including general hospitals (61). According to Goffman, a basic social arrangement involves the fact that 'we sleep, play and work in different places, in each case with a different set of co-participants, under a different authority'. In an institution these barriers are removed as all of the actions happen in the same place (e.g. a hospital bay), with the company of the same people (e.g. other patients in the same bay) who are required to do a similar activity in a similar way (e.g. washing, toileting, eating). The activities are tightly scheduled and pre-arranged by the authorities (see above restrictive routines) and form a part of an overarching plan to fulfil the official aim of the institution (e.g. treating acute illness).The above features could be described as inherently institutional and may be difficult to change.

8.1.1.4 Cultural characteristics

However, some of the negative impact results from the culture that permeates the ward environment and would require a change in attitude driven by an example from senior leaders. The characteristics mentioned by the respondents were: sedentary culture, lack of stimulation, lack of proactivity among staff, poor communication among staff and between staff and patient/family.

8.1.1.5 Organisational characteristics

Two other aspects which were particularly close to the hearts of all respondents included low staffing levels and delayed discharges which are neither institutional nor cultural (but could be termed organisational). These would lend themselves to major improvement if they presented a priority on the financial agenda of the authorities. Both of these issues, according to interviewees were the most urgent and had most potential for radical improvement of quality of care for the older patient. They were also the most frustrating and emotionally charged problems due to the fact that an average staff member, patient or relative could do nothing to help solve these problems and that they were long-standing without any prospect of solution in the near future.

8.1.1.6 Disempowerment and dependence

All above characteristics of hospitalisation coupled with patient’s vulnerability which results from frailty and acute illness may lead to disempowerment. Disempowerment can be described as being deprived of self-dependence and by losing the joy of life (Collins online dictionary). Another word used to describe this state is institutionalisation as it occurs when a person spends a long period of time outside their normal living environment, in an institution which by ridding them off their autonomy, forces them into an unnatural role which they ultimately accept as their new identity. The new identity in this case is that of being ‘sick’. Being dressed in pyjamas or hospital gowns certainly contributes to the general picture. Patients who would normally do all personal care independently at home (albeit slowly, in their own time), lose the ability to do so in hospital and become passive recipients of nursing care. A resistance against imposed routines is seen as ‘non-compliance’ rather than the urge to stay in control. Disempowerment is closely intertwined with negative emotional changes (such as low mood, anxiety, and withdrawal), loss of function, deteriorating cognition and poor motivation and leads to dependency. Consequently on discharge, the disempowered patient needs to be provided with additional support in the form of package of care or may need to change accommodation to a care home.

It is important to clarify that the above process does not necessarily explain all the cases in which the patient requires an upgrade of their social care input. Some patients may have struggled socially at home for a while and the hospital admission only uncovers the dire situation without contributing to it. Yet, in this study the main focus is on the negative effects of hospitalisation and the ways of relieving them; therefore the concept of institutionalisation which affects some of the older adults can be helpful in unravelling the network of various influences which affect their increasing social dependence.

8.1.1.7 The concept of disempowerment in wider literature

This striking image of an institutionalised patient was presented in 1946 by Marjorie Warren, who is regarded as 'the mother of geriatrics' in not only in Britain but worldwide:

> Having lost all hope of recovery, with the knowledge that independence has gone, and with a feeling of helplessness and frustration, the patient rapidly loses morale and self-respect and develops an apathetic or peevish, irritable, sullen, morose, and aggressive temperament, which leads to laziness and faulty habits, with or without incontinence. Lack of interest in the surroundings, confinement to bed, and a tendency to incontinence soon produce pressure sores, with the necessity of more nursing, of a kind ill appreciated by the patient. An increase in weight, especially in the anterior abdominal wall, and an inevitable loss of muscle tone make for a completely bedridden state. Soon the well-known disuse atrophy of the lower limbs, with postural deformities, stiffness of joints, and contractures, completes the unhappy picture of human forms who are not only heavy nursing cases and a drag on society but also are no pleasure to themselves and a source of acute distress to their friends. Still, alas, in this miserable state, dull, apathetic, helpless, and hopeless, life lingers on sometimes for years, while those round them whisper arguments in favour of euthanasia.
>
> **Marjorie Warren, Care of the Chronic Aged Sick, The Lancet, 1946**

Although the picture painted by the interviewees in this study is not nearly as disturbing, the message is similar: if the patients are left in bed, disengaged and unstimulated they will quickly become deconditioned, develop medical complications and find themselves in a downward spiral of gradual withdrawal from life.

The role of nursing staff in prevention of disempowerment and in fostering empowerment is crucial. The concept of empowerment is not easy to define but is better understood by its absence: powerlessness, hopelessness, loss of a sense of control over one's life and dependency, alienation, paternalism (62). In healthcare, empowerment is a process of helping people to assert control over the factors which affect their health. Therefore, this process entails a mutual relationship which requires trust, co-operation, negotiation but also environmental or wider social and political changes. In this relationship the healthcare professionals have to surrender the need for control and foster a sense of self-control and self-efficacy instead. Thus, the role of a nurse should be that of a facilitator, enabler and advocate rather than purely service provider. It is the results of selfdevelopment and self-awareness combined with helpful resources that empower a person not the services provided.

According to Faulkner the psychological process underlying empowerment is the concept of learned mastery (63). He argues that when people are exposed to controllable events they expect that future events will be equally controllable. This leads to enhanced motivation. Therefore, empowering actions on the part of the nurses will optimise patients' independence within their individual capabilities; learned mastery will enable patient's to perform tasks without assistance or supervision. In contrast, learned helplessness might be the theory which explains disempowerment by stating that people experiencing uncontrollable events will expect that future events will be equally uncontrollable. This leads to motivational deficit. And so, disempowering actions of hospital staff will result in dependence and patients being unable to perform tasks without supervision.

Faulkner developed valid models of empowerment and disempowerment in staff and patient interactions by using an act frequency approach (64). The principal components of empowering care he identified were: promoting patient independence, promoting information exchange and being aware of patient needs. Components of disempowerment involved: impeding patient collaboration in care planning, domination and indifference to patient needs. All the principal components can be exemplified by relevant actions e.g. staff attending to patients without asking their permission (impeding patient collaboration) or staff listening to what patients say without interrupting (promoting information exchange).

Correspondingly , other authors argued that empowering nursing care promotes patient's autonomy (the ability to make choices) and independence (the ability to perform daily activities unaided) (65). They identified similar principles that should underpin empowering care such as: individualised approach with effective multidisciplinary teamwork, facilitation of patient involvement in decisions about their care, patterns of communication that avoid exertion of control over patients and environmental modifications aimed at increasing flexibility and freedom while minimising risks. In my study, many interviewees emphasised the importance of good communication within the multidisciplinary team as well as with the patient and their family. By establishing a good relationship with the patient, healthcare professionals were able to foster self-determination and confidence in the recovery process. The volunteers noted that devoting time to patients who lack appetite can motivate them to eat more. Stimulating environment with provision of frequent mobilisation was emphasised by family members.

Deinstitutionalisation could be viewed as one way to promote personal autonomy (65) and could involve provision of own clothing which contributes to older person's dignity and changes the attitudes of care providers who start viewing the patient as an individual. In my study, therapists were strongly supportive of patients wearing their own clothes as a means of deinstitutionalisation. The first doctor, who insisted on rehabilitating older, bed bound patients in her pioneering geriatric unit created in 1935 in the UK, was Marjory Warren (66). Her holistic approach which included encouragement of patients to leave their beds still lies at the centre of care of older people nowadays. She stated that ‘it is wise to get elderly folk up as soon as their physical condition warrants, and it is of great value to their morale to get them dressed in their own clothing as soon as possible’ (67). Simple facts like this may sometimes ‘be lost in translation’ and need to be revived and remembered through fresh, inspiring approaches to an old truth. For example, the campaign EndPJparalysis which started in December 2016 and quickly spread across the NHS demonstrates a positive paradigm shift in that aspect of hospital care for older people.

8.1.1.8 The patient journey

To summarise, the patient’s journey in hospital may be seen as distressing and perplexing if viewed from the perspective of a frail and vulnerable person. Their voices were not heard directly in the interviews but through the voices of staff members and relatives.

The initial period of hospitalisation is often characterised by several ward moves and a multitude of consultations and investigations which may happen at unpredictable times of day or even night. This is followed by a period of relative standstill when patient becomes medically ready for discharge but undergoes a range of assessments before he or she can be discharged. The delays are inevitable and described by the respondents as a ‘heart sink’. The communication between the healthcare and social teams is frequently suboptimal and can be a reason of frustration on the part of the patient as well as the hospital staff. As highlighted by the therapists, those patients will often decline in function as they are no more a clinical priority on a busy ward.

8.1.1.9 Mobility as a means to empower

> Life requires movement
>
> **Aristotele**

Although there are many different institutional, cultural, organisational and patient related aspects that play a role in the negative effect of hospitalisation on an older patient the focus of this study is on mobility. Maintaining physical function is certainly one of the most important components of healthy ageing and together with good nutrition and mental stimulation enables achievement of best outcome following hospital admission. I argue that keeping patients mobile supports their self-dependence, encourages good nutrition and provides mental stimulation. Thus, mobility should be the main focus in hospital in order to bring vigour and empowerment to those who need it most.

8.1.2 Mobility of inpatients

There was a definitive gap in understanding of the importance of physical activity among the patient respondents. Although all of them felt that keeping active was essential, no-one was able to clarify any particular health benefits (apart from preventing 'stiffness'). Staff emphasised the stark difference between a patient who was normally physically active (e.g. playing golf, gardening or walking a dog) and a patient who had a sedentary lifestyle. The more active ones would recover quicker and have a better motivation to work with therapists. Even with a similar morbidity burden, they tended to be more sociable, have better coping strategies and a more positive outlook on life. There was felt to be a limited scope to educate inactive patients at this stage due to a deeply ingrained lifelong habit of sedentariness. It was noted that in hospital we can encourage activity with the aim to regaining or retaining function and discharging patients rather than impacting on their usual level of activity at home.

