



Older medical patients' experiences with mobility during hospitalization and the WALK-Copenhagen (WALK-Cph) intervention: A qualitative study in Denmark

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ABSTRACT

For years, bed rest and low mobility amongst older, hospitalized patients have attracted researchers' attention and efforts have been made to understand how and why interventions might work or not. This study explores older medical patients' experiences with the WALK Copenhagen (WALK-Cph) intervention, which aims at increasing in-hospital mobility and with mobility during hospitalization more generally. Semi-structured interviews were conducted with 20 patients aged 65 to 93 (mean=77, SD=8) in two Danish hospital departments. Overall, the fundamental idea of the intervention was regarded meaningful and relevant by the patients. The intervention components, however, were interpreted in different ways and risked becoming invisible. Thus, the intervention was not a quick fix to increase mobility, as the patients had different experiences with in-hospital mobility. The patients' practices of in-hospital mobility were influenced by personal experiences with illness and recovery, encouragement and support from others, hospital materialities and wishes to return to everyday active lives.

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Introduction

"[...] After all, the muscles will stop dead, right? When you're just sitting here [in the bed]. Now that won't do, right?" a 70-year old woman remarked, as she was asked why she found it important to leave the bed and move about during hospitalization. She was admitted to a medical department of a hospital in the Capital Region of Denmark. Thus, she was one of the citizens over 65 years, who represent 53% of all admissions to medical departments in Danish hospitals.¹ She explained that being active was associated with well-being and just as important in the hospital, as when she was at home. However, older medical patients, even those with an independent walking ability, spend most of their hospital stay in their beds.^{2–6} Previously, we have shown that they spend a median of 17 h a day in bed and walk less than one hour during hospitalization,⁶ and that their level of mobility is restricted because no profession "owns" the responsibility for increasing mobility.⁷ In relation to this, the woman's quotation illustrates her awareness of the physical consequences related to bed rest

and inactivity. Studies have shown that complete bed rest and low mobility during hospitalization in older medical patients pose serious health risks, such as increased dependency, functional decline and death.^{8–10} Functional limitations can result in slower recovery,² and hence put older medical patients at risk of further functional decline, fall incidents and dependency in daily living.^{11–13} Bed rest during hospitalization can furthermore result in complications such as pneumonia, deep-vein thrombosis, urinary tract infections and ulcers.¹⁴ Therefore, if interventions aiming to prevent this functional decline through increased in-hospital mobility are to be implemented effectively, one must explore in depth, how older patients understand and experience mobility and physical activity during hospitalization, as well as enquire into the context of these experiences.¹⁵

Patient experiences with mobility and physical activity during hospitalization

On a personal as well as inter-personal level, studies have reported that patients abstain from increasing mobility during hospitalization for different reasons, such as: fear of falling or exacerbating illness;^{16–21} expectations of bed rest as a necessary part of

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hospitalization;^{20,22} poor physical status (e.g. symptoms and pain);^{16–18,21–26} and fear of bothering the staff or non-availability of walking aids.^{17,18,21,26,27} On an external level, studies show that in-hospital mobility is limited due to lack of meaningful activities and entertainment;^{27,28} nursing interventions and functional restraints (e.g. treatment regimens and catheters);^{21,25} lack of negotiation of goals or staff underestimating the abilities of the patient;^{16,23,26} lack of opportunities for physical activity in the hospital^{17,18,21,25} and hospital routines not facilitating mobility (e.g. lack of time).^{7,27,28} At the same time, studies have identified motivating aspects of in-hospital mobility as: positive relationships with the staff and their encouragement and praise;^{17,21,23} recognition of milestones and goal-setting;²⁵ personalized and tailored care;^{23,25} an enabling environment;¹⁶ knowledge of physical activity as important in feeling better and negative effects of bed rest;^{21,27} self-determination, preparation for discharge and fear of dependency.¹⁶ Thus, these insights depict patient mobility and physical activity during hospitalization as versatile practices, influenced, restricted and enabled by different circumstances and actors.

Ageing models and “active ageing”

In recent years, scholarly attention to physical activity in old age has shifted from an exclusively biomedical focus on health benefits of physical activity to a focus on the concept as both a cultural practice and a personal endeavour shaped by socio-economic factors and lifestyle choices that must be understood within the context and culture which they take place.²⁹ Activity in old age has become a conceptual keyword, which has shaped scholars', politicians' and older adults' understanding of later life.³⁰ Two central ageing models have dominated.³¹ On the one hand, the *disengagement theory* or the *narrative of decline* in which older adults' withdrawal from society is seen as a consequence of genetically determined physical degeneration. On the other hand, the *activity theory* that accentuates old age as a period of life not necessarily marked by passivity and withdrawal, but activity and potential. Globally, the latter has become widespread and dominant within ageing policy³¹ and given rise to numerous initiatives, policies and interventions focusing on participation, empowerment and independency.³²

Aim

This study investigates Danish older medical patients' experiences with participating in the multi-component mobility intervention of the WALK Copenhagen (WALK-Cph) project (described below) and in-hospital mobility more generally. It also addresses the ways mobility during hospitalization extends beyond the hospital to the patients' everyday active lives and relates to dominating ageing models of “active ageing”.

Our definition of mobility follows the definition proposed by Satariano et al.,³³ who define mobility as movement in all of its forms, including basic ambulation, walking for leisure and completion of daily tasks, engaging in activities associated with work and play, exercising, driving a car and using public transport. Mobility thus encompasses being actively involved in movement (i.e. through engagement in physical activity) and being passively moved (i.e. moved around in bed). Our definition of mobility furthermore follows the insights from our previous work that established in-hospital mobility of older medical patients as a social practice.⁷ The current study adds knowledge of older patients' experiences with an intervention that was co-designed by patients, relatives, health professionals and researchers.

