A Key Step for Hospitalized Elders

Hospitalized adults spend the majority of their time lying in bed. Geriatric patients may be at highest risk for immobilization, with a recent study demonstrating that 83% of their time is spent in bed and only 4% standing or walking. Physiologically, immobility leads to decreased muscle strength and aerobic capacity, increased bone loss, and the development of vasomotor instability. Clinically, immobility is a risk factor for deconditioning, delirium, aspiration events, pressure ulcers, and falls. These complications lead to prolonged lengths of stay, increased likelihood of discharge to a skilled nursing facility, and increased mortality.

In the November 22, 2010, issue of the Archives, Fisher and colleagues explored the hazards of immobility and suggested that increasing ambulation by roughly 12 minutes of slow walking per day reduces length of stay. This modest yet proactive focus on early ambulation raises a number of important issues, including opportunities for improved clinical guidelines around ambulation, the role of activity orders in the hospital setting, and mechanisms to foster ambulation among those at highest risk for immobility. Despite increasing national attention to the incidence of inpatient falls and pressure ulcers, the importance of early ambulation to the geriatric hospitalized patient is understated and understudied.

STEPS FOR AMBULATION

The first step in addressing ambulation is the development of clinical guidelines for safe ambulation practices in the hospital setting. The amount of ambulation should be measured and tracked for individual patients. At many hospitals, nurses measure fall and pressure ulcer risk with standardized screening tools at admission and again each day or shift throughout the patient's stay. Patients with increased risk are placed on more aggressive fall or pressure ulcer prevention protocols. Similarly, nurses should assess ambulation status or progress on admission and throughout the patient’s stay, with low levels of ambulation triggering more aggressive protocols. Clinical protocols that safely facilitate ambulation should be further developed and studied. Such protocols would include screening and monitoring of the patient’s ambulation progress, a recommended schedule and duration or distance of ambulation, patient education regarding safe ambulation techniques, and clear expectations and guidelines for the role of designated medical staff members in promoting ambulation. The findings by Fisher and colleagues demonstrate that accelerometer use can provide a goal for the number of increased steps for the patient and their caregiver. This offers a potentially useful clinical tool. Monitored treadmill use might provide a clear ambulation goal in a more private setting and should also be further explored. Finally, “acute care for the elderly” units provide the ideal environment to test drive ambulation protocols, as in this study, given the overarching emphasis on mobility and function on these units.

A second key issue is the role of activity orders in promoting ambulation. The study by Fisher et al demonstrates that patients with an activity order of “ambulate with assist,” rather than “bed rest” or “as tolerated,” are more likely to increase their step activity. We know that patients are often placed on bed rest at admission without a valid indication and then are kept on bed rest long into their stay. Physicians should avoid bed rest orders and write more directed instructions for activity such as “ambulate 3 times a day.” Physicians should also document clear indications for bed rest in their notes or in templated order sets and reassess the need for bed rest daily. Reframing activity orders in a more active and actionable way, rather than writing “as tolerated,” will help to transform clinical attitudes regarding ambulation and engage caregivers in a more proactive approach.

A third component of increasing ambulation in hospitalized geriatric patients is to target interventions to those patient groups least likely to ambulate, particularly those who need assist devices or staff assistance when ambulating. The study by Fisher et al highlights this issue by demonstrating that independently ambulating patients are more likely to increase their ambulation and to see a reduction in length of stay. We need better mechanisms to assess the assistance requirements of patients and also optimally use available resources to provide this assistance. During regular assessments of ambulation status and progress, patients should also be assessed for the need for assist devices or staff assistance. Patient care assistants serve a key role clinically in helping patients ambulate and may be an underused service. Further training of patient care assistants in safe ambulation techniques will increase their comfort with helping more frail elderly patients ambulate and in the process better engage the patient care assistants in ambulation protocols. Additional strategies to target high-risk patients include ensuring that patients have their required assist devices, including vision and hearing aids, and are seen early on in their stay by an occupational or physical therapist if necessary. Careful hospital unit design including flooring and paint choices, guardrails, and maintenance of hallways free from computers, supply carts, and clutter can also help those patients unable to easily ambulate independently. These extra measures are required to enable more patients to fully participate in ambulation protocols.
POTENTIAL TRADEOFF

One potential tradeoff of a greater focus on ambulation is the possibility of incurring—or even the perception of incurring—more inpatient falls. “Patient death or serious disability associated with a fall while being cared for in a health care facility” is on the CMS “Never Event” list. Additional costs due to injury from an inpatient fall are no longer covered by Medicare. These new regulations have dramatically increased awareness of falls and led to the development of fall prevention programs. The unintended consequence of this increased energy for fall prevention is the potential increase in immobility and restraint use. Experts have debated this tradeoff but generally agree that immobility ultimately increases deconditioning and fall risk. Early ambulation should therefore be supported as a method to prevent falls rather than promote them. Hospitals and caregivers must prevent the unintended consequence of fall prevention by developing aggressive and rigorous clinical protocols to promote ambulation, function, and mobility. Ideally, ambulation and fall prevention protocols would be part of a larger comprehensive geriatric care bundle. The future direction of geriatric inpatient care will be to deliver integrated clinical protocols that prevent falls, pressure ulcers, delirium, polypharmacy, and aspiration events and promote mobility, function, and quality of life. Such comprehensive care bundles have been effectively modeled in “acute care for the elderly” units and are ripe for adaptation to other inpatient medical wards.

I applaud Fisher and colleagues on their study and hope future research continues to evaluate optimal ambulation clinical protocols and their impact on clinical outcomes for hospitalized geriatric patients. The development of feasible and effective ambulation protocols, refinement of activity orders, and targeting of interventions to those who require staff or device assistance will all help to promote increased ambulation. Caring for geriatric hospitalized patients will be a growing need in the coming years, and focusing on providing this patient population with high-quality and safe care requires vigilant proactive measures. The development of ambulation measurement and protocols, as components of comprehensive geriatric care bundles, is one step in the right direction—a step we hope happens without a fall.

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