The therapists described how they assess patient's function and make recommendations for the nurses to maintain mobility by walking patients to the toilet rather than bringing the commode, and functional movement by allowing patients to wash or dress. Unfortunately, this advice was often not followed due to time pressures. The patients themselves noticed that they were being 'spoilt' as everything was done for them by nurses. There was some awareness of bed rest risks among the patients and family members; but many were also strongly in favour of staying in bed as a means to rest and recovery. These views were frequently challenged by therapists who observed that relatives were able to change their attitudes and start encouraging patients to mobilise more after being educated.

8.1.3 Barriers to mobilisation

The respondents identified a range of obstacles that prevent patients from mobilising and I divided them into four groups for clarity: environmental, patient related, family related and staff related.

8.1.3.1 Environmental barriers

The balance between maintaining clutter free space around the beds and providing appropriate walking aids to all patients was certainly an issue. The institutional aspect of hospital routines warranted that the patients were too anxious to go for walks in case they missed an important consultation or an investigation. For some patients mobilisation was not attainable due to isolation in a side room. For those who were able to walk independently, having no specific goal or stimulation discouraged mobility.

8.1.3.2 Patient related barriers

There were obvious intrinsic barriers associated with patients:

- physical health (acute illness, medical attachments such as drips and catheters, symptoms such as fatigue, apathy, pain);
- psychological health (low mood or motivation, anxiety, fear of falls)
- mental health (cognitive impairment causing lack of insight and short memory loss which hindered following advice of therapists)
- lack of awareness of the risks of bed rest

All of the above barriers are well described in literature involving qualitative interviewing and surveys and were described earlier in paragraph 1.2.3.

My respondents observed that many patients choose to stay in bed rather than participating in ambulation. This passivity in institutional settings was also described by Davies et al. with one of the explanations being the theory of learned helplessness as described above (65).

The ‘risk averse culture’ influenced staff’s willingness to mobilise patients driving the assumption that all patients were potentially at risk of falling. Everybody seemed to be afraid of moving the patient without specific permissions to do so by either medical or therapy staff (depending on the clinical scenario).

8.1.3.3 Family related barriers

The relatives whom I interviewed in this study showed a remarkable level of engagement in the direct care of their mother or father. However, this stance was an exception rather than a rule according to staff respondents, who noted that a rather passive attitude among the visitors was more typical. This inertia, frequently compounded by anxiety about falls and lack of knowledge with regards to risks of bed rest, potentially contributed to patient’s immobility on the wards.

8.1.3.4 Staff related barriers

Low staffing levels were frequently reported as the main barrier to mobilisation not only by staff but also by patients and relatives. In particular, the scarcity of therapy sessions which usually happened once a day or less often was thought to impact negatively on patients' mobility levels. The relatives thought that the resources were not managed effectively, causing a vicious circle of allowing patients to decondition due to low staffing levels which then led to costly, extended hospitalisation often resulting in care home placement. They thought it would make more sense to invest more money into staffing to prevent the negative and expensive effects of delayed discharges. In a survey of nurses' perceptions of their knowledge and barriers to ambulation conducted in two USA hospitals (68) 58% admitted that patients rarely or never mobilised three times a day or as ordered. The reasons chosen by the respondents were first of all inadequate staffing numbers, closely followed by patient volume/acuity/discharge activity. Other highly rated factors competing with ambulation were: lack of equipment, lack of support from team members and unbalanced patient assignments.

The general attitude of staff with regards to mobility was often criticised by staff members themselves as well as family. It could be summarized as lack of proactivity/encouragement in mobilisation, lack of shared responsibility and lack of confidence resulting from unsatisfactory training and education of nurses and doctors on manual handling. The possibility of injury while manually handling a patient was also reported as a barrier. Claiming the responsibility for ambulating patients by nurses who are the main basic care providers to older inpatients could be a key to changing mobilisation practice on the wards. In a qualitative study of 25 nurses (69), those who claimed responsibility for ambulating patients were more proactive in mobility promotion and collaboration with therapy staff. In contrast, nurses who attributed the responsibility to others deferred patient ambulation while awaiting decisions to be made by other healthcare professionals.

8.1.4 Volunteer led mobilisation

The idea of training volunteers to mobilise older patients was generally well received. One patient commented that a walking programme would cause too much chaos on the wards; another patient had an unusually negative attitude to volunteers; one relative expressed her reservations about burdening the volunteers with too much responsibility. Staff and volunteer respondents received the idea eagerly while commenting on potential issues that would need to be considered prior to implementation. I divided these concerns into four main categories: patient selection, volunteer selection, environment and staff related. This part of my study is novel which means that there is no previously published literature around this very specific topic i.e. issues to consider when introducing volunteers to help with mobility of hospitalised older adults.

8.1.4.1 Patient selection

Suitable patients would need to be identified by healthcare professionals and a safe identification system would need to be in place. Confirmation with the nurse looking after a particular patient would need to be sought by the volunteer immediately prior to a mobility session. As the older patients are at high risk of sudden deterioration, the volunteers should be vigilant and not attempt to mobilise any person they are concerned about. Patients' motivation might present an obstacle and the volunteers would need to be prepared to encourage them.

8.1.4.2 Volunteer selection

The personal characteristics of a volunteer would need to be considered during recruitment. The therapy staff noted that working with older people required a holistic attitude and patience. The idea of engaging medical or therapy students into this programme was received positively. One doctor reflected that this could enable the medical students some insight into patients' perspective before they fully qualify. It is important to consider what would be the actual role of the volunteer. Possibilities include mobility maintenance for those discharged from therapy; guiding and prompting (e.g. in those with visual problems or requiring a walking aid); engaging patients in falls classes or chair exercises; roles other than mobility related (facilitating patient to patient interaction, providing company, reassurance and mental stimulation). Staff members emphasised the legal aspect of volunteer-led mobilisation. In particular, they were concerned about the risk of falls and subsequent legal responsibility. They also noted that there would have to be a robust volunteer training in place with competency checks. Direct supervision would need to be provided by a designated person who would support the volunteers on the wards and address any arising problems.

8.1.4.3 Environment

The nursing staff were aware of the challenges within the ward environment that warranted reflection. Timing of the mobility sessions would need to be scheduled around clinical routines. The volunteers should be prepared to cancel/reschedule the session in consideration of other patients in the same bay (who may be unwell or dying). A suitable, unobstructed space would need to be chosen in advance to facilitate safe mobilisation.

8.1.4.4 Staff related

Therapy staff were concerned that the role of a volunteer could stand in conflict with the role of therapy assistants due to their similar area of responsibility. To avoid potential misunderstandings and tensions it was crucial to educate the staff on how volunteers fit within the clinical team and what is the exact remit of their practice. Creation of additional work to supervise or educate the volunteers was another fear of the already overburdened nursing staff.

8.1.5 Proposed changes

The participants were asked about preferred changes that in their view would improve patient care. The majority of them reiterated previously stated opinions about the need to increase staffing levels. Another common theme was to provide day rooms to stimulate patients to walk, dress, eat their meals at a table rather than bedside and provide some entertainment. The nursing staff appreciated that the main limiting factor was lack of space in which case a dining table in each bay could be more achievable and would provide a similar role to a dayroom. Location of the department on the top floor of the hospital building made it difficult for patients to go for outside walks or visit the shops due to long waits for the lifts. Provision of regular, reliable mental stimulation such as free television, radio, interactive screen, volunteer befriending or recruitment of an activity organiser were all suggested as a means to improving patients' experience of hospital admission. Promotion of independence by encouraging patients to get dressed, mobilise and allow for self-medication was highlighted by therapists as an educational goal for all involved. One family member felt strongly about the need to empower patients to make informed decisions about their care in contrast to the current 'passive' culture where healthcare is done *to* patients rather than *with* patients. Other suggestions included orientation by placing clocks and calendars at bedside as well as information regarding what every individual was allowed to do without calling for the nurse. Several patients were affected by having to share a room with very confused people and thought that there should be a way to separate them to enable others a better night's sleep. Relatives proposed a more formalised approach to family involvement in care. They felt that often families were unsure of what is expected of them and this lack of confidence could be addressed by encouragement and education. It was noted that the cultural changes that resulted in empowering patients and families in other areas of healthcare such as paediatrics or obstetrics would need to take place in the care of older people. The relatives felt that the new generation of older patients would be more demanding and thus would naturally initiate the required paradigm shift.

8.2 Strengths and limitations of the study

8.2.1 Strengths

This qualitative study was designed to answer some specific questions but also to gain thorough understanding of the wider issues surrounding the immobility of older acutely hospitalised adults. The study had the following strengths:

- The study was preceded by a literature review which allowed for reflective and evidence based approach to its qualitative design.
- The Framework method provided a well-recognised analytic structure and focus.
- I chose face-to-face interviewing for patients which allowed me to remain flexible so as to adjust to the needs of the individual person within a changeable ward environment. In the same way, I used this method of interviewing for family members who were able to express their opinions comprising unfavourable views or controversial areas. I divided staff respondents into professional groups which facilitated meaningful discussion while providing an informal atmosphere among colleagues. My impression is that I created an atmosphere of security and confidentiality in which the participants were comfortable enough to share their personal and not always 'politically correct' comments. In some circumstances, I conducted one-to-one interviews with members of staff (e.g. consultant and a few nurses) in their work office due to time pressures and convenience. I felt that in general the interviewees were frank in their responses; self-reflection was evident in many resulting in interesting insights and considerations for the future.
- The interviews were semi-structured which meant that there were predetermined questions (which in most cases respondents answered in full) and open-ended questions which allowed for new ideas or paths to emerge during interviewing. I noticed that I became more proficient in interviewing during the study and learned how to probe my study participants in a more skilful manner. This insight was gained during analysis of the initial interviews.
- The participant sample was large for a qualitative study and I included a variety of staff groups which makes the findings to some extent generalizable. I recruited 20 out of intended 20 patients and 28 out of intended 30 staff members plus three volunteers.
- I recorded all the interviews and focus groups and they were transcribed verbatim by an experienced transcriber – this ensured accuracy and reliability of data collection.

