

Fitheid van patiënten rondom ziekenhuisopname

Cindy Veenhof



Disclosure belangen spreker

Potentiële Belangenverstrengeling: Niet van toepassing

Cindy Veenhof

UMC Utrecht,
afdeling revalidatie,
fysiotherapiewetenschap
en sport



Master
Fysiotherapiewetenschap,
UU



**Hogeschool
Utrecht:** Fysiotherapie

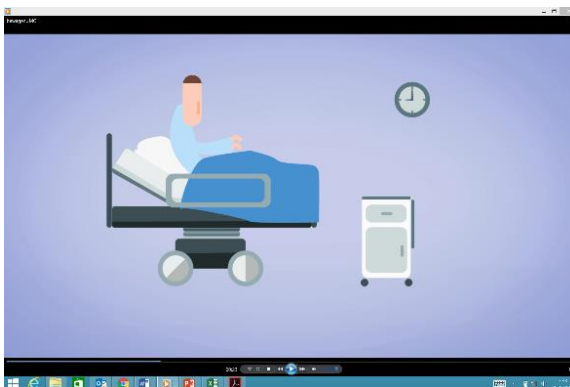
 **INNOVATIE**
van bewegezorg 



Speerpunten onderzoeksgroep Fysiotherapiewetenschap



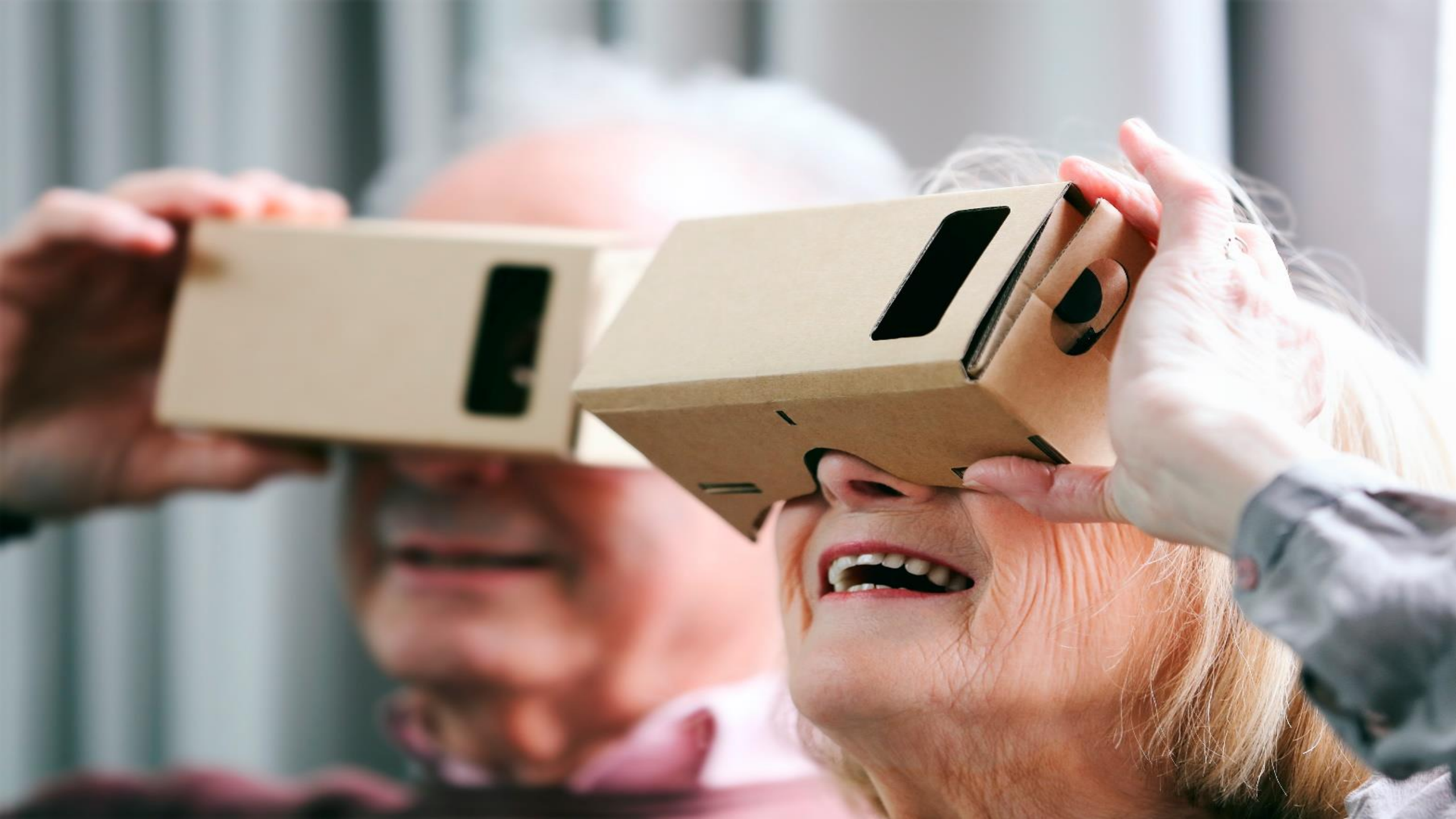
Nieuwe technologie in
beweegzorg



Fysieke zelfredzaamheid
rond ziekenhuisopname



Innovatieve
beweegzorgtrajecten







De juiste zorg op de juiste plek

Wie durft?









Iatrogen

1

2

Conclusions: The present study suggests that a significant proportion of hospitalization-associated disability may be induced by iatrogenic events, and that most of them are potentially preventable. Health care professionals need to be educated on the specific needs of elderly hospitalized patients and should consider hospitalization-associated disability as an outcome of care.

preventable. The most common health management issues identified in patients with preventable iatrogenic disability were low mobilization [by excessive bed rest (26.5%) and lack of physical therapist intervention (55.1%)], overuse of diapers (49.0%), and transurethral urinary catheterization (30.6%).

3



Sourdet S, Lafont C, Rolland Y, Nourhashemi F, Andrieu S, Vellas B.
Preventable Iatrogenic Disability in Elderly Patients During Hospitalization.
J Am Med Dir Assoc. 2015 Aug 1;16(8):674-81



Hospitalization-associated disability

This hospitalization-associated disability occurs in approximately one-third of patients older than 70 years of age and may be triggered even when the illness that necessitated the hospitalization is successfully treated.

Covinsky KE, Pierluissi E, Johnston CB.

Hospitalization-associated disability : "She was probably able to ambulate, but I'm not sure".
JAMA. 2011 Oct 26;306(16):1782-93.

Achtergrond

SPIERMASSA



ALS
EIWITVOORRAAD

1



SPIERKRACHT

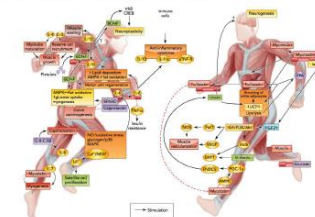


OM TE
BEWEGEN

2



SPIERACTIVITEIT



VOOR DE
GEZONDHEID

3



Figure 1. Summary of the main proteins, their putative effects, and the molecular signaling pathways involved.

Fitzze-Lorenz C, Geratichan N, Berger NA, Lucia A.
Exercise is the real polypill.
Physiology (Bethesda). 2013 Sep;28(5):330-58.

