EDITORIALS

The end of shared rooms in hospitals: a cause for celebration?

Capital investment in upgrading older hospitals and building new hospitals provides the ideal opportunity to look at the environment in which we deliver healthcare. It offers the chance to retain what works well and rectify what is suboptimal in design. The ratio of single to shared rooms in hospitals has been a particular target across much of the UK, and the availability of single rooms is steadily increasing. However, is the move to 100% single-room wards aspirational or abject failure to listen to the views of the consumers and providers of healthcare?

The drive to reduce harm, including death, in hospital from avoidable infection has been and will remain a powerful driver to support change. The evidence is compelling and hard to challenge. Antibiotic resistance is a reality, the impact of hospital-acquired infection for some is devastating and deadly, and the emergence of new pathogens is an inevitability.

In more recent years, we have listened to consumers of healthcare and more importantly taken on board their views in the design and delivery of care. Those advocating for the move to 100% single-room wards use much of the patient-centred rhetoric—privacy, dignity, quiet healing environment, family engagement, etc. The omission to this string of acknowledged and recognisable advantages is ‘choice’.

Choice has a powerful impact on our everyday life experiences—a menu at a restaurant, books, films, exercise, etc. When I asked my own clinical team their preference of room type should they require hospitalisation, there was unanimity—single room. The same response is likely of most geriatricians and most of the population who contribute to the huge number of people hospitalised for an acute problem and discharged within 2–3 days.

However, I also asked them their views in relation to the older people we were treating at the time, and the answer was more complex with some believing that a single room would actually be detrimental to the care process for a number of patients—loneliness, isolation, decreased mood, falls, impact on nutrition, etc. The responses were certainly not driven by a desire to cause harm or a lack of understanding of the evidence in relation to infection control. Perhaps we are guilty of misguided paternalism? Are company and camaraderie acceptable trade-offs for an increased risk of infection and the benefits of privacy and dignity? We should probably ask those patients with illnesses and injuries that necessitate prolonged periods of hospitalisation, particularly those where physical disability significantly impedes the opportunity to venture beyond the four walls a room. In fact, people using healthcare have been asked their views, and there is no consensus with many still advocating for smaller multi-bedded areas [1–3].

The article by Singh et al. (Ref. [4]) provides evidence of the unintended consequences in one hospital of a move to 100% single-room wards. The study is both opportunistic and pragmatic in its design and shows an increase in the rate of falls in older people associated with the move to single-room wards. For geriatricians, the result is perhaps not surprising and whilst the article is not explicit in relation to the population experiencing the greatest increased risk, most would guess that it is the confused hospitalised older person who is most at risk of falls from the change in environment. Many of us will have had experience where infection control and the requirement to ‘isolate’ have taken precedence over falls risk in a delirious older person and in the absence of an ability to provide enhanced observation, harm has eventuated from a fall. Cohorting of patients at risk of falls because of their limited cognitive reserves and impulsive behaviours is common. The cohabiting is to provide an enhanced level of supervision so as to reduce falls risk rather than a belief that putting confused people together is clinically advantageous.

We are told by advocates in the field that nursing ratios do not need to change with a move to all single rooms, particularly with the decentralised radial design of wards [5]. What is less clear is how much of this health service implementation work has been evaluated on the average aged care ward where many of the patients are cognitively impaired and a number actively delirious. Enhanced observation of these people is critical to their safety, particularly in relation to preventing falls and avoiding use of physical or chemical restraint.

It is unlikely the study by Singh et al. (Ref. [4]) will change the design of the wards at Ysbyty Ystrad Fawr and nor do we have sufficient information to know what has happened in the years subsequent to those studied. Significant changes to the design of the working environment also require changes in the systems and processes of care. Structural change can happen overnight, but changing human behaviour frequently lags behind. Rate of falls may reduce as staff become accustomed to the new layout. What is clear is that there should be adequately resourced robust systems of evaluation in place in advance of substantial change to the working environment.
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so as to measure and learn from the intended and unintended consequences of change.

So is this move to 100% single-room wards to be welcomed. For most, but not all, the answer is yes. Opinions and attitudes inevitably change over time and with experience of the ‘new way of working’, and we are all capable of adapting to changing working environments. However, I remain sceptical that people with a hyperactive delirium or behavioural and psychological symptoms of dementia can be managed in a ward of all single rooms without the need for additional staff or significant investment in technology to allow for improved monitoring.

If we are to truly deliver patient-centred care, then choice also needs to be part of the equation. A one size fits all approach rarely works when dealing with humans and human behaviour. Let’s not throw the baby out with the bathwater—we should continue to invest in more single rooms for the future as way of delivering patient-centred, safe and effective care, but remember that not everybody wants or will benefit from this approach. Modular designs of ward areas could easily accommodate flexibility in the configuration of the ward layout and allow for patient choice as well as giving staff the ability to provide enhanced supervision as and when required.

Key points

• We should continue to invest in more single rooms in hospitals as a way of delivering patient-centred, safe and effective care, but remember that not everybody wants or will benefit from this approach.

• Some elderly patients—such as those with a hyperactive delirium or behavioural and psychological symptoms of dementia—are likely to require additional staff or significant investment in technology to allow for improved monitoring if they are to be cared for safely in single rooms.

• Alternative approaches include modular design of ward areas that can accommodate flexibility in the configuration of the ward layout and allow for patient choice as well as giving staff the ability to provide enhanced supervision as and when required.

References


Move more and sit less: regular physical activity improves mobility in older age

Older people find it more strenuous than young to transition from sitting to standing, walk slower and negotiate obstacles or steps more cautiously. Progressive declines in physical function such as these lead to frailty and social isolation. Although we are still not entirely clear about the physiological processes causing mobility impairments in older age, there is more evidence that regular physical activity, or exercise, helps to preserve mobility enabling older people to live independently for longer.

Resistance training is recommended to help combat effects of ageing on physical function [1], because the main adaptations lead to bigger and stronger muscles. However, muscle mass and force are not necessarily good predictors of mobility. Instead, leg muscle power (the ability to apply high forces quickly) appears to be more relevant. Low muscle power is associated with poor mobility [2], and it follows that training muscle power through low-load, high-velocity movements improves mobility [3–5].

The work published in this edition of Age and Ageing [4] showed that mobility improved after 20 weeks of resistance training in people aged over 65 years. Interestingly, and probably surprising to some, was the finding that unloaded, high-velocity concentric movements improved chair rising, short walking and muscle power to a similar extent as conventional