The WALK-Cph intervention: A multi-component intervention to increase mobility in older patients

This study originates from the WALK-Cph project - a larger combined intervention and implementation study following a hybrid

design³⁴ with the overall aim of increasing 24 h mobility in older patients (+65 years) with walking ability during acute hospitalization for medical illness and following discharge (Appendix A). The intervention was developed in a co-design process with health professionals, patients and relatives and carried out in the hospitals as well as in the patients' homes.³⁵ Following an initial observational study, patients, relatives and health professionals from two municipalities and two medical departments participated in designing the intervention and creating an implementation plan. Hereafter, the health professionals were responsible for implementing the final intervention, which consisted of the following components: a welcome folder focusing on in-hospital mobility; posters encouraging patients to walk and exercise; a WALK-path; self-service on beverages and clothes; a physician-prescribed WALK-plan and follow-up on WALK-plans after discharge. The WALK-plan was considered a core component of the intervention, as it was regarded the essential component for increasing mobility.³⁶ It was prescribed by physicians and handed out by nurses or physiotherapists. There were three kinds of WALK-plans encouraging patients to walk three times a day for either one minute (red), five minutes (yellow) or 10 min (green). The latter contained three supplemental exercises. Patients with a WALK-plan were discharged with it and received a follow-up phone call by a health professional from the municipality encouraging them to continue following the plan. The intervention thus took place during the patients' entire stay in the intervention department as well as after discharge. Up to four weeks before the intervention was initiated (in September 2018), the staff of the two intervention departments was informed about the intervention components and the aim of the intervention at staff meetings. At these meetings, the staff was informed that the intervention encompassed that all members of the staff were responsible for motivating the patients to walk, to exercise by the posters, and to pick up clothes and beverages. Additionally, they were informed in writing through information material placed in the staff room. The intervention did not include specific training of the staff. During the design of the intervention, the issue of training need was mentioned and discussed. However, this was deemed needless by the ward nurses of the two intervention departments, who believed that the staff was already trained in motivating patients to mobilize. In preparation of the intervention, extra walking aids were placed in one of the intervention departments, which did not have a stock of walking aids, to make them more available for patients in need of one. This was done, as our initial observations in the baseline study revealed that lack of walking aids posed a barrier to mobility, as these were helpful when staff assisted patients to mobilize.⁷

Methods

Study design

The current study was not a part of the original design of the WALK-Cph project but was initiated following a request from managers and employees of the intervention departments (described below). They inquired for an investigation of the patients' views on the intervention because they had taken part in designing it. The study used semi-structured individual interviews with patients admitted to the two intervention departments. The semi-structured interviews allowed for open-ended questions and in-depth enquiry of the patients' answers and experiences.³⁷ This method ensured that all patients were asked the same questions, which we believe contributed to reliability of the study. By taking each of their experiences at face value, we wished to display the multi-faceted picture of the intervention and what practice of in-hospital mobility meant. To strengthen validity, all authors contributed to the development, conceptualization and design of the study, and the interview guide was reviewed by members of the interprofessional research group behind

the mobility intervention. By involving researchers with different professional backgrounds, we ascertained various and diverse guidance of the study design and data collection.

Setting

Interviews were carried out in two medical departments in the Capital Region of Denmark, where the healthcare system is publicly funded by taxes. The Danish welfare state provides free treatment for all citizens requiring primary medical care, as well as free hospital and home-based care services. The interviews were conducted in a department of endocrinology (Department X) with 24 beds and a department of general medicine (Department Y) with 25 beds. The clinical team in the departments had a similar number of physicians, nurses and nursing assistants. Yet, the design and furnishing of the departments differed. Department X was made up by two parallel corridors connected by two smaller corridors, which meant that patients could walk rounds in the department. In the middle of the department there was an atrium and a nursing office. Furthermore, there was a smaller office for physicians. Patient rooms were located along the length of the corridors and mainly designed as single or double rooms. All rooms were furnished with a TV. Each of the corridors had a small area, where patients could watch TV or enjoy meals. Department Y consisted of two broad corridors connected by a corner, enabling patients to walk back and forth. The department had a big nursing and conference room, a lunchroom for the staff and a reception. Patient rooms were either furnished with one, two or four beds. The department also had a living room and a dining room for patients in which meals were served. Both were furnished with tables, chairs and TVs.

Participants and sampling

A purposive sampling strategy was used with the intention to include older (+65 years) medical patients admitted to the intervention departments, who had an independent walking ability (with or without walking aid) and had been prescribed a WALK-plan. Thus, the sampling strategy was defined by a predetermined criterion of importance³⁸; the WALK-plan. Through consultation with the staff and orientation on the patient overview screen in the staff room, eligible participants were chosen. The criteria for inclusion of patients in the intervention program and for inclusion of patients for interviews were the same. We wished to include an equal amount of men and women, and preferably types of WALK-plans. At times this was difficult to achieve, due to questions of resources, time and patient variation. Therefore, the strategy at times was characterized by convenience. Patients were excluded for the following reasons: isolation, terminal illness, language other than Danish and inability to cooperate. Demographic data on sex, age, and length of stay were collected during the interviews.