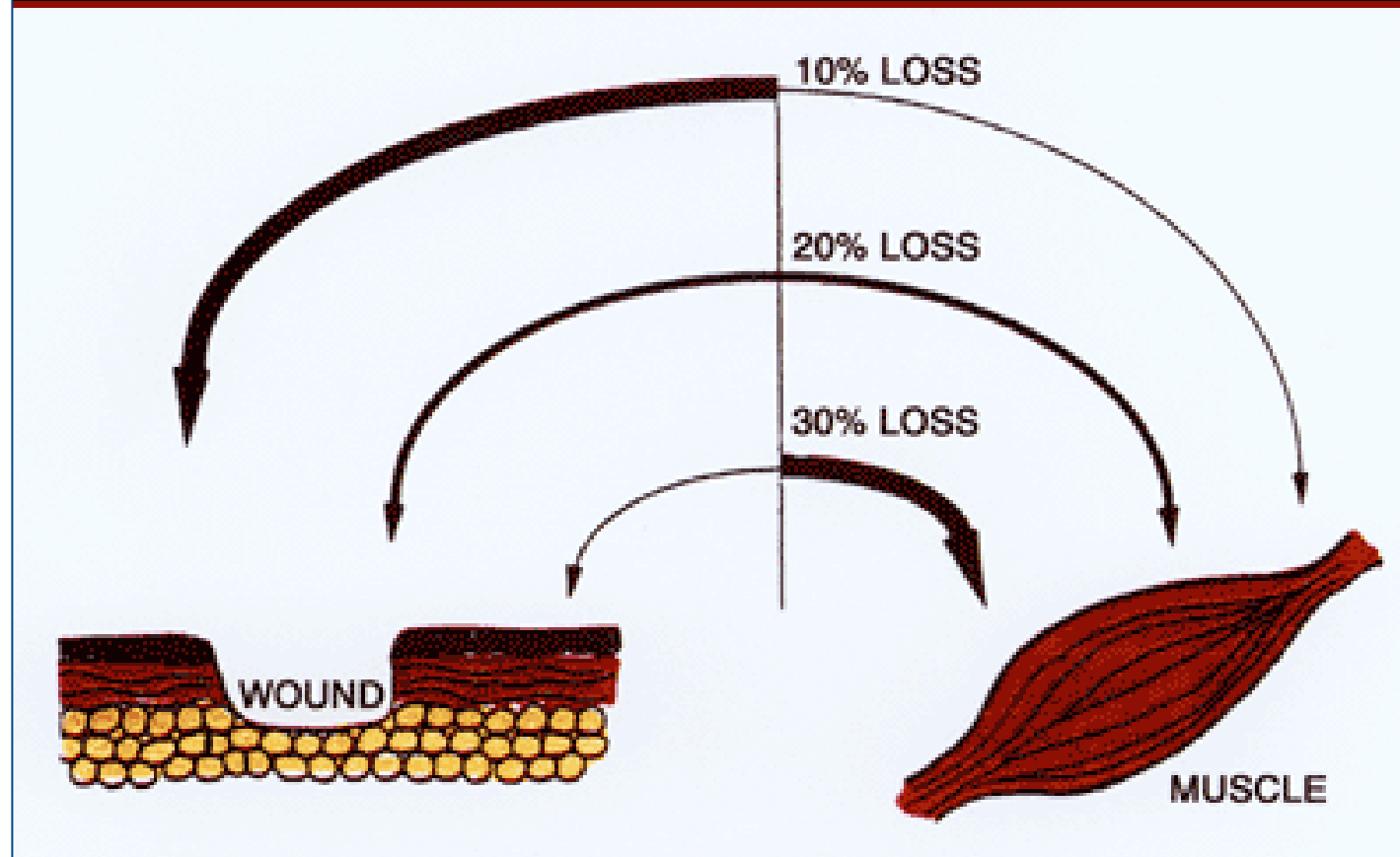
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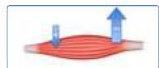


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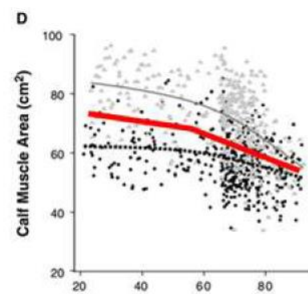
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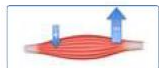


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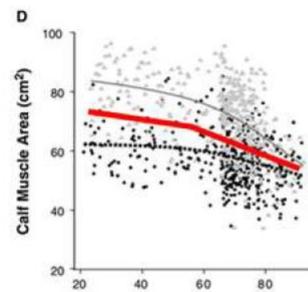


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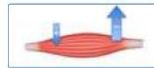




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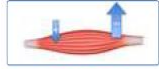
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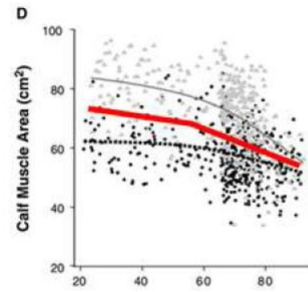
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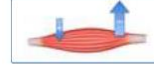
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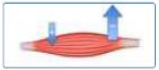
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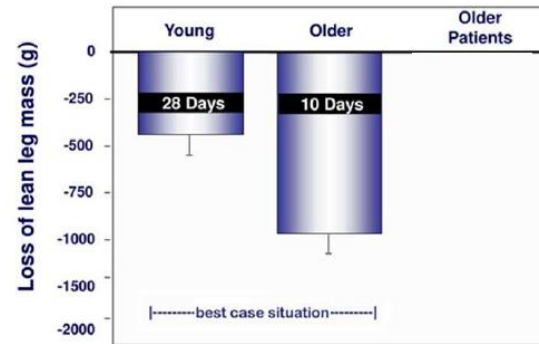
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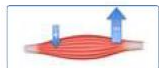


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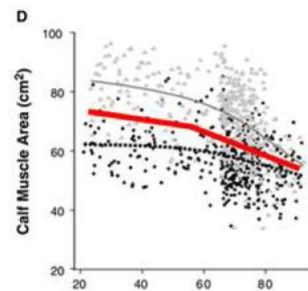


Paralysed limbs, vol. 2004
Engelke et al. 2014

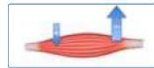
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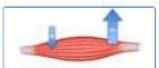
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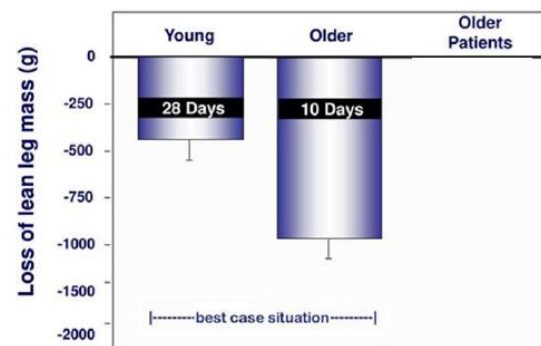
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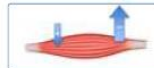


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Paralysed patients, et al. 2004
Engelke et al. 2014

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BEHANDELING

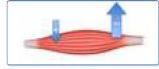


Surgery

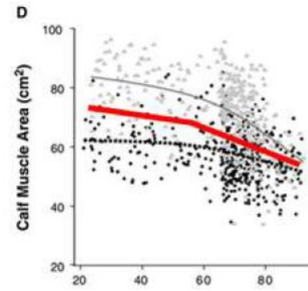


Chemotherapy

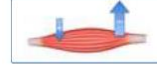
Blauwhoff-Buskermolen, et al.
Loss of Muscle Mass During Chemotherapy Is Predictive for Poor Survival of Patients With Metastatic Colorectal Cancer
J Clin Oncol. 2016 Apr 20;34(12):1339-44.



