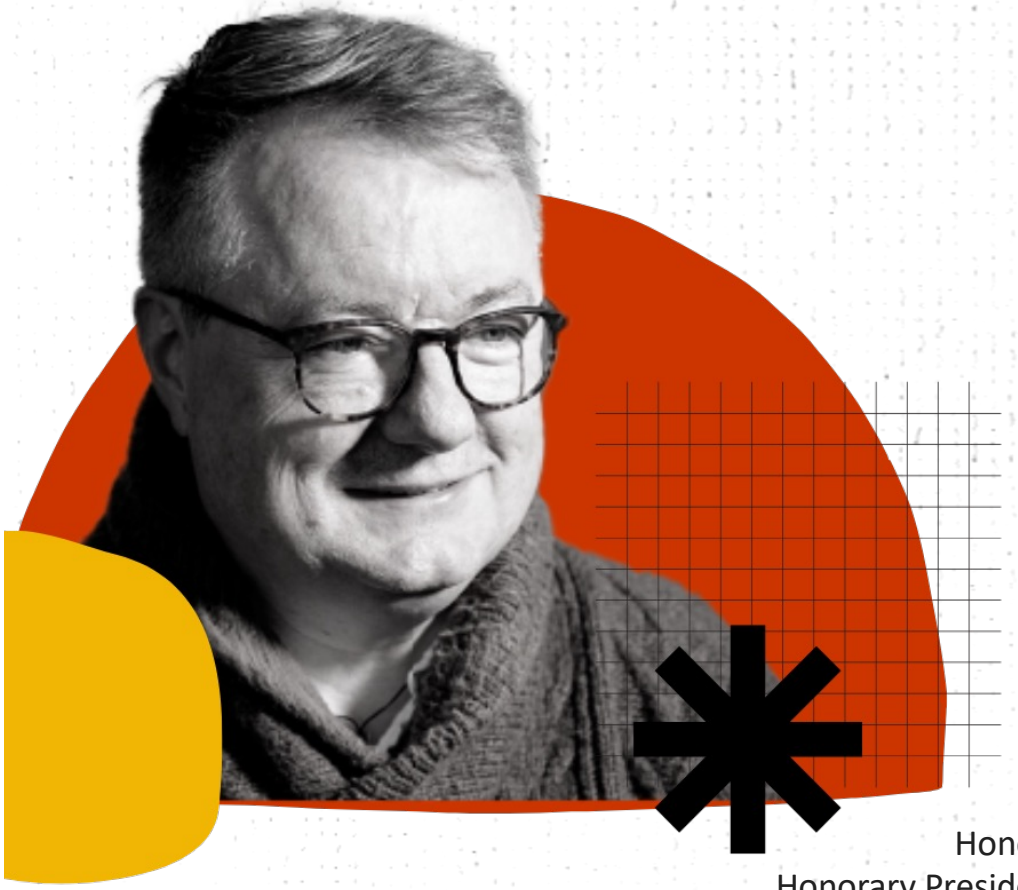
So, you made it.
Now what?!



Prof Brian Dolan OBE

FFNMRCSI, FRSA, MSc(Oxon), MSc(Nurs), RMN, RN

Director, Health Service 360 (UK)
Professor, Coventry University
Honorary Professor of Leadership in Healthcare, University of Salford
Honorary President AGILE: Network of Chartered Physiotherapists working with older people
Honorary Adjunct Professor of Innovation in Healthcare, Bond University, SE Queensland

X @BrianwDolan

BMJ - 1947

THE DANGERS OF GOING TO BED

BY

R. A. J. ASHER, M.D., M.R.C.P.

It is always assumed that the first thing in any illness is to put the patient to bed. Hospital accommodation is always numbered in beds. Illness is measured by the length of time in bed. Doctors are assessed by their bedside manner. Bed is not ordered like a pill or a purge, but is assumed as the basis for all treatment. Yet we should think twice before ordering our patients to bed and realize that beneath the comfort of the blanket there lurks a host of formidable dangers. In "Hymns Ancient and Modern," No. 23, Verse 3, we find:

> "Teach me to live that I may dread
> The grave as little as my bed."