- The transcripts were analysed by two persons: I and another researcher to increase reliability. The coding frameworks were reviewed repeatedly in accordance with emerging data from subsequent transcripts.

8.2.2 Limitations

There were following limitations to my study:

- With regards to patient and family sampling, I was not able to choose particular characteristics as per the a priori sampling criteria due to difficulties in recruitment. In other words, I had to recruit all who were eligible and agreed to participate (convenience sample). I did manage to represent most categories I aimed to sample. I only recruited seven out of intended ten relatives. Not many family members were sufficiently keen and involved in care to participate. Due to ethical considerations, I was unable to interview sicker, cognitively impaired patients or to purposefully recruit their relatives.
- I recruited 28 out of 30 staff plus 3 volunteers. It was especially difficult to recruit staff nurses – several cancelled their appointments at the last minute due to work pressures. There were only two staff nurses among the participants both from the same ward which was relatively less busy and understaffed ward than the remaining four wards – this might have introduced some positive bias. However, other staff were recruited from across all the different wards.
- Although all of the interviews were conducted in a confidential manner, in the case of patients I was unable to provide a private space on the ward; they were interviewed in a bay where other patients or staff members were likely to overhear parts of the conversation. This might have inadvertently created a bias towards expressing more positive opinions. However, in some cases (several males) patients openly voiced strongly negative opinions while others (especially females) tended to be generally content and undemanding in their attitude.
- Some of the early interviews I conducted were comparably less skilful than those conducted at a later stage. For instance, I did not probe further if a new idea was introduced or I was not able to gain responses to all of the structured questions. Also, the interviews seemed lengthy for some individuals who would become tired at the end. In a few cases, I had to cut the interview short or omit some questions if I noticed exhaustion in the participant. There

was a potential to miss some ideas with briefer interviews but the numbers of interviewed were large and no new concepts were emerging by the end of the recruitment period.

8.3 Implications for the future

There is emerging evidence that volunteer-led mobilisation in hospital is an acceptable, feasible and cost-effective intervention that could be widely disseminated across acute healthcare settings in the UK and other countries. Yet, it is important to remember that hospitalisation is and always should be a very short episode in an older persons' life. While healthcare professionals should make every effort to prevent hospital decline and resulting increased dependency, it would be short-sighted to believe that this is sufficient to stop the epidemic of sedentary lifestyle and its medical, social and individual consequences. Better links with community services should be established so that the work initiated within the hospital wards may be continued and expanded after patient's discharge. This paradigm shift with regards to immobility needs to also take place outside the hospital –within community services, GP practices, care homes and ultimately in patient's own homes and families. Physical activity is strongly related not only to physiological and cognitive function in older people but also enhances subjective well-being which is a criterion of successful ageing (70). Setting and pursuing specific personally and culturally valued goals which satisfy a person's psychological needs of autonomy, competence and relatedness enables self- regulation of subjective well-being. In the bio-psycho-social model, the older person's choice with regards to the goals is also influenced by personal dispositions (such as genotype, personality, socialisation and economic status) and the social structure e.g. stereotypes of ageing, facilities available, environment. Although the stereotype of ageing is changing, there still exists this long held view among many younger and older people that physical and cognitive decline is inevitable and expected with ageing. The majority of older people in the UK do not meet the recommended minimum physical activity levels despite the highly publicised benefits of keeping active (71). Sedentary behaviour is associated with frailty which has been recognised as a clinical syndrome and is amenable to prevention and treatment by multifaceted interventions, the core of these interventions being physical activity. An overwhelming majority (up to 98.5%) of inpatients on acute medical wards for older people are reported to be already on the spectrum of frailty i.e. either frail or pre-frail (72). This current qualitative study highlighted the needs of our frailest inpatients and potential ways of ameliorating the complications of hospitalisation by empowering care. In addition, this study also calls for a more universal, all-encompassing change in healthcare and societal attitudes to the ageing phenomenon. As healthcare professionals, it is our role and duty to promote active lifestyles in our patients as a means to frailty prevention and treatment. We need to challenge the status quo of inactivity among older people and work towards more public awareness of the prerequisites of healthy ageing.

8.4 Recommendations

My impression is that the NHS can pride itself on their employees: they remain devoted to patients, empathetic and willing to improve the care they provide despite the increasing challenges and enormous pressures experienced on a daily basis. Clearly, the problem of understaffing is a huge obstacle in delivering optimal care in hospital. It may be that we have to stop thinking about volunteers as an alternative but instead regard them as an essential link to a wider societal engagement with hospital care. In the community, older people often completely rely on informal, unpaid carers who know best what their needs, wishes and concerns are. Medicalisation of basic care needs and isolation of older people from mainstream life has contributed to a certain degree of societal fragmentation. This is unfortunately seen on the wards when most families seem to be detached from what should be a continuous, multifaceted, patient-empowering healing process. Families and friends could potentially be engaged not only in hospital but could also help by ‘bridging the gap’ between secondary care and the community rather than awaiting the final social services input prior to discharge. Closer relationships with a variety of community services could be beneficial in helping post hospitalisation recovery and signposting patients to local support groups. Although increasing the number of hospital and community staff would of course be extremely valuable, I feel that this would still be not enough to tackle this impending crisis in the care of older people. Only a strongly interrelated society can make a real difference: sharing knowledge, skills, time and caring for each other on a day to day basis should be the society’s main goal. By secluding ourselves in our individual worlds this goal is nowadays mostly forsaken. By introducing true empowering care in hospital, the NHS is well placed to challenge common misperceptions about ageing (‘too old, too ill, to tired’) and further promote the already developing movement of ‘healthy active ageing’. In this context, engaging young people in hospital volunteering (e.g. college or university students) as well as education and encouragement of families/visitors to contribute would provide excellent models of societal engagement that would hopefully translate into more interrelatedness in the community.

8.5 Conclusions

It would be easy to fatalistically conclude that care of older people in hospital has not progressed much since the times of Marjorie Warren or since the aforementioned paper on risks of going to bed (73). In many ways, this statement is true – we still need to find the best way to manage our old, frail inpatients, to learn how to best avoid hospital deconditioning and all the grave consequences of prolonged bed rest. But if you look closely at the long history of geriatrics in the UK, you will notice how from humble peripheries of modern disease-based medicine it has slowly developed into a hub of excellence in holistic, multidisciplinary, deeply humane and patient oriented care. In front of our eyes, caring for older people is transforming from an underfunded, underappreciated and under researched underdog into an exciting evidence, excellence and enthusiasm driven specialty. By setting an example of empowering care which prevents decline in hospital, we may be the beacon of healthcare driven empowerment of general public towards healthy ageing. Looking well after frail old people in hospital is crucial and there is an evident momentum driving the change but how about empowering the society to grow old without growing frail? I am prepared to be part of this vision.

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Appendices

A.1 Ethical approval

NHS
Health Research Authority
NRES Committee North East - Newcastle & North Tyneside 2
Room 002
TEDCO Business Centre
Rolling Mill Road
Jarrow
NE32 4BW

Tel: 0191 428 3565

13 September 2013

Dr Alicja Baczynska
Academic Geriatric Medicine
Level E MP807 Southampton General Hospital
Tremona Road, Southampton
SO16 6YD

Dear Dr Baczynska

Study title:	**Qualitative study to evaluate the views and perceptions of physical activity in older age, in-hospital volunteer-led mobilisation and family participation in hospital care**
REC reference:	**13/NE/0276**
Protocol number:	**RHM MED1133**
IRAS project ID:	**131776**

The Proportionate Review Sub-committee of the NRES Committee North East - Newcastle & North Tyneside 2 reviewed the above application on 11 September 2013.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Gillian Mayer, nrescommittee.northeast-newcastleandnorthtyneside2@nhs.net.

Ethical opinion

The sub-committee raised the following issues and as student investigator, you responded accordingly as follows:

1. Screening question 7 has been answered to state that individuals who lack mental capacity to give consent will not be included; however section A6-2 of the application states that the aim is to recruit carers of such individuals to *mirro*r their views. A17 also states that relatives/carers will be recruited, *'... to represent the views of confused patients who are unable to participate.'* This raised a concern for members of the sub-committee.

   With reference to SQ7 (in particular); while it is debatable if this project constitutes intrusive research, Common Law, the Human Rights Act (1998) and usual practice, however, would all indicate that Informed Consent should be obtained for the type of research proposed in this study. It was noted that it is not intended to recruit such persons in this study but it appears that the aim is to capture data on their views/opinions/experiences by proxy (i.e. via a relative or carer). The sub-committee consider this could be viewed as comparable to asking that the relative/carer acts as a consultee for the patients concerned. The process proposed would also appear to deny the patient concerned the opportunity to speak (or communicate by another means if required) and share their own views themselves. The Mental Capacity Act (2005) provides a framework for research involving persons who lack (or of whom there is doubt) mental capacity to give Informed Consent.

You acknowledged that recruitment of relatives to represent the views of confused patients would create issues regarding obtaining informed consent. Therefore, it was decided to interview relatives only with regard to their own opinions rather than with regard to the opinions of the patients. You clarified that patients unable to give informed consent will be excluded.

2. Patients' eligibility is being determined (in part) by their AMTS scores and if an AMTS score is not already available the AMTS will be applied as part of the research. It was queried if the individual's Informed Consent will be obtained and documented for the AMTS to be administered and data used in this study before it is administered. If not, clarification was requested why it is considered that this is not required. In addition, further information was requested regarding what actions will be taken, by whom and when, with respect to those patients who are excluded under this criterion.