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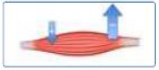
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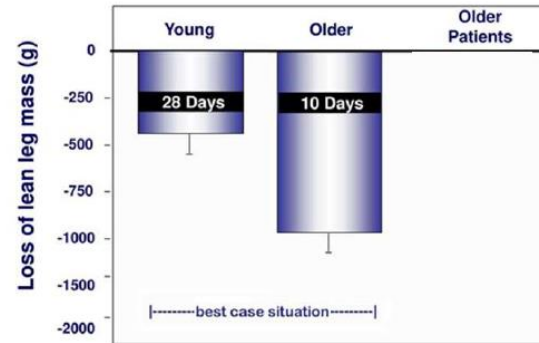
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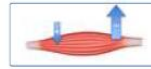
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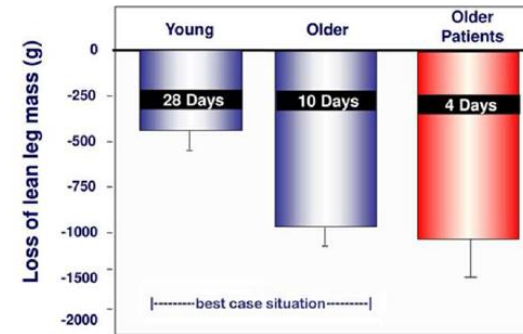
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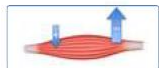
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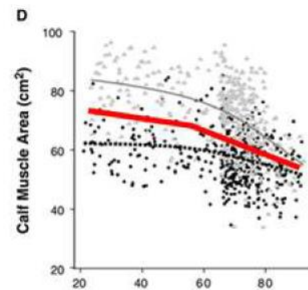
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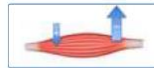
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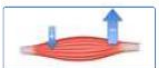
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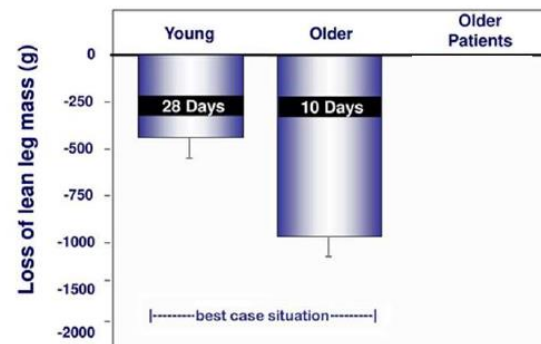
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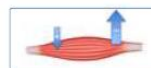


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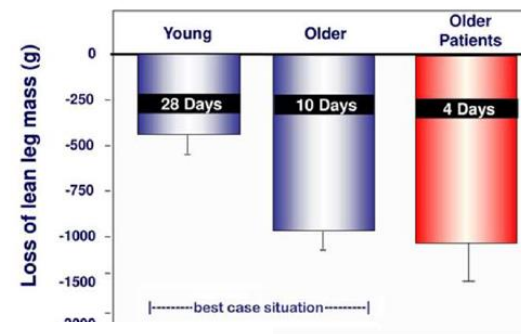


Paridon-Larsson et al. 2004
English et al. 2004

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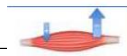


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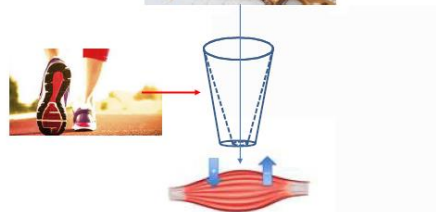


Paridon-Larsson et al. 2004
English et al. 2004

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LEEFTIJD
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BEHANDELING
VOEDING



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Rund NA, Gulliksen DE, van Loon LJ.
Anabolic resistance of muscle protein synthesis with aging.
Biom Sport Sci Rev. 2013 Jul;41(3):569-73.

SPIER KRACHT



OM TE
BEWEGEN

2



SPIER KRACHT

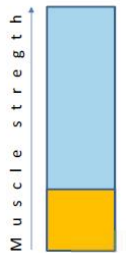
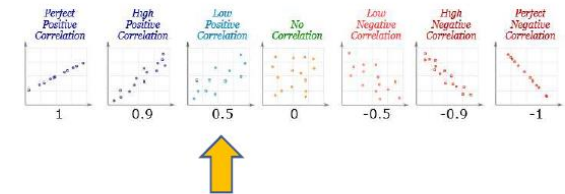


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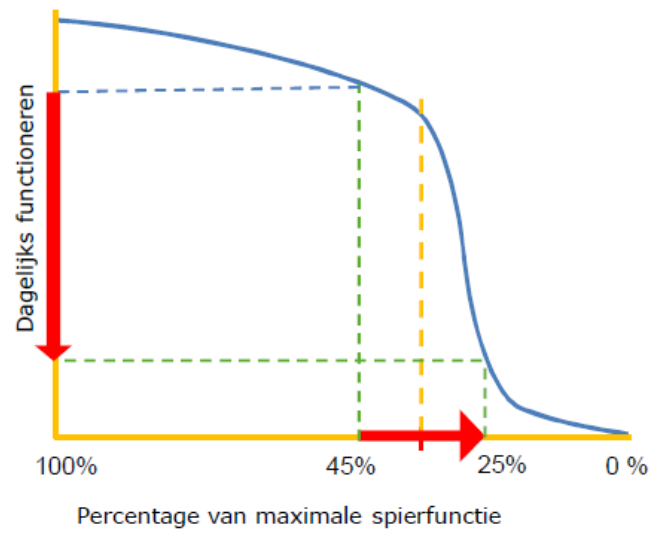


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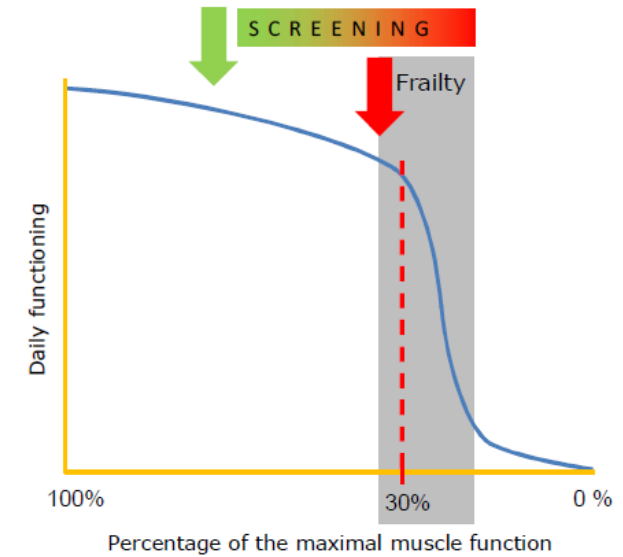


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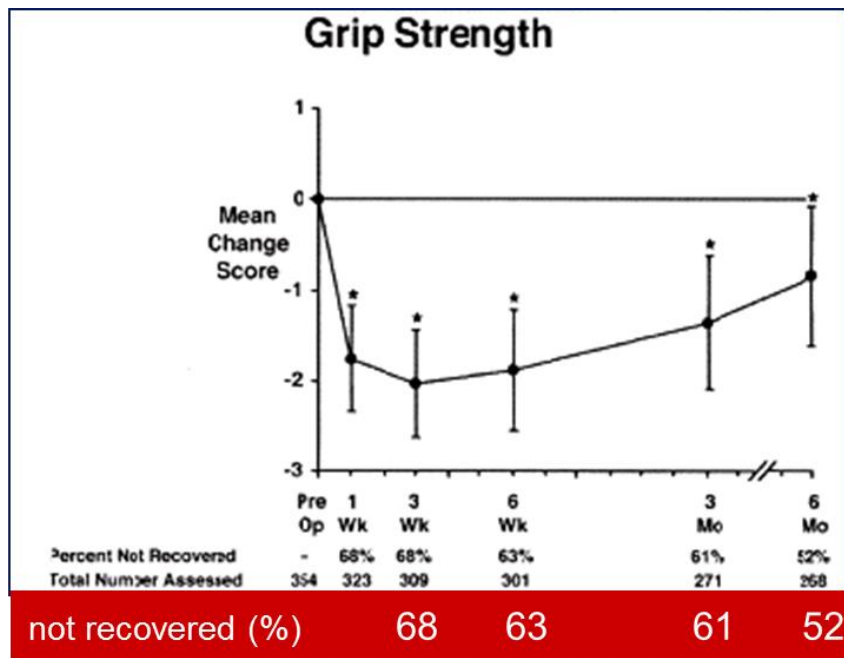
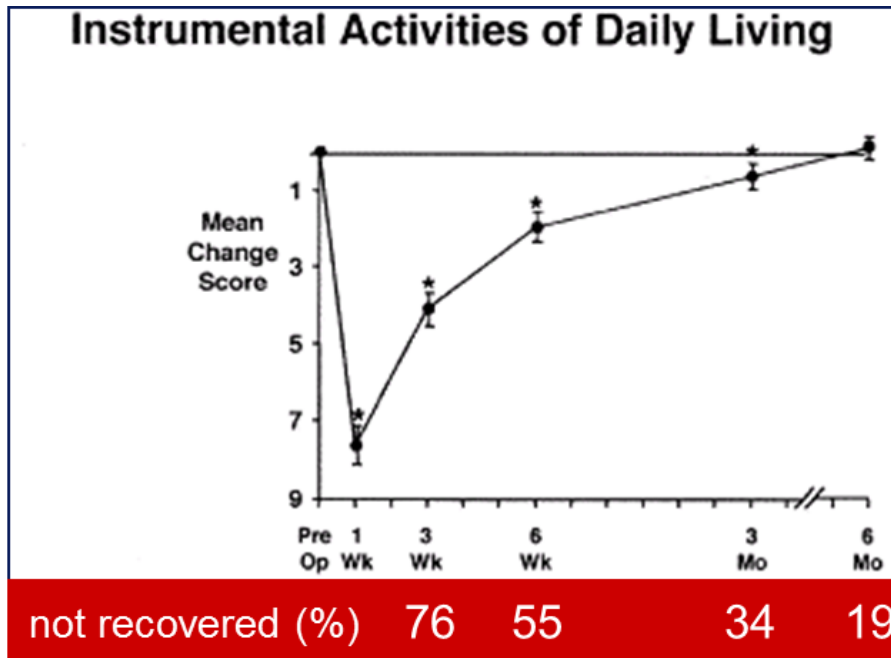
Dronkers JJ, Preoperative physical fitness in older patients, 2013