It is my intention to justify placing beds and graves in the same category and to increase the amount of dread with which beds are usually regarded. I shall describe some of the major hazards of the bed. There is hardly any part of the body which is immune from its dangers.

Respiratory System.—The maintenance of one position allows the collection of bronchial secretions, which, stagnating in the bases, encourage the development of hypostatic pneumonia.

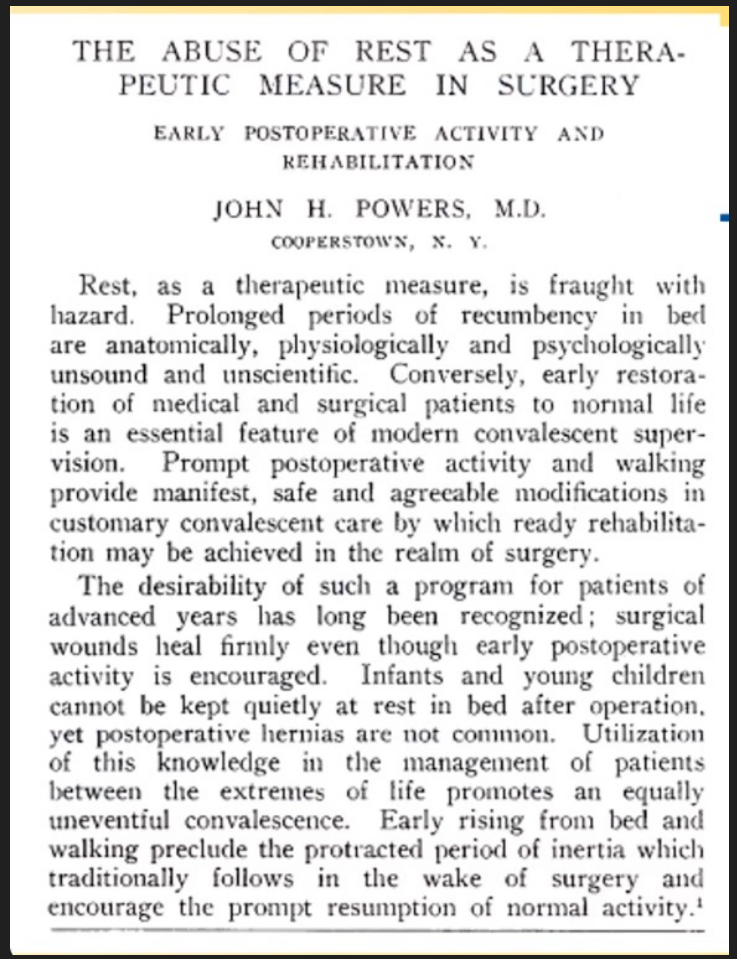
urinary tract can find difficulty in using a bottle—probably because of the horizontal position of the body coupled with the nervousness and embarrassment felt on attempting this unnatural, uncomfortable, and unfamiliar method of micturition. In older people this difficulty may lead to acute retention with overflow or to simple incontinence. Bed-sores may develop and keep the patient to bed, so initiating a vicious circle of bedridden incontinence. Prolonged incontinence leads to a deterioration of hygienic morale, and a patient may continue to be incontinent from sanitary sloth rather than urological disease. Getting a patient out of bed may turn him from an incontinent person to a clean one.

Alimentary Tract.—This too is not immune from the bad effects of rest in bed. After a few days minor dyspepsias and heartburn may be noticed; the appetite is often lost. Constipation occurs almost invariably, and even if not of grave significance is often a grievous worry to the patient. Its causes are, first, the absence of muscular movement; secondly, the change of environment (no one can say why this causes constipation, but it does); and, thirdly and most important, the difficulties of evacuating the bowel in a hospital bed-pan. On a bed-pan the patient is unable to use his abdominal muscles and his nearness to fellow-patients discomforts him. Precariously engaged in balancing himself, he sits there, poised unhappily above his own excrement in great dissatisfaction

JAMA - 1899 and 1944

Liberation is NOT a new concept

"It means a great deal. . .to be put on their own feet in a short time, rather than be confined to bed, having their weak backs and general debility increase rather than disappear after the operation which was to cure them."—Dr Emil Ries,
JAMA 1899[1]



THE ABUSE OF REST AS A THERAPEUTIC MEASURE IN SURGERY

EARLY POSTOPERATIVE ACTIVITY AND REHABILITATION

JOHN H. POWERS, M.D.
COOPERSTOWN, N. Y.