Data collection and measures

The interviews were conducted between February 28th and April 4th, 2019 by NS, who followed a topic-based semi-structured interview guide (Appendix B). The semi-structured nature of the interviews ensured that all topics were covered in each interview and allowed for the interviewer to pursue subjects and themes that occurred during the interviews.³⁹ Initially, one interview was conducted as a pilot test, which was followed by a discussion with JK. This did not lead to major revisions of the interview guide. The interviews were conducted at the bedside of the patients. Twenty patients (11 women and 9 men) between the age of 65 and 93 years (mean=77, SD=8) were interviewed. Most of the patients had been prescribed a green WALK-plan ($N = 11$), and some a yellow ($N = 6$) or

a red ($N = 2$). One patient without a WALK-plan was interviewed, because he was observed using the WALK-path, thus deemed eligible, as he utilized part of the intervention. An overview of the participants is provided in Appendix C. On average, the interviews lasted 18 min. The interviews were audio-taped and transcribed verbatim.

Ethical considerations

The study followed the ethical principles of the Helsinki declaration.⁴⁰ Participants were informed about the study orally and in writing and were provided the opportunity to ask questions before they signed a written consent. The management of the departments gave their approval prior to the data collection, when they requested the study. The study was approved by the Danish Data Protection Agency (AHH-2016-080, I-Suite no.: 05078). We acted on the basis of situational ethics by accompanying our knowledge of the context with responsibility, morality, intuition and sense during the interviews.⁴¹ This meant that we considered the condition of the participants, e.g. by asking if they felt comfortable with the interview setting and by respecting their limits.

Data analysis

The analysis was initiated after all interviews had been conducted and transcribed. NS carefully read and reread the transcripts to obtain a sense of the whole. The readings followed Graneheim and Lundman's⁴² concepts of qualitative content analysis, in which meaning units were systematically selected, grouped in subthemes and finally condensed in overarching themes. To strengthen the validity of the analysis, JK read, reread and grouped subthemes of two interviews. NS and JK's readings of the first two interviews were followed by a discussion of the results, until consensus was obtained and to secure trustworthiness and reliability. In the initial coding process, 134 codes were identified, which were then sorted in subthemes and lastly gathered in the five overarching themes presented in the study. The themes identified in the data material were presented to relevant stakeholders of the project, who recognized the findings from their practice. The grouping of subthemes and themes of all transcripts was done in QSR International's NVivo 12 software. Finally, a selection of quotations illustrating the themes was made.

Findings

The analysis showed that older medical patients' experiences with the WALK-Cph intervention and in-hospital mobility were constituted in interplays between different actors, practices and materialities, some of them extending beyond the hospital. Thus, the relationship between bed rest and mobility was ambiguous and context dependant. The analysis resulted in five overall themes. The first theme concerns the patients' experiences with the intervention components. It is followed by four additional themes that shed light on the patients' multifaceted experiences with in-hospital mobility. As will become evident, it is influenced by the patients' experiences with illness and recovery, encouragement and support from others, materialities in the hospital and wishes to return to everyday active lives.

Experiences with the WALK-Cph intervention

The invisible yet meaningful WALK-plan

Not all patients had heard about the WALK-plan, though they had been prescribed one by the staff. As part of the intervention, the WALK-plans were supposed to be introduced and handed out to the patients by either the nursing staff or physiotherapists. It became evident that the WALK-plan was not always recognized by the patients,

thus indicating that they were not aware of their participation in the intervention. A 70-year old man uttered “No, that does not ring a bell”. Receiving such an answer, the interviewer inquired into the location of the WALK-plan and sometimes found it hidden in papers on the side-table of the bed, in a drawer or hanging behind the bed. An 86-year old woman exclaimed: “Oh, that one? I haven’t seen that one at all”, and a 75-year old man proclaimed: “what a stupid place to put it” when the interviewer took it down from a board next to his bed. In this way, the WALK-plan became invisible to some patients, as it was either physically unavailable or had not been introduced. However, when recognized most patients perceived the WALK-plan as meaningful and some had taken a walk because they had been prescribed one. An 80-year old woman received the WALK-plan from a physiotherapist and walked regularly: “I have looked at it, I think it’s a good idea”. When asked about the contents of the WALK-plan, patients described it as straightforward, easy to understand and comply with. The purpose was described by a 78-year old woman in terms of “keeping the body and the muscles busy”. Others said that walking prevented weakness and enabled them to take care of themselves upon discharge. A 79-year old man pointed at his yellow WALK-plan and explained:

You know, this one [the WALK-plan], I think this is a good idea, eh, where there is an explanation and a recognizable colour [...].

Thus, the patients were not always aware of their participation in the intervention, as the WALK-plan tended to disappear. However, when introduced, the WALK-plan was perceived as meaningful.

Making sense of the WALK-path

The patients gave the WALK-path different names, such as “the walking line”, “the ruler”, “the green path/line/stripe or mile” or simply “the line”. Approximately half of the patients remembered having been introduced to it. The other half expressed that they had not been introduced to it. Patients who had either been introduced to or made their own sense of the WALK-path generally perceived it as meaningful. For example, it was viewed as a tangible tool for and marker of physical activity and walking. A 79-year old man noticed:

Well, maybe it makes it all clearer, it makes it more distinct. You aren’t in doubt, you just follow the line.

Some mentioned that it was unclear, where the WALK-path would take them, as for example a 68-year old woman, who found it boring:

I was advised to follow the green line, and then I said: “Where does it take me?”, eh, apparently it just takes you around the department, I realized.