   You clarified that you will rely on the medical/nursing team to indicate potential participants who would be willing and able to give informed consent and take part in the research. It was noted that an AMTS will not be performed as part of the research screening. As the patient would have been hospitalised for at least one week, the staff would be able to decide whether they are eligible for the study.

3. Section A17-1 states that to be eligible, relatives/carers must have a good relationship with the patient. Clarification was requested by whom and when that judgement of the quality/nature of the relationship will be made and on what criteria would it be deemed good enough for the person to be eligible. Also further information was requested regarding what actions will be taken, by whom and when, with respect to those relatives/carers who are excluded under this criterion. Clarification was also requested if those participants will be informed and if so, by whom and when, or if they will not be informed, an explanation of the reason for this to be provided.

   You agreed that it would not be appropriate to judge the quality of the relationship between the patient and their relatives but the aim is to recruit relatives who know the participants well. Thus, all relatives visiting twice or more in the week before who expressed an interest in the study would be eligible, using the frequency of visits as a measure of their awareness of the participants' current situation.

4. Clarification was requested if individuals are eligible *only* if both the relative/carer and the patient agree to take part; or if either does not wish to be involved, if the other person would still be eligible. If the latter, clarification was requested how that situation would be dealt with – if the other party would be informed and by whom and when they would be informed. Clarification was also requested how each person's independent choice will be determined regarding participation and in what order (patient or relative/carer first; or both together) this will be determined.

   You explained that it is not expected that both patient and their relative will consent to participate in the interview - it may be both patient and relative (in which case there will be two separate interviews to elicit their opinions), or if only one of them will participate there will just be one interview. If there is any concern or disagreement between the patient and relative about participation in the study, you will not insist on proceeding. However, the assumption is that both the patient and the relative will have capacity to decide for themselves.

5. Further explanation was requested why section A43 indicates that it is necessary to store/access personal data for 6-12 months after the study has ended.

   You explained that this was considered to be the usual period of data storage, however you noted that personal data could be destroyed after completion of the study as it will not be required in the future due to the nature of this research.

6. Clarification was requested if section A31 should have indicated that 24 hours will be allowed to decide on participation in the study as this would correspond with the information given at A27-1.

   You confirmed this.

7. The participant information sheet includes the phrase 'Your medical team suggested you may be interested in taking part'. This appears incorrect as it seems at this time point no one knows if the person is interested or not.

   It was explained that before being approached by the researcher the patient would have been asked by their healthcare team if they agreed to hear more about this study. This would imply that 'they <u>may</u> be interested in taking part'. If this assumption is incorrect then you would be willing to delete the sentence from the information sheet.

8. The Committee considered it important that patients should be allowed to have a family member present when they answer interview questions. They may feel very vulnerable in hospital and this option should be included in the participant information sheet.

   You agreed to include this option in the information sheet. From your experience with a previous study (qualitative research in the Southampton Mealtime Assistance Study) you noted that similar patients were happy to be interviewed alone.

9. Further information was requested regarding the research team referred to in the application - clarify who is involved and what roles they will undertake.

   It was clarified that the research team consists of only yourself as student investigator and the chief investigator/academic supervisor.

10. Questionnaire/Survey

    a. The Committee noted that if the questionnaire is being sent to individuals in the community homes/settings then they could make a private decision whether they wished to complete the questionnaire and this would be assumed to be consent to this part of the study. However the questionnaire will be administered to a group in a community setting so it should be made clear that individuals do not have to take part if they do not wish to complete the questionnaire to avoid peer group pressure. Also steps should be taken to maintain anonymity in a community setting. All questions do not have to be answered if this is the wish of the participant. This statement should be included in the questionnaire. When questionnaires are given to hospital patients they should be approached for their permission to be given the questionnaire (as they are unwell and may not wish to be troubled).

    b. There are points in the questionnaire where it appears the instructions are inadequate and inconsistent and/or the possible responses do not cover all possible responses for the given question and/or the wording is incorrect. For example, question 19: there is no option for respondents who have no experience of a hospital. Question 5: this is a multiple response question but (unlike in question 6) there is not the instruction "may be more than one". It was queried if the survey has been piloted to ensure the quality of the responses.

c. Clarification was requested regarding the survey methods - in section A13 it states that the survey will be administered in three settings: hospital wards, outpatient clinics and in the community. There is no clear statement regarding exactly what the target population in each setting is. Furthermore it states that - *To ensure the older population under study for the survey is well differentiated particular participants will be selected to include men and women, and a range of older age, mobility level and living circumstances."* This appears to indicate a quota sample – it was queried how such a sample will be selected in practice.

d. Sample size: A60 -"The number of participants who will return the survey is an estimate" - justification was requested. Also justification was requested why 300 survey respondents are required and also the expectation of the number of surveys distributed and to which groups. Although this will not be a random sample, in terms of justifying the sample size, a statement about acceptable margins of error on estimates derived from the survey would be helpful; for example, if there are 100 surveys returned from respondents who have cared for a relative in hospital then the margin of error on any percentage would be +/- 10%.

   After consideration you decided to withdraw the survey from this application altogether and will redevelop it for a future application taking into account these comments.

The sub-committee was satisfied with the responses given to the issues raised.

On behalf of the Committee, the sub-committee gave a **Favourable** ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Additional conditions specified by the REC

1. The participant information sheet to add the following statement –

   “You can be interviewed on your own or you can bring someone with you if you would prefer”.

2. Confirm that all personal data collected in the study to be confidentially destroyed when the study is completed.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Covering Letter		04 September 2013
Evidence of insurance or indemnity	Zurich Municipal (for Southampton University) + covering ltr	01 August 2013
Interview Schedules/Topic Guides	1 (Family Caregivers)	12 August 2013
Interview Schedules/Topic Guides	1 (Schedule for Patients)	12 August 2013
Interview Schedules/Topic Guides	1 (Schedule for staff members and volunteers)	12 August 2013
Investigator CV	Helen Roberts	
Letter from Sponsor		23 July 2013
Other: Student CV	Alicja Baczynska	
Other: Older Patient care and mobility in hospital survey	1	12 August 2013
Other: Verification of Insurance		30 July 2012
Participant Consent Form: Patient	1	12 August 2013
Participant Consent Form: Staff & Family Member	1	12 August 2013
Participant Information Sheet: Patient	1	12 August 2013
Participant Information Sheet: Family Caregiver	1	12 August 2013
Participant Information Sheet: Staff	1	12 August 2013
Protocol	1	12 August 2013
REC application		05 September 2013
Referees or other scientific critique report		16 July 2013

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
information is available at National Research Ethics Service website > After Review

13/NE/0276 **Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee’s best wishes for the success of this project.

Yours sincerely
pp

G. Mayer

Dr Alasdair MacSween
Chair

Email: nrescommittee.northeast-newcastleandnorthtyneside2@nhs.net

Enclosures: ‘After ethical review – guidance for researchers’

Copy to: Dr Helen Roberts - Clinical Senior Lecturer & Honorary Consultant Geriatrician, Academic Geriatric Medicine, Southampton General Hospital

Dr Jan Westbury – R&D Dept, University Hospital Southampton Foundation NHS Trust

NRES Committee North East - Newcastle & North Tyneside 2

Attendance at PRS Sub-Committee of the REC meeting on 11 September 2013 (by Correspondence)

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Alasdair MacSween (Chair)	Principal Lecturer in Research Governance	Yes	
Mrs Gaynor Mitchell	Part-time Biology Lecturer (Retired)	Yes	
Ms Vicky Ryan	Statistician	Yes	

A.2 R&D approval

University Hospital Southampton NHS Foundation Trust

Please reply to:
Research and Development
SGH - Level E, Laboratory & Pathology Block, SCBR - MP 138
Southampton General Hospital

Telephone: 023 8120 8689
Fax: 023 8120 8678
E-mail: mikayala.king@uhs.nhs.uk

Dr Alicja Baczynska
Academic Geriatric Medicine
Level E, Centre Block
University Hospital Southampton NHS Foundation Trust
Tremona Road
Southampton
SO16 6YD

07 May 2014

Dear Dr Baczynska

ID: RHM MED1133 Qualitative study to evaluate the views and perceptions of physical activity in older age, in-hospital volunteer-led mobilisation and family participation in hospital care

EudraCT:

Thank you for submitting all the required documentation for Trust R&D approval. I write to inform you that your study has full UHS R&D approval. Please find attached the Conditions of Trust R&D approval which you are obliged to adhere to.
Please note that according to the 70 day benchmark you should aim to recruit your first patient by 16/07/2014.

You are required to keep copies of all your essential documents relating to this study. Please download a copy of the relevant Investigator Site File template from the R&D website: http://www.uhs.nhs.uk/Research/For-investigators/Sitefile.aspx.

Your project is subject to R&D monitoring and you will be contacted by our office to arrange this.

Please note: A condition of approval is that any changes need to be timeously notified to the R&D office. This includes providing copies of:

. All NRES substantial amendments and favourable opinions;
. All Serious Adverse Events (SAEs);
. NRES Annual Progress Reports;
. Annual MHRA Safety Reports;
. NRES End of Study Declaration;
. Notifications of significant breaches of GCP or protocol

Please quote the above RHM No. On any correspondence with our office.

Should you, or any of your team, require training in any of the policies and procedures required to ensure compliance with the conditions of approval, please refer to the R&D Training website http://www.uhs.nhs.uk/Research/For-investigators/Mandatory-training-governance-and-safety-management/Mandatory-training-governance-and-safety-management.aspx for an up-to-date calendar of training events.

Yours sincerely

Dr Mikayala King

A.3 Study protocol

A study to evaluate the views and perceptions of physical activity in older age, in-hospital volunteer-led mobilisation and family participation in hospital care.

