

# Self-Reported Versus Performance-Based Assessments of a Simple Mobility Task Among Older Adults in the Emergency Department

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**Study objective:** Accurate information about the mobility of independently living older adults is essential in determining whether they may be safely discharged home from the emergency department (ED). We assess the accuracy of self-reported ability to complete a simple mobility task among older ED patients.

**Methods:** This was a cross-sectional study of cognitively intact patients aged 65 years and older who were neither nursing home residents nor critically ill, conducted in 2 academic EDs. Consenting participants were asked whether they could get out of bed, walk 10 feet, turn around, and get back in bed without assistance, and if not, whether they could perform this task with a cane, walker, or assistance. Each participant was then asked to perform the task and was provided with a mobility device or assistance as needed.

**Results:** Of 272 patients who met eligibility criteria and answered the physical task question, 161 (59%) said they could do the task unassisted, 45 (17%) said they could do it with a cane or walker, 21 (8%) said they could do it with assistance, and 45 (17%) said they would be unable to do it even with assistance. Among those who said they could do the task either with or without assistance and who were subsequently willing to attempt the task (N=172), discrepancies between self-reported ability and actual performance were common. Of those who said they could perform the task without assistance, 12% required some assistance or were unable to complete the task. Of those who said they could perform the task with a cane or walker, 48% required either assistance or were unable to perform the task. Of those who said they could perform the task with assistance, 24% were unable to perform the task even with assistance.

**Conclusion:** In this sample of older adults receiving care in the ED, the accuracy of their self-reported ability to perform a simple mobility task was poor, particularly for those who reported some need for assistance. For older adults being considered for discharge who report a need for assistance with mobility, direct observation of the patient's mobility by a member of the emergency care team should be considered. [Ann Emerg Med. 2016;67:151-156.]

Please see page 152 for the Editor's Capsule Summary of this article.

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## INTRODUCTION

Emergency department (ED) visits in the United States by adults aged 65 years and older now exceed 20 million annually. The majority of these patients live independently and are discharged home after their ED evaluation.<sup>1</sup> Avoiding unnecessary hospital admissions for older adults is important because hospitalizations are expensive and expose patients to the risk of iatrogenic injury and a period of profound activity restriction.<sup>2,3</sup> Ensuring that older adults discharged home from the ED are able to safely function in their home environment is also important because those who are unable to function safely at home are at risk for falls and return ED visits.<sup>4</sup> Thus, accurately determining the ability of older ED patients to care for

themselves at home is an important task frequently faced by emergency providers.

How emergency physicians assess the ability of older adults to function at home before discharge has not been well characterized and likely varies across providers and patients. Available evidence and clinical experience indicate that direct observation of physical function of older patients is not routinely performed by emergency providers.<sup>5</sup> Among hospitalized patients, discrepancies between a patient's self-reported ability to perform activities of daily living and their actual ability to perform these activities are common, with patients overestimating their ability 35% of the time for some tasks.<sup>6,7</sup> Older ED patients are on average healthier than older hospital inpatients but have

**Editor's Capsule Summary***What is already known on this topic*

There is no valid, widely accepted method of assessing safe mobility for elderly patients being discharged from the emergency department.

*What question this study addressed*

Among cognitively intact, older adults who dwell in independent-living settings, what is the accuracy of self-reported ability to rise from bed, walk 10 feet, and return?

*What this study adds to our knowledge*

These 172 patients with a mean age of 75 years tended to overestimate their ability to perform this simple task, particularly if they needed a cane, walker, or assistance.

*How this is relevant to clinical practice*

Self-reported mobility, particularly if assistance is needed, is frequently inaccurate, and direct observation of the elderly patient should be considered before discharge.

high rates of acute illness and injury that might reduce their mobility or alter their ability to assess their mobility.<sup>8</sup> Thus, conclusions derived from inpatient data may not be valid for ED patients. The Timed Up and Go test has been examined as a possible predictor of return ED visits and hospitalizations,<sup>9</sup> but to our knowledge no published studies have described the accuracy of self-reported assessments of functional status in older patients in the ED despite this being identified as a priority by experts in geriatrics and emergency medicine.<sup>10</sup>

The purpose of this study is to determine the accuracy of self-reported ability to get out of bed, walk 10 feet, and return to bed, among cognitively intact, independently living older adults in the ED. We hypothesized that a substantial portion of older patients would overestimate their ability to perform this task.

**MATERIALS AND METHODS****Study Design, Setting, and Selection of Participants**

This was a cross-sectional study of adults aged 65 years or older presenting to 2 academic EDs in the United States, serving racially and socioeconomically diverse populations of older adults. Enrollment was conducted between 9 AM and 9 PM 7 days a week during 2 months at each site. At each site, potentially eligible patients were identified by review of the

electronic tracking board for individuals aged 65 years or older. Patients were eligible if they did not experience cognitive impairment and were not experiencing a life-threatening illness or injury. Cognitive impairment was defined by a Six-Item Screener score of 3 or less.<sup>11</sup> Life-threatening illness was considered present for patients with an Emergency Severity Index triage score of 1 or based on the judgment of the treating emergency provider. The study was approved by the institutional review boards at both sites, and signed informed consent was obtained from all participants who stated they were willing to attempt the physical task.

**Data Collection and Processing**

Data were collected by research assistants using an in-person interview in the ED with a standardized questionnaire. Responses were recorded on paper and then entered into a secure electronic database. Before beginning the study, research assistants completed training sessions on the general conduct of clinical studies and on the specific protocol of the present study. Additionally, a study investigator observed each research assistant until he or she demonstrated the ability to independently complete the study protocol.

**Outcome Measures**

After collection of sociodemographic information, participants were asked a physical task question: "In your current state of health, do you think you can get out of bed, walk 10 feet, turn around, and get back in bed? If so, would you be able to do so without assistance, with a cane or walker, or with someone assisting you?" This question was asked of all eligible patients regardless of the presence of acute or chronic lower-extremity pathology that might make ambulation difficult or impossible. When participants answered this question, they had already been informed, as part of the initial description of the study, that they would subsequently be asked to perform this task. Participants who agreed to attempt the task and stated that they thought they could do the task either with or without assistance were then asked to perform the task. Before initiation of the task, the gurney was lowered as much as possible, the back of the gurney was raised to a sitting position, the guard rail was lowered, and the floor space next to the bed was cleared. A distance of 10 feet from the side of the gurney was measured and marked. A cane, a walker, and assistance were made available to the patient but provided to the patient only if requested or if the patient was unable to progress with the task. Patients who were visibly unstable were shadowed by one or more research assistants to ensure that they would not injure

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