She furthermore missed something to reach for when walking and jokingly suggested that entertainment would take place at the end of the line, like hospital clowns, as she asked: “why is it only children who benefit from those?” This resembled a 77-year old man’s view on the WALK-path:

[...] they could have made it a bit more exciting [...] I mean, walking the path three times makes me tired of looking at the same people all the time.

A few patients assigned the WALK-path purposes unrelated to mobility. They perceived it as an aid to find one’s way around the hospital or as a means to make sure that patients stuck to one side when moving around the department and thereby not disturb the busy staff. In this way, the WALK-path was a visible marker indicating where to be physically active in the department, although some attached their own meaning to it and interpreted it in other ways than originally intended in the intervention.

Views on self-service

As with the WALK-path and the WALK-plan, not all patients were aware of the option of self-service on beverages and clothes. Approximately half of the patients were aware of this option, either because the staff had introduced them to it or because they found out by themselves. The other half did not know about it. When made aware of the option, the patients were asked what they thought of it. The majority had a positive view on it, both because it encouraged them to get out of bed and because it relieved the pressure on the staff. An 88-year old woman explained:

[...] The advantage is for oneself – that you get some exercise and relieve the staff [...] This means, you don’t need the staff in such situations.

Some patients described the option as self-evident and did not think of it as a distinctive feature of the department and collected their beverages and clothes themselves. Other patients, however, were aware of and acknowledged the potential advantages of it but did not utilize the self-service options. Instead they had beverages brought to them by the staff. A 75-year old man mentioned that service in the department could pose a challenge to increasing mobility:

Maybe there’s too much service, you know, you get too much service [...] instead the staff could say: “Well, now it’s time for breakfast, which you can pick up by yourself”.

The patients also called the staff if they needed anything, thus indicating a certain expectation of the staff to cater to them. An 88-year old woman answered the following, when she was asked what she did, if she was thirsty: “I have a cord here, where I can call the staff and then they come”. On the one hand some patients expected service, and on the other hand, the staff brought things to the patients although they, by virtue of their WALK-plan, had the ability to walk and get out of bed. Few disadvantages of the self-service options were mentioned, but they were listed as either hygienic challenges or problems with reaching clothes that were inconveniently placed in the closets. In sum, the patients perceived the option of self-service as a positive, sometimes self-evident option. However, expectations of service from the staff were also widespread.

Invisible posters and welcome folders

Most of the patients did not notice the posters encouraging in-hospital mobility. In Department X, the posters were located on a wall in each patient room and by the rest areas in the corridors. In Department Y, they hung on the walls in the corridors. This did not seem to make a big difference, as neither patients from Department X nor patients from Department Y saw the posters. Some mentioned that they could not read them due to poor eyesight, as this 78-year old woman:

[...] I can’t read, well I do wear glasses, but I can’t read for long and not much, so I can’t see what it [the poster] says. I’ve tried [...] but I can’t read it, though I’d like to.

Others said that they did not notice them, like a 77-year old man who with a twinkle in his eye pointed at his neighbour heavily sleeping and remarked:

I just don’t think people notice it [the poster], because I think people just don’t think it concerns them. You see my mate over there, he’s pretty indifferent about it.

Others misinterpreted the posters’ message. A 74-year old man thought the poster was a map of escape routes, and the woman

mentioned above, who had problems with reading, thought it addressed the staff. Some patients described the posters as boring and suggested that they were designed in a more exiting way. As for the welcome folder, only one patient recalled having received it upon admission to the department. The patients' explanations for this were that they had been in a very bad condition, when they were admitted to the hospital. This for some resulted in no remembrance of the first day of hospitalization, nor of whether they had received the welcome folder or not. These results indicate that neither the posters, nor the welcome folder encouraged patients to exercise during hospitalization. First and foremost because they did not notice them.

The questions about the intervention components gave rise to conversations about more general aspects of what the practice of mobility during hospitalization meant to the patients. Therefore, the next sections depict four themes dealing with different aspects, that influence this practice. These different aspects might explain, why some patients did not realize their involvement in the intervention.

Mobility in the light of experiences with illness and recovery

Most frequently patients mentioned how difficulties with increasing mobility during hospitalization were related to what could be termed as their illness experiences of symptoms, such as pain and weakness. A 93-year old man explained:

[...] you don't get up more than strictly necessary, when you have [a leg] that hurts, although it can easily be done.

Patients also mentioned that fatigue restrained them from leaving the bed. This was a result of lack of sleep due to noises or diuretic medicine that demanded frequent visits to the toilet during the night or fear of falling. An 86-year old woman, who did not dare to go to the bathroom by herself, said: *"I don't dare to go out there by myself, I just don't. I am very frightened of falling"*. Some patients also mentioned feelings of demotivation such as laziness and self-pity as reasons why they were not motivated to get out of bed. A 69-year old man with a red WALK-plan explained that nothing really motivated him to get out of bed and that he was *"never much of an athlete"* but *"more the working kind of type"*, which had now taken a toll on his body. He acknowledged the importance of getting out of bed, but his despondent answers indicated that he did not consider the "active" idea of the intervention relevant, nor could he live up to it. In contrast, most patients emphasized their own responsibility in increasing mobility, as explained by a 78-year old woman:

Honestly, I think it's a question of pulling oneself together, and it's a question of wanting to, and that's it.