Rest, as a therapeutic measure, is fraught with hazard. Prolonged periods of recumbency in bed are anatomically, physiologically and psychologically unsound and unscientific. Conversely, early restoration of medical and surgical patients to normal life is an essential feature of modern convalescent supervision. Prompt postoperative activity and walking provide manifest, safe and agreeable modifications in customary convalescent care by which ready rehabilitation may be achieved in the realm of surgery.

The desirability of such a program for patients of advanced years has long been recognized; surgical wounds heal firmly even though early postoperative activity is encouraged. Infants and young children cannot be kept quietly at rest in bed after operation, yet postoperative hernias are not common. Utilization of this knowledge in the management of patients between the extremes of life promotes an equally uneventful convalescence. Early rising from bed and walking preclude the protracted period of inertia which traditionally follows in the wake of surgery and encourage the prompt resumption of normal activity.[1]

Florence Nightingale – 1870s

arrangements of the building. There could be no excuse for complacency. Even St Thomas's, with its pavilions of air, had been revealed, in a report of 1878, to be far from hygienic. 'It is now a well-known rule,' Florence had written in a note to herself: 'keep no patient in hospital a day longer than is absolutely necessary . . . And even this may be days too long. The patient may have to recover not only from illness or injury but from hospital.'

In the last phase of her working life, Florence would redouble her


REBEL
WOMEN
FLORENCE NIGHTINGAL

'Is the patient safe for admission?'…

…may sometimes be a better question than
'Is the patient safe for discharge?'

DISABILITY AND REHABILITATION
https://doi.org/10.1080/09638288.2024.2335662

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RESEARCH ARTICLE

Impact of the End PJ Paralysis interventions on patient health outcomes at the participating hospitals in Alberta, Canada

Gurech James Wai[a], Zihang Lu[b], Sudeep Gill[c], Isabel Henderson[d] and Mohammad Auais[a]

[a]School of Rehabilitation Therapy, Queen's University, Kingston, Canada; [b]Department of Public Health Sciences, Queen's University, Kingston, Canada; [c]Medicine, Queen's University, Kingston, Canada; [d]Clinical Operations, Alberta Health Services, Edmonton, Canada

ABSTRACT

Purpose: Multiple hospitals in Alberta implemented the End PJ Paralysis – a multicomponent inpatient ambulation initiative aimed at preventing the adverse physical and psychological effects patients experience due to low mobility during admission. To inform a scale-up strategy, this study assessed the impact of the initiative based on select process and outcome measures.

Materials and methods: Clinical and administrative data were obtained from the hospital Discharge Abstract Database, Research Electronic Data Capture (Redcaps), and Reporting and Learning System for Patient Safety. The variables explored were length of stay, inpatient falls, discharge disposition, pressure injury, patient ambulation, and patient dressed rates. We then used the Interrupted Time Series design for impact analysis.

Results: The analysis included discharge abstracts for 32,884 patients and the results showed significant improvements in outcomes at the participating units. The length of stay and inpatient falls were reduced immediately by 1.8 days (B_2=-1.80, p=0.044, *95% CI [-3.54, –0.05]*), and 2.2 events (B_2=-2.22, p=005, *95% CI [-3.75, –0.69]*). The percentage of patients discharged home increased overtime (B_2=.39, p=.006, *95% CI [.11, .66]*). Mobilization and dressed rates also improved.

Conclusions: The findings imply the interventions safely mitigated the risk of immobility-induced complications, including deconditioning and hospital-acquired disability.