Study protocol

1. Introduction

Hospitalisation increases the risk of physical as well as cognitive decline ultimately leading to loss of social independence (Wilson et al., 2012) (Zisberg et al., 2011).
Previously independent older inpatients spend only about 43 minutes per day in upright position i.e. standing or walking (Brown, Redden, Flood, & Allman, 2009). A local study of inpatients wearing accelerometers before being discharged home showed that patients only spend on average 25 mins in standing position per day(Haslam, SC, 2012). Bed rest results in loss of 1-5 % of muscle strength per day (Creditor, 1993). Given that the average length of stay in the UK hospitals is 7.7 days (11 days for the over 85's) (Royal College of Physicians, 2012), it is not surprising that most of the elderly become seriously deconditioned and require increased support at home, a period of rehabilitation or even institutionalisation on discharge.
There is silver (Cochrane Musculoskeletal Group grading of levels of evidence) level evidence from the 2009 Cochrane systematic review that targeted exercise intervention may be beneficial (increased proportion of patients discharged home and reduced length and cost of hospital stay) All the studies included in the review were conducted outside UK and were based on employment of additional, trained staff members to deliver the intervention (N, Jl, & Jeffs, 2009). The additional cost of implementing such a programme by hospitals is clearly a deterrent in the current financial climate, especially with lack of overwhelming evidence from well designed trials.

The idea of using volunteers to help with some aspects of care for hospitalised older people has arisen as part of a multicomponent clinical trial to prevent delirium in the USA (The Hospital Elder Life Program - HELP). Early mobilisation was included in the 6-point protocol with an 84% level of adherence to this particular intervention. The incidence of delirium declined significantly from 15% to 9.9% in the intervention group (Inouye et al., 1999). Since then HELP has been disseminated to many hospitals worldwide; the website contains easily accessible materials required for successful implementation (www.hospitalelderlifeprogram.org).

The CAHO MOVE ON (The Council of Academic Hospitals in Ontario Mobilisation of Vulnerable Elders in Ontario) Project, implemented in 14 Canadian acute hospitals in early 2012 focuses on early mobilisation of older patients using an interprofessional approach (nursing and therapy staff led by the project implementation team). However some of the hospitals are using volunteers and family members to instigate progressive, scaled mobilisation at least three times a day within 24 hours of admission. The primary outcome will be frequency of mobilisation obtained through direct observation and chart abstraction. Secondary outcomes will include: length of stay, functional status on admission and discharge, discharge destination, falls, stakeholders' perceptions, rate of function documentation (Straus & Liu, 2012). The results are expected to be published next year (personal correspondence).

The Footprints Walking Program is another volunteer-based project commenced in 2011 at a USA acute hospital. More than 50 volunteers were trained to assist adult patients in 15-minute walking sessions using motivational 10–feet distance markers in the hallways. Around 20-25% patients from clinical units participate in the programme. The Footprints project was embraced by the hospital as one of the initiatives to improve patient care and experience in general. A brief report stated combined outcomes of increased patient and staff satisfaction as well as reduced length of stay (Boyd & Lipowich, 2011). It is also important to note that this undertaking has now become part of the hospital culture and has been extended to another unit in the form of dog assisted ambulation (personal correspondence).

In Australia, a service development to improve acute hospital experience of older patients by introduction of the ACTIVe Program (Aged Care Therapeutic Interventions by Volunteers) was reported in 2011 (internet source). The interventions delivered by a team of 20 volunteers consisted in: meal assistance, mobility assistance, companionship (reassurance, reducing anxiety and confusion) and therapeutic activities such as reminiscence, memory games, arts and crafts, reorientation. A twice weekly exercise class was established to maintain physical function and social interaction among the patients. The collaborators state that there was a reduction in the number of nurse specials required on the wards for confused patients and improved patient and family carer satisfaction but this was not formally evaluated. In addition, the staff felt more supported in the prevention of delirium and functional decline. Noticeably, the project encouraged the families to be more involved in the care of their hospitalised relatives (Tawbe, 2011).

Despite a thorough literature search involving Medline, Embase, CINAHL, Cochrane and Google no studies of volunteer assisted mobilisation based in the UK were identified. Therefore, it would be particularly important to find out whether introducing this type of early mobilisation in a British acute geriatric ward is feasible and acceptable to patients, their families and staff.

The Southampton Mealtime Assistance Study was established in 2010 to improve nutritional intake of elderly inpatients by providing trained volunteers to help at lunchtimes (Roberts et al., 2013). The intervention together with other innovations introduced at the same time in the hospital (ie. 'red trays' and protected mealtimes) improved the quality of mealtime care. The volunteers have become popular both with patients and staff members who appreciate their competent input on busy wards. They have continued to be an essential part of the ward teams at the University Hospital Southampton (discussion with author). Drawing on this valuable experience we are now planning to train the volunteers to assist with patients' mobility.

In the UK typically there are relatively low staff to patient ratios and more dilute skill mix on most wards for older people than other wards in hospitals. A recent report states that there are 9.1 to 10.3 patients per registered nurse (RN) on older people's ward whereas there are 6.7 and 4.2 patients per RN on medical/surgical and paediatric wards respectively. This means that on an average 28-bed ward there are 3 registered nurses and 6 staff members in total (including healthcare assistants) (Royal College of Nursing, 2012).

In fact, most older inpatients require at least some assistance with their care and even unpredictable 1:1 specials in particular cases of confusion. It is unsurprising that inadequate staffing levels may result in poorer care of this vulnerable group of patients. In comparison, medical/surgical wards tend to have less dependent patients, whereas paediatric units are supported by parents actively involved in the care of their children.

To be able to provide basic safe care Royal College of Nursing recommends at least 4 or more RN's and 8 or more staff members in total. The safe/ideal number of staff required will vary from day to day depending on the specific case mix of patients.

The two aspects of care reported to be most frequently neglected due to time pressures according to nurses are talking/comforting patients, promoting mobility and self-care. These important activities could be embraced by well trained and committed volunteers in addition to the already established mealtime assistance at Southampton Hospital.

A qualitative USA study explored perceived barriers to increased mobility among 10 patients, 10 nurses and 9 resident doctors on medical wards at a university hospital. The barriers most commonly described by all three groups of participants involved symptoms of weakness, pain and fatigue, presence of urinary catheters or intravenous lines and being concerned about falls. Lack of staff to assist with mobility was a major obstacle. Although doctors and nurses pointed towards lack of motivation this view was not reflected by patients themselves who in turn commented on the staff's apparent lack of interest in promoting mobility. Absence of ambulatory devices or appropriate dressing was also been reported as a concern (Brown, Williams, Woodby, Davis, & Allman, 2007).

In a UK study a structured, face-to-face questionnaire was administered to 44 inpatients at an urban hospital exploring the views around participation in physical activity. Most of the participants (52%) wrongly believed that their normal level of activity is adequate. They main reported barriers to increased activity were related to symptoms ('breathing' and leg' problems). Only 11% recalled that they received advice from healthcare providers to stay physically active (Buttery & Martin, 2009).

Despite fear of falling being a potential obstacle there is no current evidence that increased mobility results in more falls. It is thought that falls are more likely to be associated with cognitive and environmental factors rather than the level of mobility itself. Providing safe systems to mobilise for cognitively impaired inpatients and preventing delirium may reduce both falls and low mobility leading to huge cost savings (Fisher et al., 2011).

Another theme that arises from the above concepts is family participation in the care of their older hospitalised relative. A recent Chilean controlled clinical trial of non-pharmacological intervention (excluding early mobilisation) delivered by family members has shown reduced risk of delirium incidence in older medical patients (RR 0.41, P value= 0.027) (Martinez, Tobar, Beddings, Vallejo, & Fuentes, 2012).

The feasibility of family participation in delirium prevention was assessed as extension of The Hospital Elder Life Program in the USA with encouraging results. Fifteen family members together with their hospitalised relatives were included in the study. The caregivers were asked to implement five of the original six HELP protocols for delirium prevention and document their contributions after receiving training from the research team. They were able to complete the orientation, therapeutic activities, vision and hearing protocols at least 75% of the time. The early mobilisation proved to be most challenging (completed 50% of the time) due to fears about relatives' health state and various symptoms.

The authors produced recommendations for practice in three areas that were identified from the interviews with patients, family caregivers and nurses: to adopt family-centred care approach, to enhance therapeutic relationships, to introduce environmental strategies (adequate space, staffing, noise control) (Rosenbloom-Brunton, Henneman, & Inouye, 2010).

Qualitative study

2. Aim

The primary aim of this pilot study is to explore stakeholders' views and perceptions surrounding mobility of acutely hospitalised older people and acceptability of using volunteers to assist with early mobilisation. The secondary aim is to explore views around family participation in the care of their relatives on geriatric wards.

3. Study design

This is a qualitative study utilising both focus groups and semi-structured interviews with a purposive sample of patients, carers and staff members

4. Participants

Approximately, twenty patients who have been hospitalised for at least 1 week will be interviewed. About 10 patient relatives will be interviewed. Thirty multidisciplinary staff including doctors and nurses (various grades), physiotherapists, occupational therapists, healthcare support workers and about twenty hospital volunteers will be either interviewed or engaged in a focus group discussion.

5. Recruitment

There will be concurrent recruitment of patients, caregivers and staff during a 10-12 week period on acute geriatric wards.

6.1 Patients

A purposive sample of patients from different wards across a spectrum of following characteristics will be chosen:

Ward 1

	lives alone	care home/lives with family
Younger (<75)		
Older (>80)		
Female		
Male		

Eligibility criteria for patients selected for interview will include: stable medical condition, Abbreviated Mental Test Score (AMTS) 9-10, hospitalised for at least 1 week and likely not to be discharged within 2 days, ambulatory 2 weeks prior to admission with or without aids, able and willing to be interviewed. Patients who are unwell, dysphasic, confused or cognitively impaired or unable to mobilise 2 week prior to admission will be excluded.