Moreover, this was underlined when patients expressed how they were already motivated towards getting out of bed. They described how walking during hospitalization was beneficial and they described how they got *"stronger"* and gained *"more energy"*, how they *"could breathe easier"* and how it helped them to *"think more clearly"*. In this way, the practice of mobility was perceived as a means for recovery, part of one's treatment and a way to avoid symptoms. This was often linked to experiences with or knowledge about the consequences of inactivity and bed rest. Patients described how their muscles weakened the more days they spent in bed. A 74-year old man said:

I simply know that it does me good to move my muscles. If you just stay and stay in bed, eventually the muscle mass will disappear [...] once I was hospitalized for a longer period of time, and I lost weight and went from seventy-odd kilos to 57 kgs.

When patients described the positive bodily experiences of leaving the bed and walking in the department, they perceived this ability both as a means to and a sign of recovery. They were motivated by a wish for recovery, but this was often counteracted by illness experiences and despondency hindering them from increasing mobility.

Encouragement and support from others

Encouragement and support from the staff and relatives also influenced the patients' practices of mobility. Most commonly, the patients mentioned how encouragement and praise from the staff were sources of motivation. Encouragement encompassed the staff praising, showing patience and providing information about consequences of bed rest. This was suggested to be done in polite and kind ways. A few patients even considered the staff's encouragement as care for them. A 77-year old man described how the staff praised him, when he went for a walk around the department:

The ones [the staff] that come here often and who know me a little say: "Hello there, how nice that you are out walking" and things like that. [...] it cheers one up [...].

The patients also mentioned how it motivated them if the staff had time to assist them walking or exercising, as it could be hard to rise to one's feet. The staff's encouragement, praise and assistance were deeply interrelated in what could be conceptualized as the patients' wish for care that centred around them as individuals or "patient-centred care". For example, an 80-year old woman felt that people reacted differently, when they were encouraged to pick up beverages by themselves:

If the staff says: [...] "I think you should pick up your coffee by yourself", right? Then maybe some people are offended [...] I think it's fine that they ask me to do it.

However, patients also mentioned that the staff's busyness influenced on their practice of mobility. This meant that patients would refrain from asking for assistance when wanting to go for a walk or get out of the bed. As promptly answered by a 65-year old man:

NS: *How would it affect you if the staff said: "Get out of the bed!"*
Respondent: *Well, they never have time for that [...]. I have a permanent home help, she kicks me out of bed if she thinks I'm too slow, she does something about it.*

Some patients, especially female, mentioned that they did not want to bother the staff more than strictly necessary. Additionally, a few patients mentioned the role of relatives in motivating them to increase mobility. For example, a few patients had taken a walk, because their relatives encouraged them to do so. A 73-year old woman explained:

And my family says: "It's time for you to take a walk, mom, because you have been feeling ill for quite a while" And [...] on their request, I'll do it, and eventually I actually feel like doing it, right?

In this way, the practice of mobility was influenced by encouragement and support from others, especially the staff, and for some patients also relatives.

Materialities in the hospital

A third aspect of the patients' practices of mobility was related to the physical environment of the hospital, which we have termed materialities of the hospital and their properties of either encouraging or discouraging increased mobility. Artefacts such as medical devices, e.g. intravenous lines and urinary catheters, were mentioned by some patients as impeding their practice of mobility. A 75-year old man experienced a relief when his catheter was removed:

You see, now the catheter and all that shit have been removed [...] it really bothered me that bag and the catheter [...]. Now I can pull up my pants where they're supposed to be, [...] so now I'll probably start walking around in the hospital corridor.

In contrast, a 73-year old woman felt supported by an intravenous stand, as she could lean against it, when walking. Medical devices thus posed a barrier for some patients while for others they enabled them to increase mobility. The patients also described the design and furnishing of the department as uninviting. Patients depicted the department as "boring" and "unexciting". They missed something to do, see or experience. For example, an 82-year old woman walked to the hospital vestibule with three relatives and she "didn't feel as ill out there" as when she was in the department. She said she felt better when surrounded by people, who were not ill. Interestingly, the views regarding the general design and furnishing did not vary between the two departments, although Department Y had a dining and living room, in which the patients could have their meals and watch TV. A 93-year old man said that his neighbour patient had his meals there. However, he himself, liked to eat in his room. In contrast, a 78-year old woman regarded the option of being able to pick up meals and beverages in the dining room as a motivation to get out of bed. The bed also appeared as an object affecting patients' mobility. On the one hand, some patients described it as imprisoning. Here described by a 73-year old woman:

Physically, if this barrier [the guard rail of the bed] is put up, you can't move, and I hate to be locked up [...] I can't take it.

Other depictions of the bed were that it was "causing back pain", that lying in it felt like "being glued to the bed", or that it was "dangerous", as an 82-year old woman recounted:

I know that the most dangerous place to stay is in your bed, because that's where most people die [...] if you place ten healthy people in a bed, eventually, they will fall ill.

These remarks indicated that negative qualities attached to the bed motivated the patients to leave it as soon as possible. However, the bed was also regarded safe. While the aforementioned woman regarded the bed dangerous, she also described it as her "home" and as a "refuge". In this way, the patients' utterances regarding physical objects, such as the bed and medical devices, and the hospital environment underlined the important role materialities play in their practice of in-hospital mobility.

Returning home to everyday active lives

Finally, the patients' practice of mobility was influenced by meaningful activities and goals within and outside the hospital. Patients mentioned activities such as being able to walk one's dog, attend chair fitness or play cards with friends. Thus, motivation could be found in what has been termed "transfer value"⁷ elsewhere. That is, when patients perceive physical activity in the hospital as a key to re-establishing independence and returning to pre-admission everyday life. For instance, a 78-year old woman explained:

[...] when I say that I want to stay active, it's because I have a hobby called bridge, and I give the highest priority to that [...] if I can't stay active, well, then I can't go and play bridge, and eh, what can I say? To put it bluntly, then I don't have anything to live for.