Dronkers JJ, Preoperative physical fitness in older patients, 2013



Functional decline after surgery

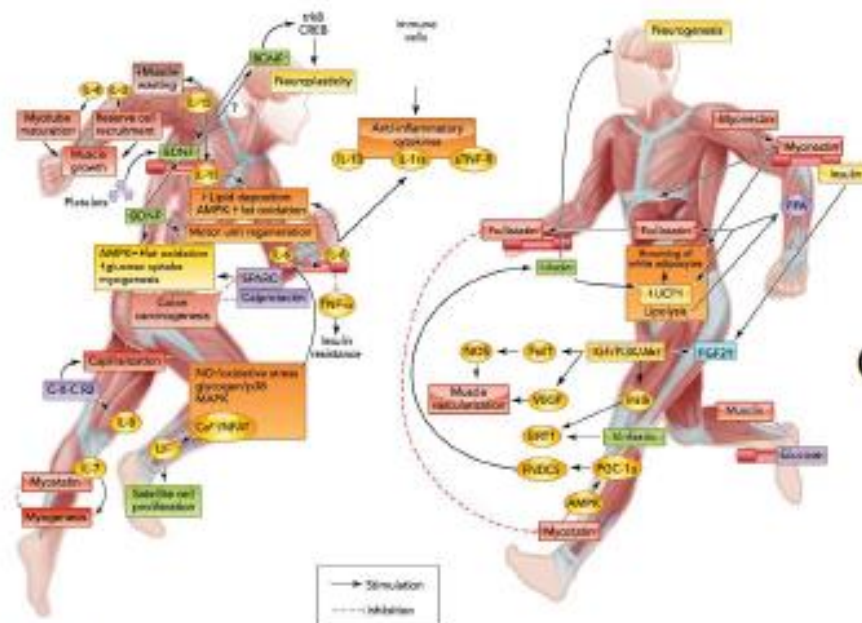


Lawrence VA, Hazuda HP, Cornell JE, Pederson T, Bradshaw PT, Mulrow CD, Page CP.

Functional independence after major abdominal surgery in the elderly.

J Am Coll Surg. 2004 Nov;199(5):762-72

SPIER ACTIVITEIT



VOOR DE
GEZONDHEID

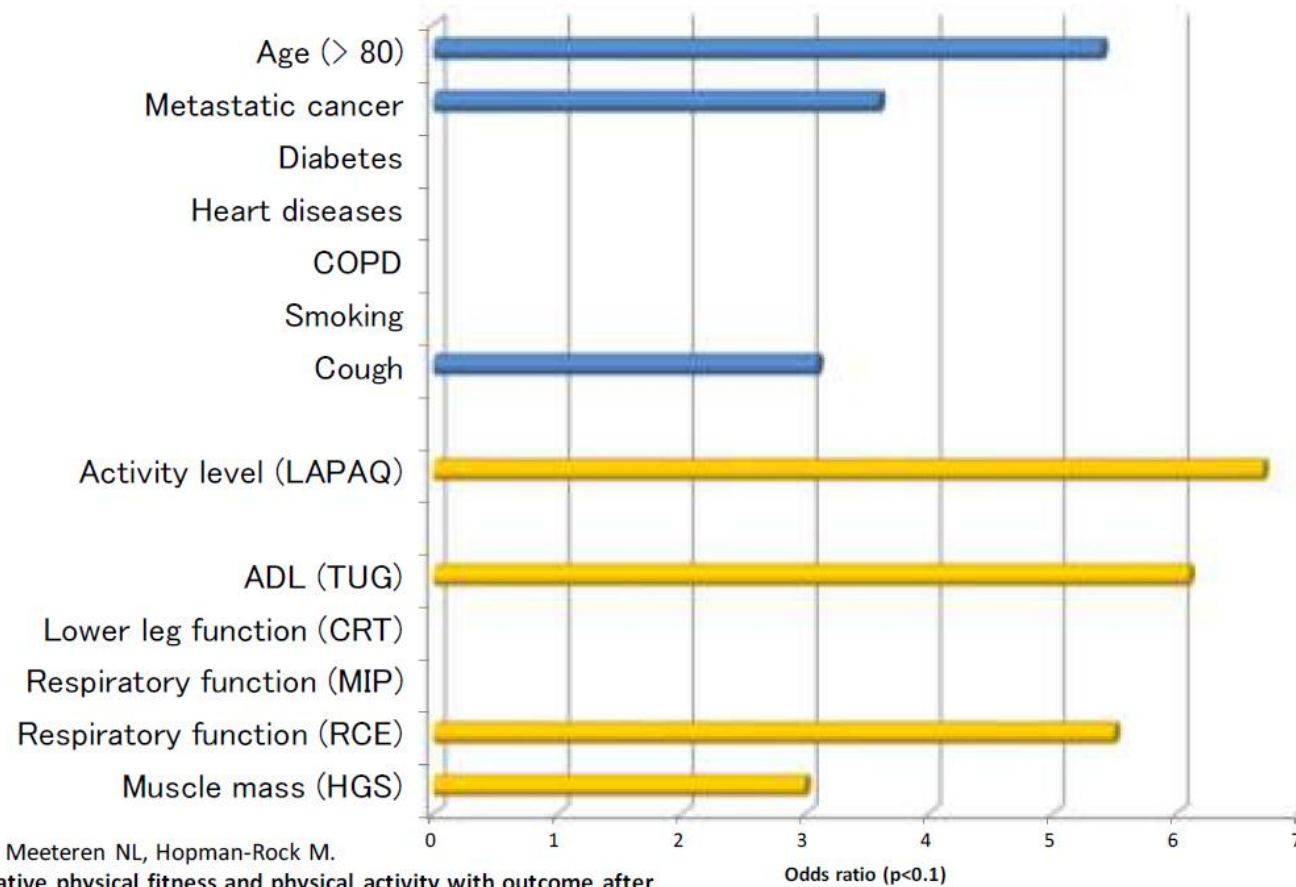
FIGURE 2. Summary of the main molecules, their putative effects, and the molecular signals/pathways involved

Fluza-Luces C, Garatachea N, Berger NA, Lucia A.
Exercise is the real polypill.
Physiology (Bethesda). 2013 Sep;28(5):330-58.