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KEYWORDS
Hospital-acquired disability; physiological deconditioning; pajamas (pyjamas) paralysis; PJ Paralysis; patient ambulation; mobilization; functional capacity

Wai et al (2024) (n=32,884)

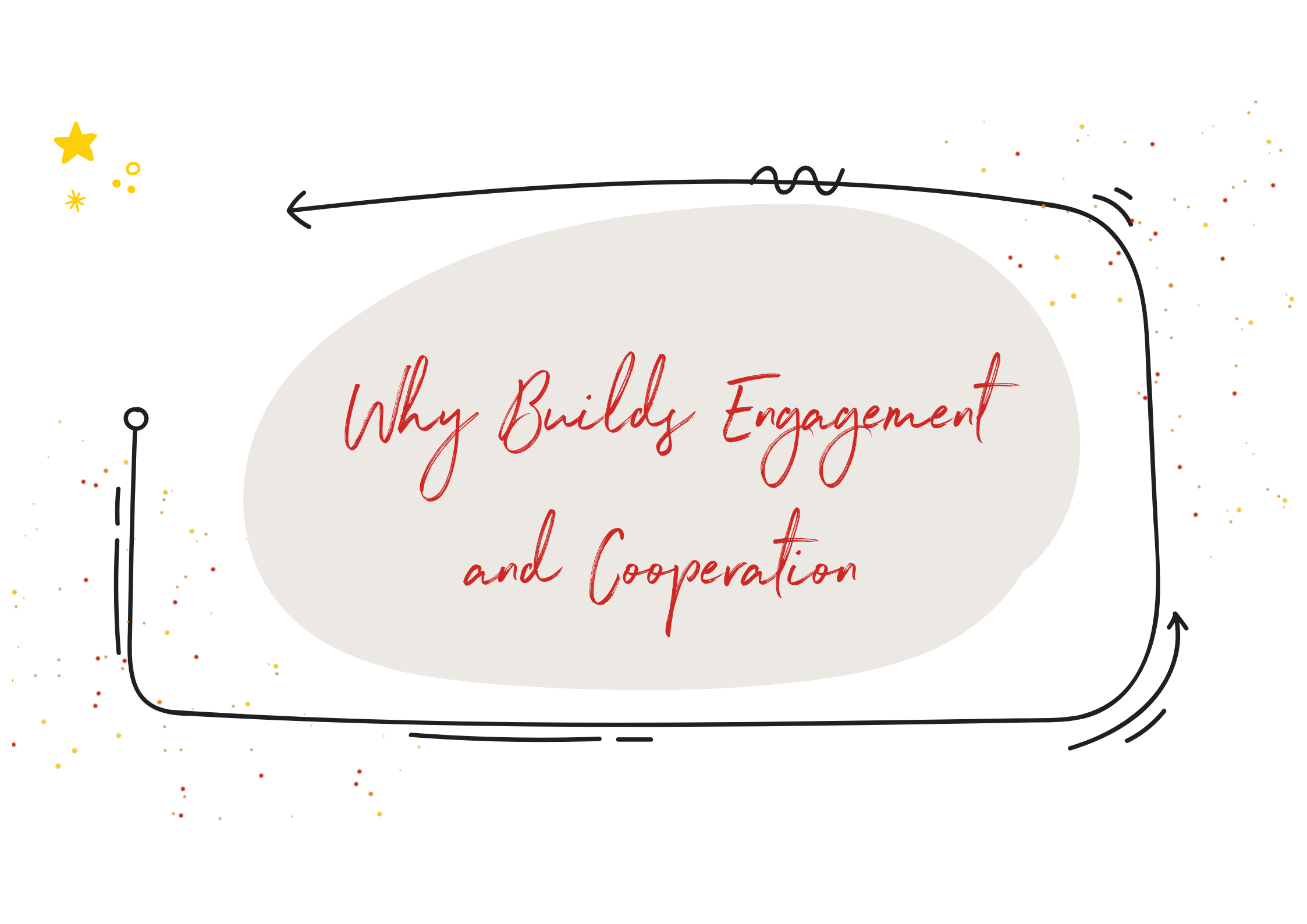
- LOS 1.8 days,
- Falls 2.2 events,
- Discharged back to their 'home' not a care home