The patients explained how they were motivated to get out of bed, when they had something to reach for. This goal-orientated motivation was visible in two ways. On the one hand, a goal was to be discharged, return home and regain independence. For example, this was related to being able to climb stairs, socialize, avoid discharge to a nursing home or to continue to drive one's car. An 82-year old woman answered the following when asked what she saw as the purpose of the WALK-plan:

[the purpose] is to get people out and move about instead of lying in the bed, and to ensure that you can take care of yourself, once you return home. You know, hopefully you return home to the same life as before you fell ill. And I sure hope to be able to do so [...] I really hope that I will be able to drive my car again.

On the other hand, goals were also explained in more tangible ways in terms of concrete goals to reach or activities to attend during hospitalization. A 68-year old woman was motivated by:

Something tangible. Last week I got my hair fixed, had it cut, because I really needed a haircut. And I walked to the hairdresser in the lobby of the hospital.

Other patients mentioned trips to the kiosk in the hospital, a wish for a library to visit, newspapers in the hospital hallway and artwork to look at. Thus, this goal-orientated part of in-hospital mobility both related to activities in the hospital, but most strongly to wishes to return to active everyday lives.

Discussion

This study explored how older medical patients experienced the WALK-Cph intervention and shed light on different aspects of in-hospital mobility. The idea of the intervention was perceived meaningful and relevant by most of the patients, though not all of them were aware of their participation in the intervention. Components of the intervention were left open for interpretation and even invisible, if they were not introduced and explained. The study showed that the patients had different ideas and expectations of in-hospital mobility. Our findings suggest that the practice of mobility was made up of and influenced by the patients' experiences with illness and recovery, encouragement and support from others, materialities in the hospital and wishes to return to everyday active lives. Thus, increased in-hospital mobility was not only a matter of keeping oneself in shape physically, but also a means to return to everyday lives and activities. For years, bed rest, low mobility and low physical activity have been problematized and mentioned as targets for intervention by policymakers, health professionals and researchers,⁴³ which the WALK-Cph intervention in this study sought to address. But, as has become evident in this study the patients' practice of in-hospital mobility was linked to more than physical well-being. Interventions such as the WALK-Cph intervention must be implemented with attention to older patients' diverse practices of mobility, which are situated and experienced within different everyday practices and ideas of ageing.

Mobility interventions and "active ageing"

In Denmark, the relationship between the welfare state and its older citizens has changed within the last couple of decades from

being characterized by ideas of disengagement (*disengagement theory*, or the *narrative of decline*) and as “a paternalistic state, responsible for delivering care to its older citizens in need” to a “state [that] today encompasses the vision of moulding and transforming its older citizens through “active ageing” policy programs”.³² This development is rooted in a general movement from regarding older people as passive targets in need, to an approach based on rights and emphasizing qualities such as choice, individual responsibility and participation.^{32,44} This change has given rise to numerous initiatives and policies focusing on participation, empowerment and independency, also in hospital contexts in which initiatives of involving older patients (e.g. the WALK-Cph intervention) have increasingly gained a footing. Scholars have argued that old age within these policies becomes constructed as a life phase where potentials can be realized^{45,46} and where old age is “*unmade*”.⁴⁷ This tendency has been criticized as a process of neoliberalization, in which ideals of productivity are extended into old age. In this way activity and social engagement are constituted as positive characteristics, whereas dependency, solitude and illness are negative characteristics.^{30–32} This, it has been argued, results in a neglect of the complex relationship between dependency and independency and pathologizes passivity and stagnation.³² The WALK-Cph intervention is inevitably entangled in and promoting this discourse of “active ageing” exhibited through its wish to facilitate a healthy choice and invitation to “*Move to preserve yourself*” (In Danish “*Bevæg dig – Bevar dig*”) as signs on the WALK-path recommended. It is grounded in an extensive body of biomedical evidence of consequences related to bed rest in older, hospitalized patients. It is valuable to reflect on the ways in which the intervention can both embrace patients, who identify with ideals of active ageing and those who do not. In our study, half of the patients emphasized their active everyday lives outside the hospital, without having been asked directly. This they often linked to their motivation to increase mobility during hospitalization (“transfer value”). Lassen and Moreira have called for an understanding of activity as a “*culturally specific form of practice*” and pointed out that activity and passivity are part of the same continuum and thus constitute each other.⁴⁷ In this way, the concept of activity within the paradigm of active ageing should not contrast activity and passivity, but rather grasp them as prerequisites of each other.⁴⁸ Keeping this in mind is pivotal, if a mobility intervention as the WALK-Cph intervention is to be implemented successfully in the eyes of the patients. In our study, the patients called for an acknowledgement of attaching in-hospital mobility to their everyday life activities, while they also asked for time to sleep, rest and recover. Rest and activity went hand in hand. In practice this meant that the components were most effective, if presented with respect for what was meaningful to the individual patient. Studies have pointed out how patients suggest that health professionals appeal to mobility as a means to prepare for discharge and inform patients about the consequences of bed rest and the benefits of leaving it.^{16,21} In accordance with the research of Boltz et al.¹⁶ and Holst et al.,²⁷ patients in our study mentioned how walking was regarded a means to improve well-being and the ability to maintain everyday life activities after hospitalization. This was furthermore linked to the goal of returning home and taking part in different sorts of activities, as Koenders et al.²⁵ also conclude. These activities varied and exhibited, how the patients in our study were not a homogenous group. Being active could mean to be able to socialize by playing bridge with friends, while for others it meant something else. Thus, patients’ values and wishes for relating activities in the hospital to those outside of it became central in understanding what motivated them to increase in-hospital mobility. enquiry into the patients’ personal experiences with and everyday practice of mobility and ageing, then, could supplement the way in which WALK-plans and the WALK-path are introduced and adjusted to the patients by the health professionals. Lassen