3



MORTALITY

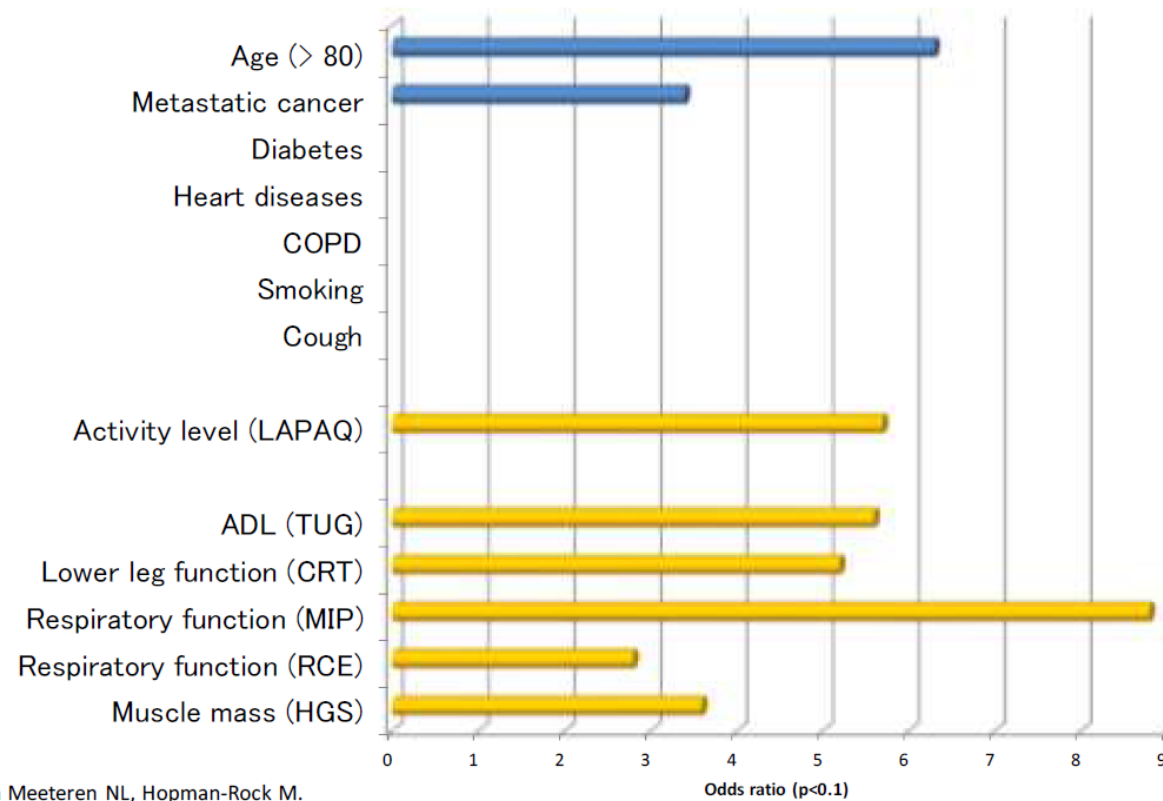


Dronkers JJ, Chorus AM, van Meeteren NL, Hopman-Rock M.

The association of pre-operative physical fitness and physical activity with outcome after scheduled major abdominal surgery. Anaesthesia. 2013;68(1):67-73.

10 % nursing home n=169

DISCHARGE DESTINATION

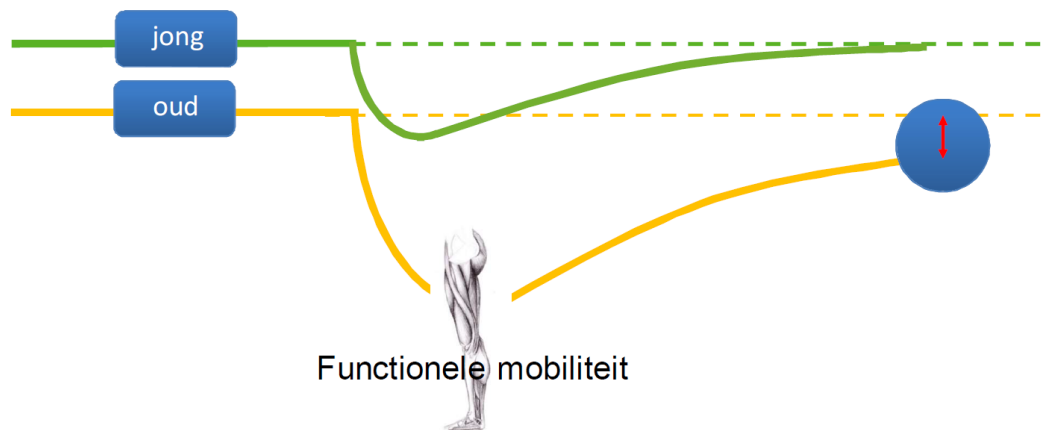


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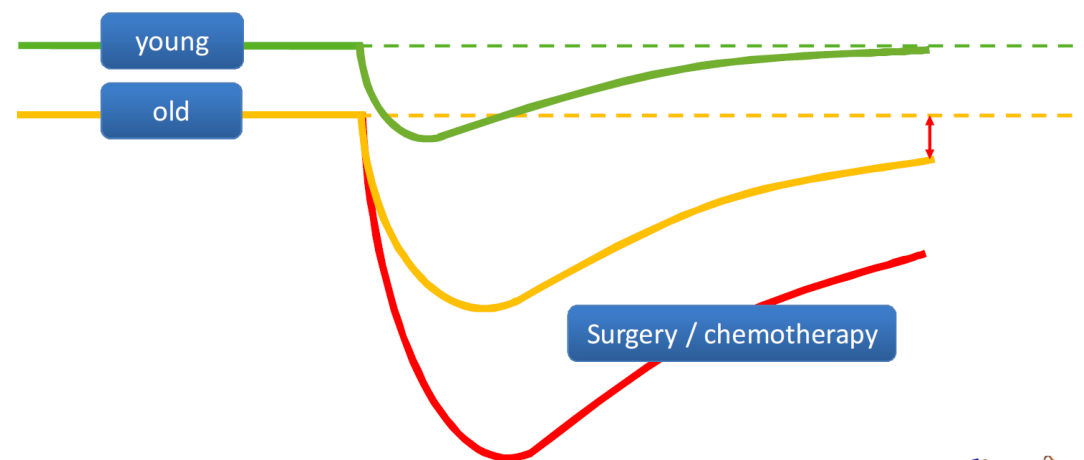