The Shadow of K2

There is no ‘no risk’ or ‘safe’
There is ‘lower risk’ or ‘safer’

Dr Ben Owens


August 2023
Monday
Tuesday
Wednesday
Thursday


Why Builds Engagement
and Cooperation

- We under communicate by x 10
- Questions do not mean resistance
- Never underestimate the power of permission giving

It Takes Time

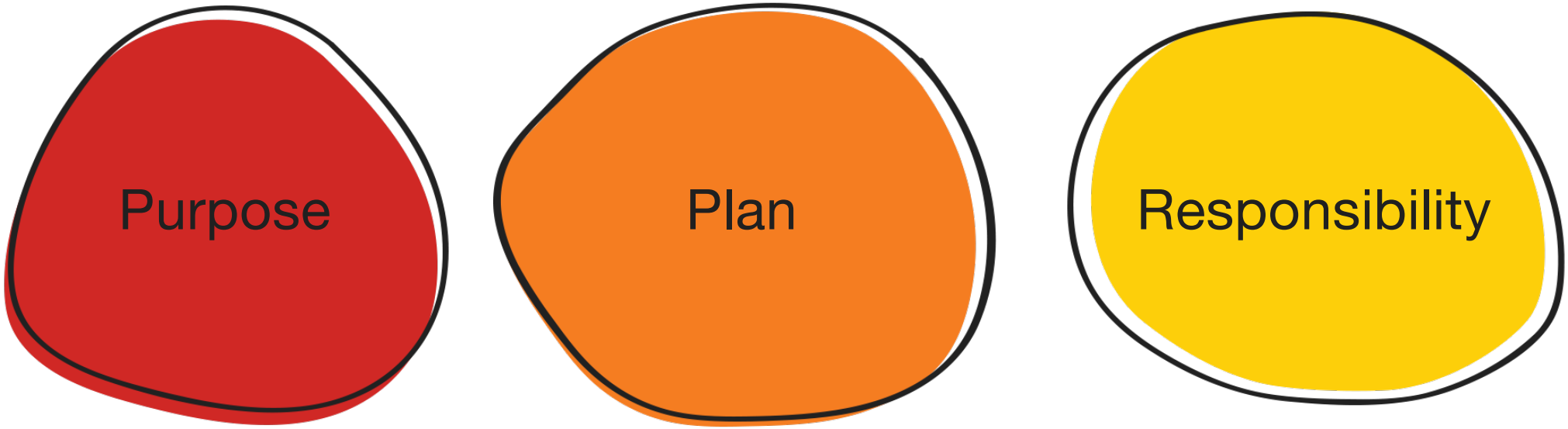
Need a compelling story?