writes how his interlocutors (older people at two Danish activity centers) emphasized that being “*an active older person*” was a matter of “*being physically, socially and/or mentally active, entrepreneurial or independent*”, while most important to them was to be able to continue their everyday lives.⁴⁹ This resonates with the wishes of the patients in our study, but also underlines how being hospitalized might hinder this because of the hospital’s design and routines. According to the patients, the hospital did not offer much room or opportunities for meaningful activities. This is commonly identified as a central point in questions of in-hospital mobility and physical activity.^{17,18,21,25,27,28} In a study by So and Pierluissi²¹ patients reported that they were motivated for increasing mobility, because they wished to avoid negative effects of bed rest, which was also mentioned by patients in our study. This was particularly uttered by patients, who had prior experiences with these consequences. Encouragement from others had a positive effect on motivation, which has also been identified elsewhere.^{16,23} In these studies, this was particularly related to the staff’s ability to praise, recognize and encourage patients to perform physical activity. In our study, we found that encouragement and praise additionally were connected to the components of the intervention, as they could potentially facilitate a conversation about mobility. When patients utilized the WALK-path, they recounted how the staff encouraged them to continue. Thus, the WALK-plan and WALK-path constituted hands-on tools for creating positive relationships between patients and staff in conversations about mobility. However, our results show how the components became invisible. The patients had other concerns and found themselves in unaccustomed surroundings, which underlined the necessity of the staff introducing, articulating and brushing up of the purpose of the WALK-plan and the WALK-path. Thus, our findings emphasize the importance of incorporating and operating with a broad concept of active ageing – and ageing in general – when promoting increased mobility in the hospital. One that counts in and identifies the positive communities and activities that older patients are already part of upon admission to the hospital. This demands an acknowledgement of the heterogenous character of older people and means that motivation for practice of mobility varies. Some components of the intervention made sense to some patients, while for others they were considered provocative. Some easily bought into the premises of the “active” intervention, while others were more sceptical or did not notice that the two departments had a particular focus on increasing mobility.

Strengths and limitations of the study

When interpreting the findings of this study, its’ strengths and limitations should be considered. A strength of the study is the qualitative research design, which allowed participants to describe their attitudes and expectations to in-hospital mobility in their own words. Qualitative methods are particularly suitable for exploring knowledge produced between people, situations and their context, so-called ideographic knowledge.⁵⁰ Twenty older patients were included in our study, which must be considered a high number, as this group is often regarded difficult to access, due to their vulnerable situation. Various limitations should be taken into account. First, it is relevant to consider different aspects of the sampling strategy and size. The participants were recruited from two Danish departments, which might limit the transferability of the study. Transfer of the findings to other settings requires adaptation to the local context. However, the two departments were initially selected for intervention, as their patient population generally represent older medical patients. Transferability of the findings was also supported through descriptions of the context of the study, as well as in the discussions of similarities with other studies of in-hospital mobility in older

medical patients. We aimed at including patients, who had been prescribed a WALK-plan, but selecting patients, who met this specific criterion, we might have failed to capture the experiences and views of other important groups that might just as well have had relevant experiences.³⁸ Second, collection of specific demographic data and disease histories could have contributed to a deeper data analysis. This could have added valuable insight into the influence of e.g. one's social background on one's practice of mobility. Third, the study strictly focused on the experiences of patients and did not include the insights of other relevant actors, such as health professionals and relatives. This was an active decision, as others have inquired into the practice of health care professionals.^{7,51,52} The views and potentials of relatives in increasing mobility during hospitalization remain open for further research.

Conclusion

The patients interviewed in this study perceived the idea of the WALK-Cph intervention - an in-hospital mobility intervention - as meaningful, but the components were freely interpreted and risked becoming invisible, if they were not introduced by the staff. In this way, the intervention components could not stand alone and required thorough introduction and adjustment to the specific patient in question. This was underlined by the patients' diverse practice of mobility during hospitalization, which was influenced by the patients' experiences with illness and recovery, encouragement and support from others, materialities in the hospital and wishes to return to everyday active lives. Thus, the impetus behind interventions such as the WALK-Cph intervention should not solely be a question of reshaping older patients at risk of decline to physical active subjects, but also be concerned with the various ways mobility plays out in and outside the hospital, and how these are shaped by discourses and ideas of active ageing.

Declaration of Competing Interest

None.

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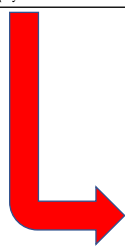
Data statement

The dataset generated and analyzed during the current study is not publicly available because it contains potentially identifying or sensitive information that could compromise the privacy of the respondents according to regulations set out by the Danish Data Protection Agency.