Potential participants will be approached by a member of their clinical team who will outline the study and offer them the opportunity to have a detailed description of the study including a patient information sheet from a member of the research team. Potential participants will have a minimum of 24 hours to reflect before being asked to sign a consent form if they are willing to participate.

6.2 Caregivers

A purposive sample of family members from acute medical wards across a spectrum of following characteristics will be chosen:

Ward 1

	female	male
Younger		
Older		

Eligibility criteria will include: regular hospital visitor and good relationship with patient. They will be recruited to also represent views of confused patients who are unable to participate.

Potential participants will be approached as above.

6.3 Staff members and volunteers

A purposive sample of senior and junior staff from following groups will be recruited: medical staff, nursing staff including healthcare assistants, physiotherapists, occupational therapists and hospital volunteers. Ward managers will be informed of the study and asked to compile a list of individuals willing to participate. The potential participants will be then sent the full information sheet. Once confirmation is received about participation the researcher will arrange a time and place for the interviews and focus groups that is most suitable. The participants will be consented on the day, prior to the interview/focus group.

6.4 Consent forms attached as separate documents.

6. Interviews

The patients will be interviewed either at their bedside or in a private room (according to their preference) after agreement with their responsible nurse so that the interview does not interfere with care delivery.

Suitable appointments will be arranged with the caregivers in a private place either on the ward or away from the ward.

Staff members will choose the most suitable day, time and place for the interviews and focus groups following consent from their managers if applicable. Focus groups will likely involve several members of a particular professional group within similar level of seniority if possible. Interviews will be offered as an alternative.

One researcher will be facilitating the focus groups and interviews and audiotaping the discussions with express consent from the participants.

The researcher will continue to arrange interviews and focus groups until there is no new data emerging.

7.1 Interview schedules attached as a separate document

7. Transcription

The audiotaped conversations will be transcribed verbatim; checked and anonymised by the researcher.

8. Data analysis

Participants demographics will be analysed using summary statistics (age, gender, role). The transcriptions will be coded using NVIVO 9 by two researchers working independently and then together. Using grounded theory techniques, the tapes will be evaluated for themes by the principal investigator and another researcher, looking for commonality and differences within and between the participants. Themes that emerge from this pilot study will be explored in subsequent interviews as part of the main study.

9. Ethical issues

The patients and caregivers will be given at least 24 hours to consider whether they would like to take part in the study. Time will be allowed for arranging a suitable date and time for an interview to take place as some of the patients may be close to discharge date.

If at any point during the conversation the patient expresses or displays fatigue, the interview will be concluded and either completed at a later stage or regarded as impossible to complete.

The staff members will be given at least 24 hours to consider participation in the study. They will be then approached by ward sisters to share their decision rather than by one of the researchers to avoid direct confrontation.

It will be made clear that participants can withdraw from the study at any point. They will also be offered any support they may need in case of any distressing issues emerging as a result of the discussions.

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A.4 Patient interview schedule

Mobility of older people in hospital – qualitative study

Interview schedule for patients

We are interested in the views of patients and their informal carers about physical activity in hospital and beyond and I would like to ask you some questions around that topic.

In the first place I would like to ask a broad question about being in hospital.
How do you feel about being in hospital? Are there any advantages of being in hospital?
What do you feel is the main disadvantage of being in hospital (apart from being ill)? What could make a change?

Normal mobility level when at home
How do you walk? How far? Do you require assistance?

Perception of exercise in general
What do you think about exercise in older people?
Do you do any regular exercise? What kind of and how often per week?
If not, why not? What prevents you from doing regular exercise?
Are you aware of the benefits of exercise in your age group? Has anybody mentioned to you the benefits before (nurse or doctor) or advised you to undertake regular exercise?
Would you like to become more active?

Current mobility level in hospital
How do you get about at present?
Are you using any walking aids?
Independently or with help?
Who helps you – nurse, physiotherapist, family? How often in a day?
Do you think you walk about enough on the ward?
Is it a struggle or do you enjoy keeping active on the ward?

Perception of exercise and bed rest in hospital
What do you think about bed rest when staying in hospital? Are there any risks or benefits of bed rests? Does this concern you?
Would you be keen to increase your physical activity on the ward?
Who do you think should be helping you to walk or get about in hospital? Whose responsibility is it?
What would you think about a special programme to increase mobility of older inpatients? Do you think this would be useful?

Barriers to mobilisation
Are there any reasons why it is difficult to walk around the ward?
What are the main obstacles?

Coping mechanisms
What helps you cope with any limitations in your mobility?
Where do you find the strength to cope with any problems in everyday life?

Volunteer perception
Have you had any contact with volunteers while in hospital?
What do you think about hospital volunteers in general?
Are you aware that there are volunteers on the ward helping patients at mealtimes? What do you think about this?
What do you think about training volunteers to assist patients with walking on the wards?
Would you agree to be assisted by a suitably trained volunteer?

Family participation
What do you think about family involvement in care of their relatives on the ward?
Do you think your relative would be keen to help you in some way?
How would you feel about it?
Which aspects of care would you allow them to help with: feeding, mobilising, washing, dressing?
Would you like your family members to help with walking regularly on the ward? Why not? What would be the problems associated with that?

Is there anything else you would like to add?

A.5 Family interview schedule

Mobility of older people – qualitative study

Interview schedule for family caregivers

We are interested in the views of patients and their informal carers about physical activity in hospital and beyond and I would like to ask you some questions around that topic.

In the first place I would like to ask a broad question about your relative being in hospital.
How do you feel about your relative being in hospital? Are there any advantages of them being in hospital?
What do you feel is the main disadvantage of hospitalisation (apart from being ill)? What could make a change?

Normal mobility level when at home

How does your relative walk? How far? Do they require assistance? How much help are you able to offer them? Do you take them out?
What is their memory like?

Perception of exercise in general

What do you think about exercise in older people?
Does your relative do any regular exercise? What kind of and how often per week?
If not, why not? What prevents them from doing regular exercise?
Are you aware of the benefits of exercise in older age group?
Would you like them to become more active? Have you done anything in particular to encourage them?

Current mobility level in hospital

How does your relative get about currently on the ward?
Do you think they walk about enough?
Who helps them – nurse, physiotherapist, family? How often in a day?
Do you think it is a struggle or do they enjoy walking around?

Perception of exercise and bed rest in hospital

What do you think about bed rest when staying in hospital?
Are there any risks or benefits of bed rests? Does this concern you?
Would you be keen for your relative to increase their physical activity on the ward?
Who do you think should be helping them to walk around in hospital? Whose responsibility is it?
What do you think about patients taking part in an organised walking programme while in hospital (tailored to individual needs)? Would you be keen for your relative to participate?

Barriers to mobilisation

Are there any reasons why it is difficult for patients to walk around on the ward?
What are the main obstacles?

Volunteer perception
Have you had any contact with volunteers while in hospital?
What do you think about hospital volunteers in general?
Are you aware that there are volunteers on the ward helping patients at mealtimes? What do you think about this?
What do you think about training volunteers to assist patients with walking on the wards?
Would you agree for your relative to be assisted by a suitably trained volunteer?

Family participation
Do you think it is currently feasible for nurses to be actively involved in walking with patients regularly?
Do you think that current situation needs changing? Can you think of any ways to make things better?
What would be helpful in your opinion?
What do you think about family involvement in patient care?
Would you be keen to be more involved in you relative's care in hospital?
Which aspects of care would you be able to help with: feeding, mobilising, washing, dressing? How often and for how long would you be available?
Would you like to help your relative with walking around regularly on the ward? Why? What would be the positives and negatives associated with that?

Is there anything else you would like to add?

A.6 Staff interview schedule

Mobility of older people in hospital – qualitative study
Interview schedule for staff members and volunteers

We are interested in the views staff about physical activity in hospital and beyond and I would like to ask you some questions around that topic.

In the first place I would like to ask a broad personal question about your perception of hospital environment.
What are your thoughts around older patients staying in hospital?
What do you feel are the advantages and disadvantages of hospitalisation?
What could make a change?
How would you feel about your relative becoming an inpatient on this ward? Would you feel that it is a good place for them to be looked after?

Perception of exercise in general
What do you think about exercise in older age group? Are there any benefits? Are there any downsides**?**
Are you aware of the benefits of exercise in older age group?
Do you recommend exercise to your patients or older relatives? Do you actively encourage them to undertake regular exercise?

Perception of mobility in hospital setting
How much do you think patients mobilise in hospital?
Is it important for patients to mobilise or should they be staying in bed?
Are you aware of the risks of bed rest when staying in hospital?
Who helps them to mobilise – nurse, physiotherapist, family, doctors? How often in a day?
Who do you think should be helping them to mobilise in hospital? Whose responsibility is it?
Should they be mobilising more? Is it a part of their care plan or a whim?
Is there a mobility promoting culture on the ward?
Do you think that patients and their families are aware of risks of bed rest and of benefits of staying active?
What would you think about a special programme to increase mobility of older inpatients? Do you think this would be useful/feasible/acceptable?

Barriers to mobilisation
Is it easy of difficult for patients to mobilise?
What are the main obstacles for patients to mobilise regularly?

Volunteer perception
Have you had any contact with volunteers while in hospital?
What do you think about hospital volunteers in general?
Are you aware that there are volunteers on the ward helping patients at mealtimes? What do you think about this?
What do you think about training volunteers to assist patients with mobility/walking on the wards?

Do you think this could work?

Family participation

Do you think it is currently feasible for staff members to be actively involved in mobilising patients regularly?

Do you think that current situation needs changing? Can you think of any ways to make things better?

What would be helpful in your opinion?

What do you think about the concept of family participation in patient care?

If your relative was in hospital would you be keen to be involved in their care?

What would you be able or want to help with?