Inactiviteit

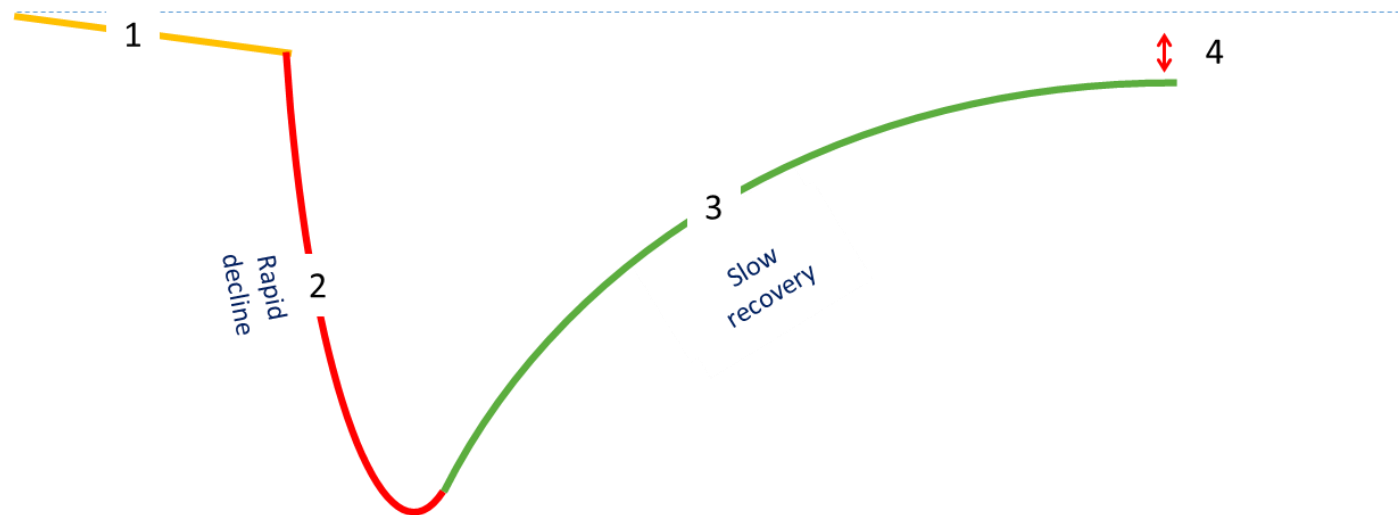


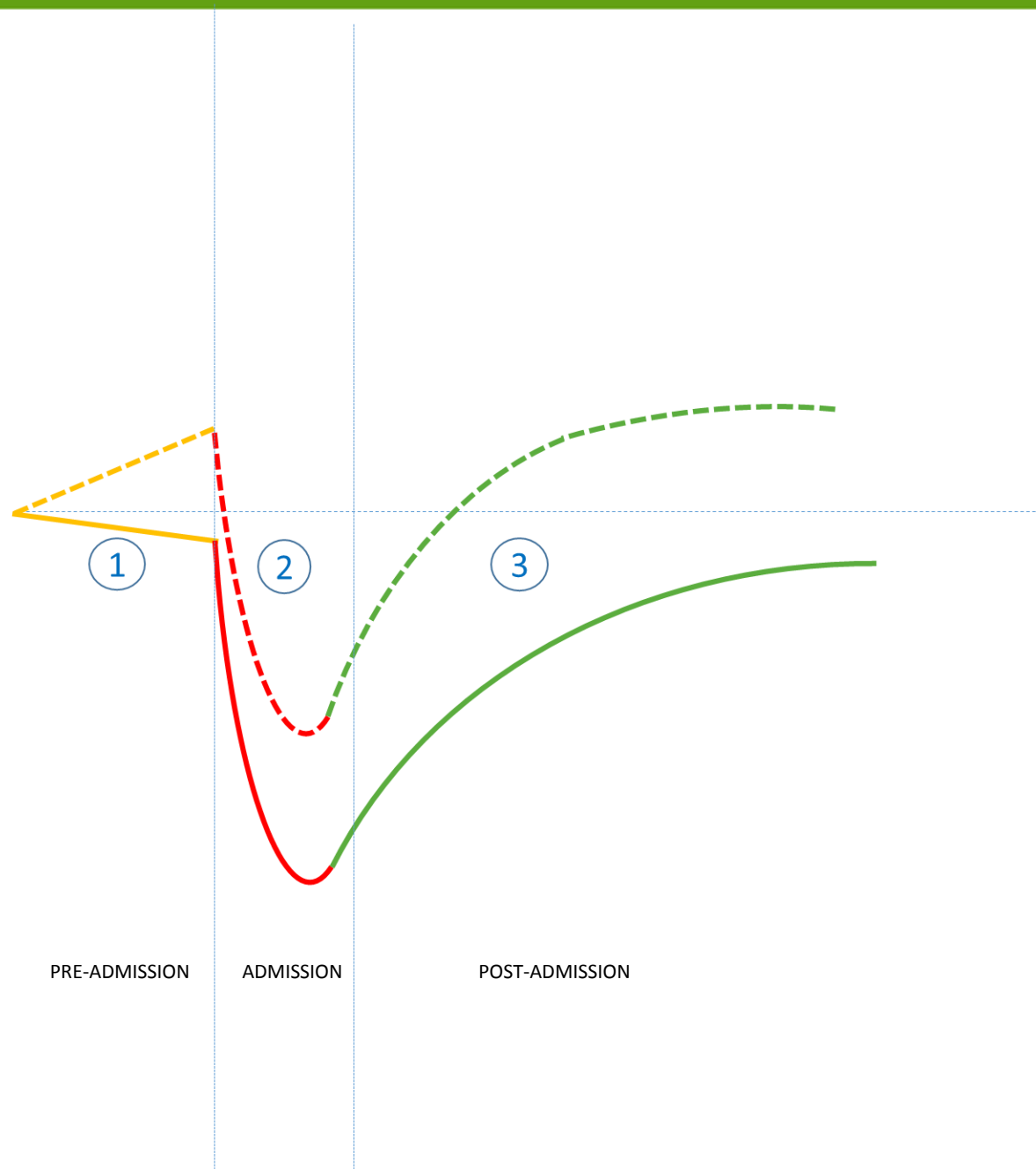
Kortebein P, et al.
Functional impact of 10 days of bed rest in healthy older adults.
J Gerontol A Biol Sci Med Sci. 2008 Oct;63(10):1076-81.

OPERATIESTRESS

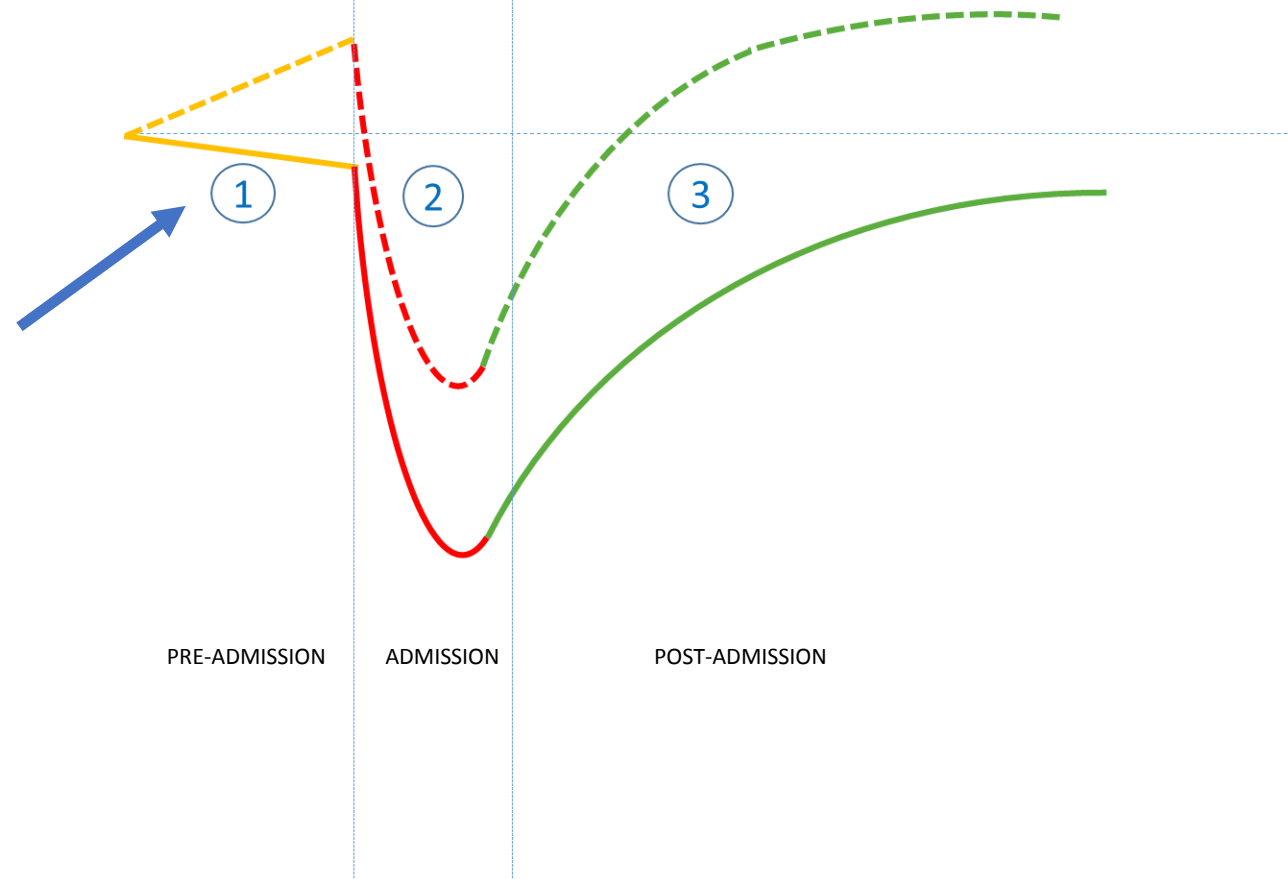


Samenvattend





Pre-operatieve / Pre-opname traject





Eur J Cancer Care (Engl). 2019 Mar 11:e13023. doi: 10.1111/ecc.13023. [Epub ahead of print]