Appendices

Appendix A:

Appendix A. The WALK-Copenhagen (WALK-Cph) intervention and implementation study, Hybrid II design

	PHASE 1		PHASE 2				PHASE 3	PHASE 4	
WALK-Cph intervention	Collaborative design of the intervention (study 1a)		Fidelity and feasibility of intervention (study 2a) x 2	Re-design of intervention (study 2c) x 2	Fidelity and feasibility of intervention (study 2e)	Re-design of intervention (study 2g)	Effect of intervention (study 3a)		
	Ethnographic study: observation of everyday practice to understand the context and culture Design workshops I-V: with users and researchers to design the intervention Determinant study: Semi-structured single interviews for identifying barriers and facilitators among physicians		Observational study: to observe fidelity of intervention Feasibility study: to test recruitment strategies, patient willingness, and estimate inclusion rate	Workshop VIII: with users and managers for further development and refinement of the intervention	Observational study: to observe the fidelity of the intervention Feasibility study: to test recruitment strategies, patient willingness, and estimate inclusion rate	Workshop XI: with users and managers for further development and refinement of the intervention Semi-structured single interviews with patients	Cohort study with status meetings		
WALK-Cph implementation			Design and develop implementation strategies and plan (study 1b)	Fidelity of implementation strategies (study 2b) x 2	Re-design of implementation strategies (study 2d) x 2	Fidelity of implementation strategies (study 2f)	Re-design of implementation strategies (study 2h)	Implementation study (study 3b)	Adoption (study 4)
			Workshops VI-VII: with managers and key implementation staff to identify and select relevant implementation strategies	Observational study and questionnaire: to measure fidelity of implementation strategies	Workshop IX and X: with managers and key implementation staff to re-design and monitor relevant implementation strategies based on the fidelity study and workshops	Observational study and questionnaires: to measure fidelity of implementation strategies	Workshop XII: with managers and key implementation staff to re-design and monitor relevant implementation strategies based on fidelity study and workshops	Observational study: to support the implementation by using three implementation strategies: facilitation, social influence and outreach visits	Ethnographic study: six months after end of cohort study to observe everyday practice and compare with initial observations and semi-structured single interviews with managers and key implementation staff

Appendix B. Interview guide

Introduction

- Short description of the WALK-Copenhagen project (the purpose, length and form of the interview)
- Consent confirmed

Opening questions

- When were you admitted to this department?
- How did the staff introduce you to the department?
- Did the staff provide you with information about the importance of physical activity during your hospital stay?
- In which way do you experience that the staff talks about the importance of getting out of bed during hospitalization?

The physician-prescribed WALK-plan

- On which occasion did you receive the WALK-plan?
- How was the WALK-plan introduced?
- What does your WALK-plan contain?
- In your opinion, what is the purpose of the WALK-plan?
- What motivates you to get out of bed/perform physical activity during your hospital stay?
- What keeps you in bed during your hospital stay?
- Is there anything in particular that motivates you to get out of bed?

The WALK-path (if recognized by the patient)

- Have you been introduced to the WALK-path? How and by whom?
- Have you used the WALK-path? What was your experience with this?
- What made you use the WALK-path?
- In your opinion, what is the benefits of using the WALK-path?
- What do you think of the WALK-path's location (on the floor)?
- Have you noticed the whiteboards on which you can mark your rounds? (Department X only)
- What could prevent you from using the WALK-path?

Self-service on clothes and beverages

- What do you do, when you need new clothes or if you are thirsty?
- Did the staff introduce you to the option of self-service on clothes/beverages?
- Have you collected clothes and/or beverages?
- What are the advantages of this option?
- What are the disadvantages of this option?

Posters encouraging patients to walk and exercise

- Have you noticed the posters encouraging patients to walk and exercise in the department?
- Have you been introduced to them by the staff? By whom and how?
- Have you performed any of the exercises? What worked/did not work?
- What kind of effect do posters encouraging physical activity have on you?

Physical activity during hospitalization

- Do you think it is important to exercise during hospitalization? Why/Why not?
- How have the staff's and the welcome folder's articulation of the importance of physical activity during hospitalization influenced you?
- Which opportunities of exercising and being physically active are available in the department?
- What is your opinion about a hospital department promoting physical activity as part of the treatment?
- Is it advantageous to unfold this focus to other departments in the region? Why/why not?
- Could you think of initiatives to motivate older, medical patients to exercise during hospitalization?

Closing and thanks for participation

- Do you have any additional information or questions you would like to add?

Appendix C. Overview of participants

No.	Sex	Age (years)	Length of stay at the time of the interview (days)	Medical department Department X (Department of Endocrinology) Department Y (General Medical Department)	Type of walk-plan (colour)	Walking aid
001	W	68	14	Department X	Green	Walker
002	W	70	7	Department X	Green	Walker
003	W	75	4	Department X	Green	Walker
004	M	69	7	Department X	Red	Walker
005	M	77	8	Department X	Green	None
006	M	94	4	Department Y	Red	Assistance from the staff
007	M	75	3	Department Y	Green	None
008	W	86	7	Department Y	Yellow	Walker
009	M	93	5	Department Y	Yellow	Assistance from the staff
010	W	73	5	Department Y	Green	None
011	M	65	2	Department Y	None	Walker
012	W	80	4	Department Y	Green	None
013	W	88	4	Department Y	Yellow	Walker
014	W	78	5	Department Y	Green	Walker

(continued)

(Continued)

No.	Sex	Age (years)	Length of stay at the time of the interview (days)	Medical department (Department of Endocrinology)	Department X (Department of Endocrinology) Department Y (General Medical Department)	Type of walk-plan (colour)	Walking aid
015	M	70	9		Department X	Yellow	Cane
016	W	82	20		Department X	Yellow	Cane
017	W	73	4		Department Y	Green	None
018	M	74	8		Department X	Green	None
019	M	79	7		Department X	Yellow	None
020	W	80	7		Department X	Green	None

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