Do you feel that generally families are keen to get involved or not?

Would it be acceptable for them to help with: feeding, mobilising, washing, dressing on a regular basis?

Is there anything else you would like to add?

A.7 Patient information sheet

PATIENT INFORMATION SHEET

A research study to explore views on mobility assistance in hospital

LREC number: 13/NE/0276

We would like to invite you to take part in a research study. Before you decide we would like you to read the following information in order for you to understand why the research is being done and what it will involve.
Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.
Take time to decide whether or not you wish to take part.

PART 1

What is the purpose of the study?

The aim of this study is to explore the views of patients, their family caregivers and healthcare staff members on physical activity and delivery of care in hospital. We are interested to hear your opinion about exercise in older people, especially in hospital setting and about methods of delivering fundamental care.

Why have I been chosen?

We are asking several patients from medical wards to participate in this study. The patients who are eligible must have been in hospital for at least 1 week. Your medical team suggested that you may be interested in taking part.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do, you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

We will arrange a day and time that is suitable for you to conduct a 20-30 minute interview (either on the ward or in a private room according to your preference) which will be facilitated and audiotaped by one of the researchers. You can be interviewed on your own or you can bring someone with you if you would prefer.

Are there any risks or disadvantages associated with taking part?

The individual interviews will be anonymised. We will be sensitive to any feelings of tiredness or discomfort. You can ask the researcher for a break, to come back later or to stop altogether at any time. In the unlikely event that you find any of the questions difficult or distressing you can choose not to answer and we can offer further opportunity for support if necessary.

We will arrange the appointment so that it does not interfere with the daily care that you receive on the ward. However, if a situation arises in which the interview impacts on an immediate aspect of care we will reschedule the appointment for another time or day.

What are the possible benefits of taking part?

The information that is obtained during this study will allow us to determine what are the issues surrounding mobility and care of the patients from different perspectives. This valuable knowledge will be then used to inform the design of a future clinical trial.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. More detailed information on this is given in part two of the sheet.

Will my taking part in the study be kept confidential?
Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

PART 2

What if there is a problem?
If you have any cause for concern regarding your participation in the study, please contact one of the researchers in the first instance (see contact details at the end of this sheet). If this is unsatisfactory, they will be able to direct you to an alternative person who will be able to help.
If you have a complaint, which cannot be resolved by these measures, you may wish to complain formally. You can do this through the NHS Complaints Procedure. Details can be obtained from University Hospital Southampton Foundation NHS Trust, which sponsors this study and provides indemnity against clinical negligence during the study.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. We have permission from your Hospital Consultant to carry out this study.
The audiotapes with the interview will be transcribed and anonymised. You will not be identifiable from any quotes used in future publications. In the analysis of results, your data will be used anonymously. Our procedures for handling, processing,

storing and destroying data relating to your participation in the study are compliant with the Data Protection Act 1998. In accordance with this Hospital's regulations we are required to keep your data secure for 10 years. For the purposes of monitoring research there is a possibility that the hospital's Research and Development department will audit the data that we have collected.

What will happen to the results of the research study?

The results of the research will be published in medical scientific journals. Research staff may also present the results at conferences and local meetings. We may use quotes but you will not be identified in any report produced.

Who is organising and funding the research?

This research is being funded by the National Institute of Health Research, part of the Department of Health.

Who has reviewed the study?

This study was given a favourable ethical opinion for conduct in the NHS by the local research ethics committee and has been reviewed by the research and development team at University Hospitals Southampton NHS Trust.

This information sheet is for you to keep. If you are interested in participating in this study, please speak to your nurse who will contact the research team. Thank you very much for reading this information and considering taking part in the study.

For any further information please contact either

Dr Alicja Baczynska, Academic Clinical Fellow

or

Dr Helen Roberts, Senior Lecturer in Geriatric Medicine
University Hospital Southampton
E-mail: a.baczynska@soton.ac.uk
Telephone 023 8079 6128

A.8 Family information sheet

FAMILY CAREGIVER INFORMATION SHEET

A research study to explore views on mobility assistance in hospital

LREC number: 13/NE/0276

We would like to invite you to take part in a research study. Before you decide we would like you to read the following information in order for you to understand why the research is being done and what it will involve.
Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.
Take time to decide whether or not you wish to take part.

PART 1

What is the purpose of the study?

The aim of this study is to explore the views of patients, their family caregivers and healthcare staff members on physical activity and delivery of care in hospital. We are interested to hear your opinion about exercise in older people, especially in hospital setting and about methods of delivering fundamental care.

Why have I been chosen?

We are asking several family members from medical wards to participate in this study. The caregivers who are eligible would be a regular visitor on the ward. Your relative’s medical or nursing team suggested that you may be interested in taking part.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do, you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

We will arrange a day and time that is suitable for you to conduct a 20-30 minute interview (either on the ward or in a private room according to your preference) which will be facilitated and audiotaped by one of the researchers.

Are there any risks or disadvantages associated with taking part?

The individual interviews will be anonymised. In the unlikely event that you find any of the questions difficult or distressing you can choose not to answer and we can offer further opportunity for support if necessary.

What are the possible benefits of taking part?

The information that is obtained during this study will allow us to determine the views and experience of mobility and care of older patients from different perspectives. This valuable knowledge will be then used to inform the design of a future clinical trial.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. More detailed information on this is given in part two of the sheet.

Will my taking part in the study be kept confidential?
Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

PART 2

What if there is a problem?
If you have any cause for concern regarding your participation in the study, please contact one of the researchers in the first instance (see contact details at the end of this sheet). If this is unsatisfactory, they will be able to direct you to an alternative person who will be able to help.
If you have a complaint, which cannot be resolved by these measures, you may wish to complain formally. You can do this through the NHS Complaints Procedure. Details can be obtained from University Hospital Southampton Foundation NHS Trust, which sponsors this study and provides indemnity against clinical negligence during the study.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential.
The audiotapes with the interviews will be transcribed and anonymised. You will not be identifiable from any quotes used in future publications.
In the analysis of results, your data will be used anonymously. Our procedures for handling, processing, storing and destroying data relating to your participation in the study are compliant with the Data Protection Act 1998. In accordance with this Hospital’s regulations we are required to keep your data secure for 10 years. For the purposes of monitoring research there is a possibility that the hospital’s Research and Development department will audit the data that we have collected.

What will happen to the results of the research study?
The results of the research will be published in medical scientific journals. Research staff may also present the results at conferences and local meetings. We may use quotes but you will not be identified in any report produced.

Who is organising and funding the research?
This research is being funded by the National Institute of Health Research, part of the Department of Health.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS by the local research ethics committee and has been reviewed by the research and development team at University Southampton Hospitals NHS Trust.

This information sheet is for you to keep. If you are interested in participating in this study, please speak to your nurse who will contact the research team. Thank you very much for reading this information and considering taking part in the study.

For any further information please contact either

Dr Alicja Baczynska, Academic Clinical Fellow

or

Dr Helen Roberts, Senior Lecturer in Geriatric Medicine

University Hospital Southampton
E-mail: a.baczynska@soton.ac.uk
Telephone 023 8079 6128,

A.9 Patient consent form

University Hospital Southampton NHS
NHS Foundation Trust

Dr Alicja Baczynska
Academic Clinical Fellow
Tel: 02380796128
Email: a.baczynska@soton.ac.uk

PATIENTS INFORMED CONSENT FORM

A research study to explore views on mobility assistance in hospital

LREC number: 13/NE/0276
Participant ID:
Name of Principal Investigator: Dr Helen Roberts

Thank you for reading the information about our research project. If you would like to take part, please read and sign this form.

PLEASE INITIAL THE BOXES IF YOU AGREE WITH EACH SECTION:

1.	I have read the information sheet version.....dated ....for the above study and have been given a copy to keep. I have been able to ask questions about the study and I understand why the research is being done. I have been informed about any risks or inconveniences involved and the conditions under which the study is to be conducted.	☐
2.	I understand that I can withdraw from the study at any time without my medical treatment or legal rights being affected.	☐
3.	I agree for someone from the research team to look at my records to obtain the information as described in the use of routinely collected hospital data part of the information sheet.	☐
4.	I agree that if I withdraw from this study, all data that has been collected up to this point can still be used, in an anonymised form in the final analysis.	☐
5.	I agree to my interview being audio taped and I understand that transcripts of my interview will be anonymised	☐

……………………………………………………………………………………………

Name Date Signature

……………………………………………………………………………………………

Person taking consent Date Signature
(If not researcher)

……………………………………………………………………………………

Researcher Date Signature

Original for site file/researcher, one copy for participant

A.10 Family/staff consent form

University Hospital Southampton NHS
NHS Foundation Trust

Dr Alicja Baczynska
Academic Clinical Fellow
Tel: 02380796128
Email: a.baczynska@soton.ac.uk

INFORMED CONSENT FORM STAFF AND FAMILY MEMBER

A research study to explore views on mobility assistance in hospital

LREC number: 13/NE/0276
Participant ID:
Name of Principal Investigator: Dr Helen Roberts

Thank you for reading the information about our research project. If you would like to take part, please read and sign this form.