Prehabilitation for adults diagnosed with cancer: A systematic review of long-term physical function, nutrition and patient-reported outcomes.

Faithfull S¹, Turner L², Poole K¹, Joy M¹, Manders R³, Weprin J⁴, Winters-Stone K⁴, Saxton J⁵.

Author information

Abstract

OBJECTIVE: Prehabilitation is increasingly being used to mitigate treatment-related complications and enhance recovery. An individual's state of health at diagnosis, including obesity, physical fitness and comorbidities, are influencing factors for the occurrence of adverse effects. This review explores whether prehabilitation works in improving health outcomes at or beyond the initial 30 days post-treatment and considers the utility of prehabilitation before cancer treatment.

METHODS: A database search was conducted for articles published with prehabilitation as a pre-cancer treatment intervention between 2009 and 2017. Studies with no 30 days post-treatment data were excluded. Outcomes post-prehabilitation were extracted for physical function, nutrition and patient-reported outcomes.

RESULTS: Sixteen randomised controlled trials with a combined 2017 participants and six observational studies with 289 participants were included. Prehabilitation interventions provided multi-modality components including exercise, nutrition and psychoeducational aspects. Prehabilitation improved gait, cardiopulmonary function, urinary continence, lung function and mood 30 days post-treatment but was not consistent across studies.

CONCLUSION: When combined with rehabilitation, greater benefits were seen in 30-day gait and physical functioning compared to prehabilitation alone. Large-scale randomised studies are required to translate what is already known from feasibility studies to improve overall health and increase long-term cancer patient outcomes.

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World J Surg. 2019 Feb 20. doi: 10.1007/s00268-019-04950-y. [Epub ahead of print]

Prehabilitation Before Major Abdominal Surgery: A Systematic Review and Meta-analysis.

Hughes MJ¹, Hackney RJ², Lamb RJ², Wigmore SJ², Christopher Deans DA², Skipworth RJE².

Author information

Abstract

INTRODUCTION: Prehabilitation prior to major surgery has increased in popularity over recent years and aims to improve pre-operative conditioning of patients to improve post-operative outcomes. The beneficial effect of such protocols is not well established with conflicting results reported. This review aimed to assess the effect of prehabilitation on post-operative outcome after major abdominal surgery.

METHODS: EMBASE, Medline, PubMed and the Cochrane database were searched in August 2018 for trials comparing outcomes of patients undergoing prehabilitation involving prescribed respiratory and exercise interventions prior to abdominal surgery. Study characteristics, overall and pulmonary morbidity, length of stay (LOS), maximum inspiratory pressure and change in six-minute walking test (6MWT) distance were obtained. The primary outcome was post-operative overall morbidity within 30 days. Dichotomous data were analysed by fixed or random effects odds ratio. Continuous data were analysed with weighted mean difference.

RESULTS: Fifteen RCTs were included in the analysis with 457 prehabilitation patients and 450 control group patients. A significant reduction in overall (OR 0.63 95% CI 0.46-0.87 I² 34%, p = 0.005) and pulmonary morbidity (OR 0.4 95% CI 0.23-0.68, I² = 0%, p = 0.0007) was observed in the prehabilitation group. No significant difference in LOS (WMD -2.39 95% CI -4.86 to 0.08 I² = 0%, p = 0.06) or change in 6MWT distance (WMD 9.06 95% CI -35.68, 53.81 I² = 88%, p = 0.69) was observed.

CONCLUSIONS: Prehabilitation can reduce overall and pulmonary morbidity following surgery and could be utilised routinely. The precise protocol of prehabilitation has not been completely established. Further work is required to tailor optimal prehabilitation protocols for specific operative procedures.

PMID: 30789535 DOI: 10.1007/s00268-019-04950-y

Ann Surg. 2018 Jan;267(1):50-56. doi: 10.1097/SLA.0000000000002293.

Personalised Prehabilitation in High-risk Patients Undergoing Elective Major Abdominal Surgery: A Randomized Blinded Controlled Trial.

Barberan-Garcia A¹, Ubré M², Roca J¹, Lacy AM³, Burqos F¹, Risco R², Momblán D⁴, Balust J², Blanco J¹, Martínez-Pallí G⁵.

Author information

Abstract

OBJECTIVE: The aim of this study was to assess the impact of personalized prehabilitation on postoperative complications in high-risk patients undergoing elective major abdominal surgery.

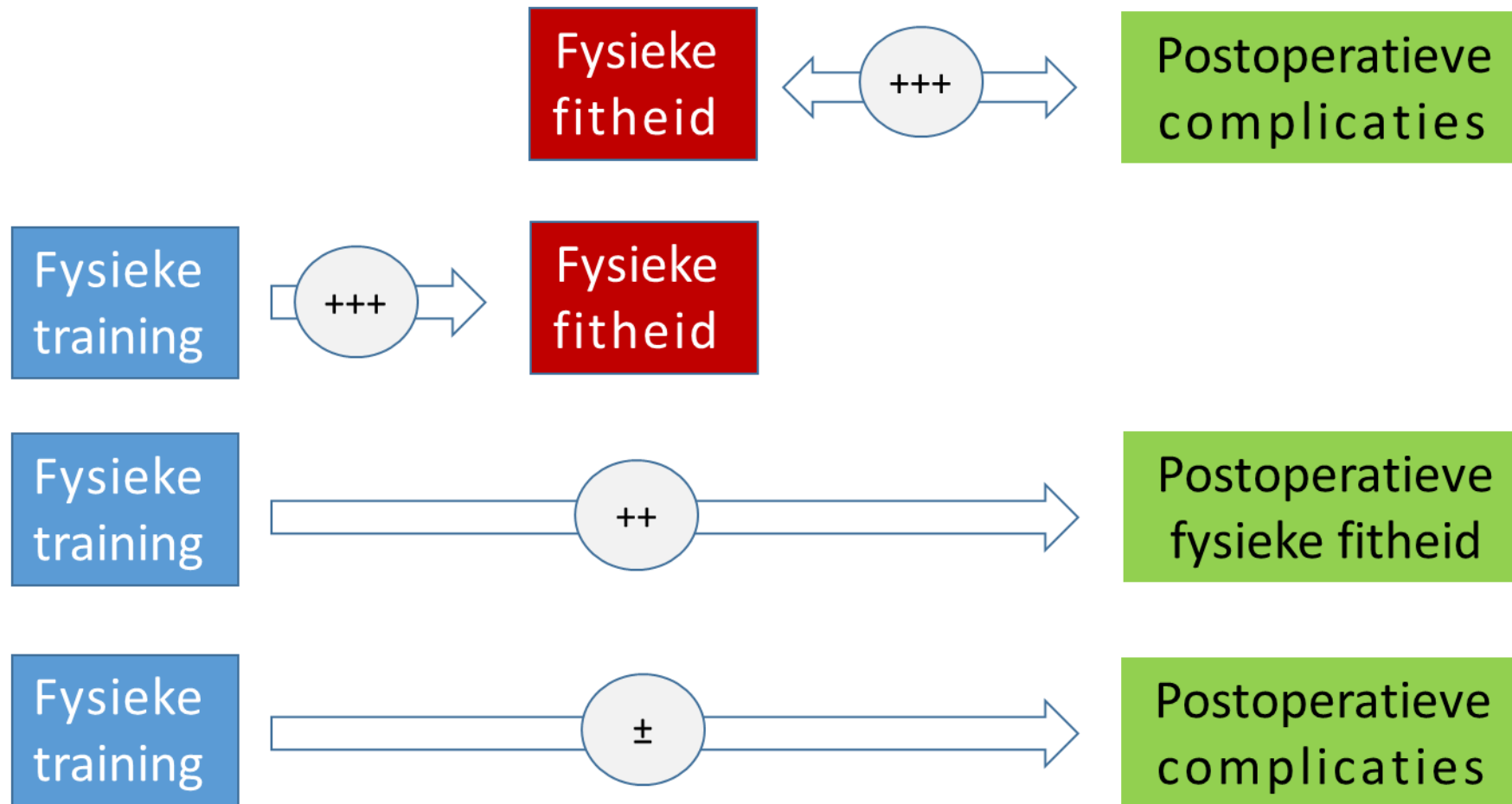
SUMMARY BACKGROUND DATA: Prehabilitation, including endurance exercise training and promotion of physical activity, in patients undergoing major abdominal surgery has been postulated as an effective preventive intervention to reduce postoperative complications. However, the existing studies provide controversial results and show a clear bias toward low-risk patients.