Here's 3

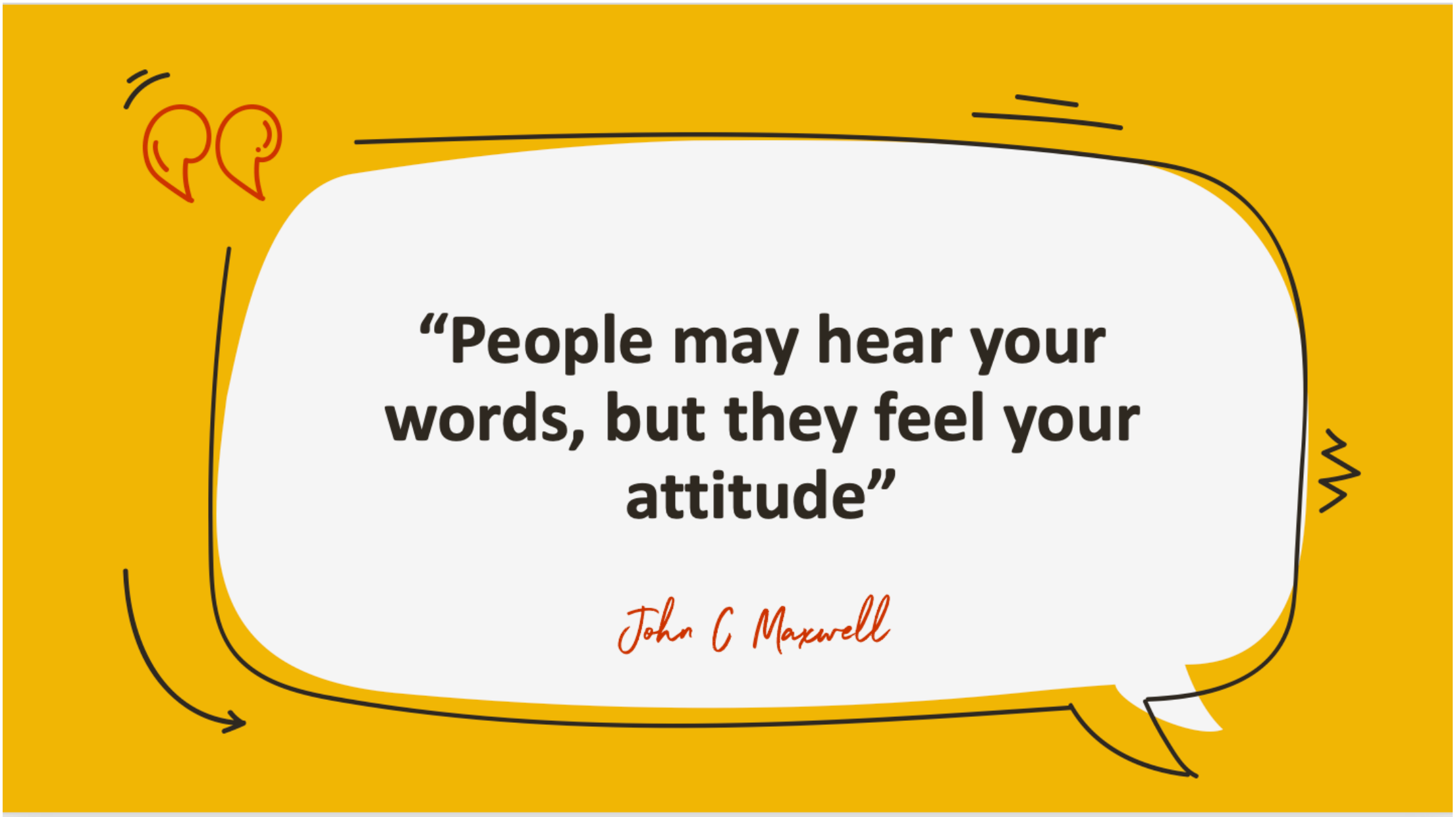
1. Patient's time is the most important currency
2. 48% of people over 85 will die within a year of a hospital admission (Clark et al 2014)
3. If you had 1,000 days to live, how many of them would you choose to spend in hospital?


One early safe discharge benefits five patients

Followers Need Clarity




Focus on what you
can control
Explore what’s possible


“People may hear your words, but they feel your attitude”
John C Maxwell

Culture change combines hearts, heads and hands – in that order!

1

Hearts

We connect with stories – it's the why

2

Heads

Strategy is context and plans – the what and how

3

Hands

'OK, I want to be part of this' – the who

Rethinking Our Framing

OLD FRAMING

Falls Prevention
Reducing LOS
Days in hospital
History taking
Hospital in the home