PLEASE INITIAL THE BOXES IF YOU AGREE WITH EACH SECTION:

1.	I have read the information sheet version.....dated .... for the above study and have been given a copy to keep. I have been able to ask questions about the study and I understand why the research is being done. I have been informed about any risks or inconveniences involved and the conditions under which the study is to be conducted.	☐
2.	I understand that I can withdraw from the study at any time without my work situation or my legal rights being affected. I agree that all data that has been collected up to this point can still be used, in an anonymised form in the final analysis.	☐
3.	I agree to my interview being audio-taped and I understand that transcripts of the interview/focus group will be anonymised.	☐
4.	I agree to the Research team contacting me at a later date to see if I want to participate again in this study.	☐
5.	I agree to participate in this study.	☐

……

Name	Date	Signature

……

Person taking consent (If not researcher)	Date	Signature

……

Researcher	Date	Signature

Original for site file/researcher, one copy for participant

A.11 Barriers to mobilisation theme – doctors’ quotes

	Barriers to mobilisation	Consultant	SpR's	SHO/FY1
	No obstacles			
Environmental/organisational	Lack of space/ crowded space			
	Mechanical obstacles			
	No goal/lack of stimulation	And also the environment is not particularly stimulating, so what's the motivation to mobilise to, there's no dayroom to be encouraged to walk to. D06 I think that's a tricky one. I think staff-wise, it would be harder in some ways, but it probably would be feasible in some wards, but I think the more potent factor is the bed space that would be lost in order to create these spaces, and I think that's why there's resistance to having dayrooms back again. D06	There's nowhere they've got to go though, you're not very far. D05	
	Location of facilities			
	Infection spread	Also there's all sorts of infection control issues for certain patients and, but I think overall it's beneficial and we certainly see that benefit in rehab ward settings. D06	Then people get fit, and a lot for quite silly reasons, and then we've got a guy who had MRSA three years ago or something and he's now, they can't eradicate it, and he's just, so he's stuck in a side room and he's just not interacting with anybody and he's getting very depressed and yeah you can't really go very far then D03 Well he's not, he's not really, he's not mobile because can't be bothered, he's like there's nowhere to go. D03	
	Hospital routines/ institutionalisation		D03: I think patients don't go off the ward that often either. They go off for a scan and then they come back, but very rarely see like relatives them off in a wheelchair down to get a coffee or like just for a bit of fresh air or something. I very rarely see them off the ward. D05: That's awful.	

			D04: Yeah. D05: I was just thinking that. We've got somebody who's been in since in November, who must have been in that same bay for three months. Quite frankly that must be. D04: Oh my God! D05: And especially once they get medically fit, they're not even going off for scans or anything, they literally. D04: Yeah, they sit in there.	
	Inappropriate clothing			
	Lack of equipment			
Patient related	Lack/loss of motivation/low mood	A mixture of all of them really. I find quite a lot of motivational problems within my patients, because they're generally they're not feeling well and I think it's difficult to persuade someone who's feeling unwell and low, because they're in hospital, they're missing their relatives, they're missing their routine, to then get up and mobilise for essentially a bunch of strangers. D06 But I think the majority of our patients who are immobile feel that actually in hospital they have kind of carte blanche to lie in bed, because they're ill, and don't need to get up if they don't feel like it. So I think it's up to us, part of our role really to encourage them to mobilise as they are able.(D6)	I don't think it's that they don't believe you sometimes, it's just, you know it's just some people just really can't be bothered to get out. D05	
	Anxiety/ fear of falls			
	Medical condition/ attachments			And I think that's also difficult, because if they're ill, that's restricting. D02
	Confusion			
	Pain			
	Lack of strength/ener			

	gy			
	Loss of function			
	Health and safety issues (patient related)		And it’s potentially risky (mobilisation). D03 Yeah. I guess with mobility, there’s always that they could fall over and break their hip, and there’s that kind of I’d rather step back and not do it than take a chance. And I think that. D03 I think we are quite risk averse. D05 like you order a test, like you might order a CT Head and then no-one, and it’ll be like the physio will come along and write, well we won’t see this person until they’ve got the result, and no-one will move them, and then you have to come along and feel like it’s like a battle, and you have to write, oh my goodness, you can move this patient, this is ridiculous. It’s like you can’t order anything anymore. D04 And you know it’s like they’re afraid, well I don’t know what they’re afraid of. I’m sure it can’t always have been like that. They must have been. D05 No, and I think that it’s borne out of a sort of health and safety culture thing. D04 Yeah. But we’re constantly no, no, come back, sit down, because there’s you know a risk of falls and all that stuff, but which you can’t prevent anyway. D04	
	Lack of knowledge/ awareness of bed rest risks			
Family related	Anxiety/fear of falls			one daughter, very caring but wanted to have mum in bed all the time as if it was a sign that she is still being looked after ‘cosy and safe’ D01
	Hands-off culture			
	Lack of			

	knowledge/awareness of bed rest risks			
Staff related	Staffing levels/Staff time		‘if pt not able to feed themselves, we would stop and help’ (meaning the doctor) D01 But I can see why people would be loathe to do this, because mobilising people, it’s a lot of time. D04 And it’s potentially risky. D03 And people think, people just don’t have the time to do it. D04 Staffing levels. Because if there were more people, I guess more of everyone, more trained physios, more healthcare assistants who were trained how to mobilise, like therapy assistants. Not, they don’t, that doesn’t necessarily mean need a physio, but a therapy assistant who’s able to just go, take them for a walk off the ward somewhere or. D05	And I do wonder whether it’s staffing, because it’s easier for patients, you know safer for patients in some ways to be sitting in bed, in terms of the acute ward situation, and so they end up sitting in bed for long periods and not getting the encouragement to get out. I think if there was a lot more physios and a lot more nurses and lot more doctors I think we would have a bit more time to encourage them. D01 Nursing staff are ‘stretched, on their feet all the time’ Older people need more time Physios involved a lot but stretched as well, they have to prioritise; Sometimes physio would be indicated to continue until discharge but that is not available D01, D02
	Lack of assistance			
	Medical orders			
	Lack of encouragement/ discouragement			
	Staff attitude		I suppose there’s a lot of reasons why isn’t there. Everyone thinks it’s the physiotherapist’s job, which I think is probably the wrong attitude. So there’s not enough physiotherapists to come in and do, I think it should, and we’re just as bad, I think it should be everyone’s job really. I think you might	However, the culture is more about making the pt sit down –guiding them to the bedside rather than encouraging them in walking round. The assumption is usually that they are confused and got lost, can't find their

			need a therapist doing an initial assessment and telling you what they should be achieving, but I don't see why we shouldn't all be able to get that patient up. D03 And you know like the nursing staff, but they will be like, you'll say can you get this person out of bed? Oh they need a therapy assessment first. And then three days later they're still sat in bed, and you're like, but so. I think people think it is someone else's job. D03 They just sit in there saying. I mean the League of Fiends man comes round and offers to take people out in a wheelchair, but most, I think the number of our patients that are actually appropriate to go are probably, I think there are more than the nurses would let on, but they're very, well again it comes back to being risk averse, because if there's any chance they have any element of confusion or anything then they won't go. D05 Like wandering round and round, and you're like, and then you say where are you going, come back here, come and sit in your own chair, you're like, then you've stopped them moving haven't you. D03 D03: Yeah. D04: Yeah, and I think it would be nice. D03: I think they should be allowed to wander. D04: If we could just let them wander around. D03: I think so, yes. D04: In a safe environment, and just let them do their own thing without having to chase them. Because if they just walked for ages, and they'd soon get tired and then sit back down again. I suppose there's a lot of reasons why isn't there. Everyone thinks it's the physiotherapist's job, which I think is probably the wrong attitude. So there's not enough physiotherapists to come in and do, I think it should, and we're just as bad, I think it should be everyone's job really. I think you might need a therapist doing an initial assessment and telling you what they should be achieving, but I don't see why we	bedside. D01, D02

			shouldn't all be able to get that patient up.(D3)	
	Staff education/confidence issues	I think it varies from ward to ward. And I think the MOP wards are, well they have more specialised nurses who are educated in the needs of elderly frail patients, and I think they're very aware of the need to mobilise, so I think the MOP wards are much better geared up for that. The environment is still the same in all of the wards really, it's very clinical looking and with no dayrooms. However I do sometimes feel that my outlying patients who are on non-speciality, on other speciality wards rather than having MOP staff, there's not always the awareness. On some wards there is very good awareness and others there isn't, and there are sometimes issues of patients not being sat out. And often they have actually approached the patient and the patient has declined, and it's been left at that, whereas on other speciality wards were there's more awareness of the needs of elderly patients the staff would work much harder to try and persuade that patient to get up rather than taking their word for it. D06		
	Health and safety issues (staff related)		It's not just the risk to the patients, it's also the risk to yourself. D04 It's the risk to yourself, yeah. D05And you know the amount of sick days and absenteeism that the Public Sector has to bear means that it's just not worth someone being laid off for weeks with a back injury. D04 You know because there's obviously you can mobilise a patient any way, and I'm sure that when we sit someone up in bed, we'll try and mobile someone we'll do it completely well, because you know anyone whose done manual handling has to do it properly, which is why we don't tend to do it very much, we don't get that sort of training, but. D04	

A.12 Research outputs

A.12.1 First author publications:

Baczynska, A. M., Shaw, S., Roberts, H. C., Cooper, C., Aihie Sayer, A., Patel, H. P. Human *Vastus Lateralis* Skeletal Muscle Biopsy Using the Weil-Blakesley Conchotome. *J. Vis. Exp.* (109), e53075, doi:10.3791/53075 (2016).

Baczynska AM, Lim SE, Sayer AA, Roberts HC. The use of volunteers to help older medical patients mobilise in hospital: a systematic review. J Clin Nurs. 2016 Nov;25(21-22):3102-3112. doi: 10.1111/jocn.13317.

Baczynska AM, Shaw SC, Patel HP, Sayer AA, Roberts HC Learning from older peoples' reasons for participating in demanding, intensive epidemiological studies: a qualitative study, BMC Medical Research Methodology (2017) 17:167 DOI 10.1186/s12874-017-0439-9

A.12.2 Conference abstracts:

Why do older people participate in intensive research: a qualitative study , *Age and Ageing,* Volume 46, Issue suppl_2, 1 July 2017, Pages ii15–ii16

Acceptability of use of volunteers for fundamental care of older inpatients, Age Ageing (2015) 44 (suppl 1): i1

Volunteer-assisted mobilisation of older people in hospital – systematic review, Age and Ageing 2014; 43: i30-i31