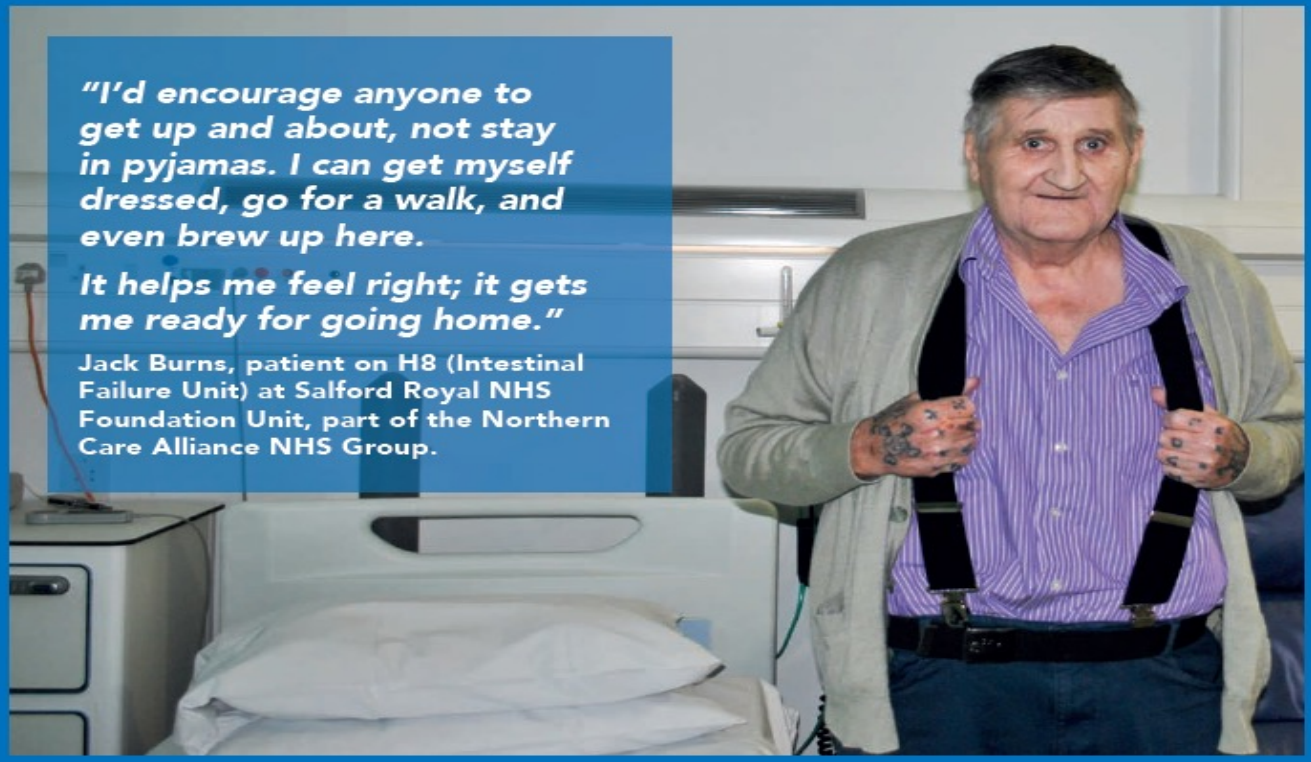
NEW FRAMING

Safer mobility
Giving patients back time
Days away from home
Story sharing
There’s no ward like home

Up
Dressed
&
Feeling Good

#EndPJparalysis

70 Day Challenge



Join the NHS 70-day, 1 million patient day, #EndPJparalysis Challenge

17 April 2018 – 26 June 2018

GERONTOLOGISTS are like ARCHEAOLOGISTS,

THEY LOOK PAST WHAT OTHERS SEE AS RUINS to the Beauty that LIES WITHIN.

@crabtree-amelia


Remember: All of us are memory makers….

Hopeful Thinking:

01

The future will be better than the present

02

I have the power to make it so

03

There are many paths to my goals

04

None of them is free of obstacles

People belong when they feel:

1. Seen & Heard
2. Connected
3. Supported
4. Proud

Manage your energy

AA = Attention & Affection

AAA = Attention, Affection & Acceptance

C = Compassion

D = Direction

Energises

Depletes

We are, as a species, addicted to story. Even when the body goes to sleep, the mind stays up all night, telling itself stories.

– Jonathan Gottschall,

The Storytelling Animal


We Connect Through Story

Derek Laidler, Professional Lead Physiotherapist, (Argyle & Bute), Lorne & Islands Hospital, Oban

‘Hope is the conviction that despair will never have the last word’

Cory Booker

Perception becomes reality

We should keep our feet on the ground to signify that nothing is beneath us, but we should also lift our eyes to say that nothing is beyond us.

Séamus Heaney

Irish poet and Nobel Laureate

Brian Dolan OBE

brian@healthservice360.com

@BrianwDolan

Thank You

www.healthservice360.co.uk

Endpjparalysis.org/join

health service 360