METHODS: This was a randomized blinded controlled trial. Eligible candidates accepting to participate were blindly randomized (1:1 ratio) to control (standard care) or intervention (standard care+prehabilitation) groups. Inclusion criteria were: i) age >70 years; and/or, ii) American Society of Anesthesiologists score III/IV. Prehabilitation covered 3 actions: i) motivational interview; ii) high-intensity endurance training; and promotion of physical activity. The main study outcome was the proportion of patients suffering postoperative complications. Secondary outcomes included the endurance time (ET) during cycle-ergometer exercise.

RESULTS: We randomized 71 patients to the control arm and 73 to intervention. After excluding 19 patients because of changes in the surgical plan, 63 controls and 62 intervention patients were included in the intention-to-treat analysis. The intervention group enhanced aerobic capacity [Δ ET 135 (218) %; P < 0.001], reduced the number of patients with postoperative complications by 51% (relative risk 0.5; 95% confidence interval, 0.3-0.8; P = 0.001) and the rate of complications [1.4 (1.6) and 0.5 (1.0) (P = 0.001)] as compared with controls.

CONCLUSION: Prehabilitation enhanced postoperative clinical outcomes in high-risk candidates for elective major abdominal surgery, which can be explained by the increased aerobic capacity.

Bewijslast prehabilitatie



Veel literatuur...

Eur J Cancer Care (Engl). 2019 Mar 11:e13023. doi: 10.1111/ecc.13023. [Epub ahead of print]

Prehabilitation for adults diagnosed with cancer: A systematic review of long-term physical function, nutrition and patient-reported outcomes.

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RESULTS: Sixteen randomised controlled trials with a combined 2017 participants and six observational studies with 289 participants were included. Prehabilitation interventions provided multi-modality components including exercise, nutrition and psychoeducational aspects. Prehabilitation improved gait, cardiopulmonary function, urinary continence, lung function and mood 30 days post-treatment but was not consistent across studies.

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Abstract

INTRODUCTION: Prehabilitation prior to major surgery has increased in popularity over recent years and aims to improve pre-operative conditioning of patients to improve post-operative outcomes. The beneficial effect of such protocols is not well established with conflicting results reported. This review aimed to assess the effect of prehabilitation on post-operative outcome after major abdominal surgery.

METHODS: EMBASE, Medline, PubMed and the Cochrane database were searched in August 2018 for trials comparing outcomes of patients undergoing prehabilitation involving prescribed respiratory and exercise interventions prior to abdominal surgery. Study characteristics, overall and pulmonary morbidity, length of stay (LOS), maximum inspiratory pressure and change in six-minute walking test (6MWT) distance were obtained. The primary outcome was post-operative overall morbidity within 30 days. Dichotomous data were analysed by fixed or random effects odds ratio. Continuous data were analysed with weighted mean difference.

RESULTS: Fifteen RCTs were included in the analysis with 457 prehabilitation patients and 450 control group patients. A significant reduction in overall (OR 0.63 95% CI 0.46-0.87 I² 34%, p = 0.005) and pulmonary morbidity (OR 0.4 95% CI 0.23-0.68, I² = 0%, p = 0.0007) was observed in the prehabilitation group. No significant difference in LOS (WMD -2.39 95% CI -4.86 to 0.08 I² = 0%, p = 0.06) or change in 6MWT distance (WMD 9.06 95% CI -35.68, 53.81 I² = 88%, p = 0.69) was observed.

CONCLUSIONS: Prehabilitation can reduce overall and pulmonary morbidity following surgery and could be utilised routinely. The precise protocol of prehabilitation has not been completely established. Further work is required to tailor optimal prehabilitation protocols for specific operative procedures.

PMID: 30789335 DOI: 10.1007/s00268-019-04950-y

Ann Surg. 2018 Jan;267(1):50-56. doi: 10.1097/SLA.0000000000002293.

Personalised Prehabilitation in High-risk Patients Undergoing Elective Major Abdominal Surgery: A Randomized Blinded Controlled Trial.

Barberan-Garcia A¹, Ubré M², Roca J¹, Lacy AM³, Burgos F¹, Risco R², Momblán D⁴, Balust J², Blanco I¹, Martínez-Pallí G⁵.

Author information

Abstract

OBJECTIVE: The aim of this study was to assess the impact of personalized prehabilitation on postoperative complications in high-risk patients undergoing elective major abdominal surgery.

SUMMARY BACKGROUND DATA: Prehabilitation, including endurance exercise training and promotion of physical activity, in patients undergoing major abdominal surgery has been postulated as an effective preventive intervention to reduce postoperative complications. However, the existing studies provide controversial results and show a clear bias toward low-risk patients.

METHODS: This was a randomized blinded controlled trial. Eligible candidates accepting to participate were blindly randomized (1:1 ratio) to control (standard care) or intervention (standard care+prehabilitation) groups. Inclusion criteria were: i) age >70 years; and/or, ii) American Society of Anesthesiologists score III/IV. Prehabilitation covered 3 actions: i) motivational interview; ii) high-intensity endurance training; and promotion of physical activity. The main study outcome was the proportion of patients suffering postoperative complications. Secondary outcomes included the endurance time (ET) during cycle-ergometer exercise.

RESULTS: We randomized 71 patients to the control arm and 73 to intervention. After excluding 19 patients because of changes in the surgical plan, 63 controls and 62 intervention patients were included in the intention-to-treat analysis. The intervention group enhanced aerobic capacity [Δ ET 135 (218) %; P < 0.001], reduced the number of patients with postoperative complications by 51% (relative risk 0.5; 95% confidence interval, 0.3-0.8; P = 0.001) and the rate of complications [1.4 (1.6) and 0.5 (1.0) (P = 0.001)] as compared with controls.

CONCLUSION: Prehabilitation enhanced postoperative clinical outcomes in high-risk candidates for elective major abdominal surgery, which can be explained by the increased aerobic capacity.

Pre-operatieve training lijken effectief; wel nog genoeg discussiepunten

- Voor wie? Wie zijn high risk?
- Bij welke aandoeningen?
- Multimodaal (welke componenten?)
- Wat is beste trainingsvorm?
- Op welke uitkomstmaten?

Twée voorbeelden van projecten

PRIOR

 **Beter**
vorbereid
voor een sneller herstel

± 2500 mensen per jaar

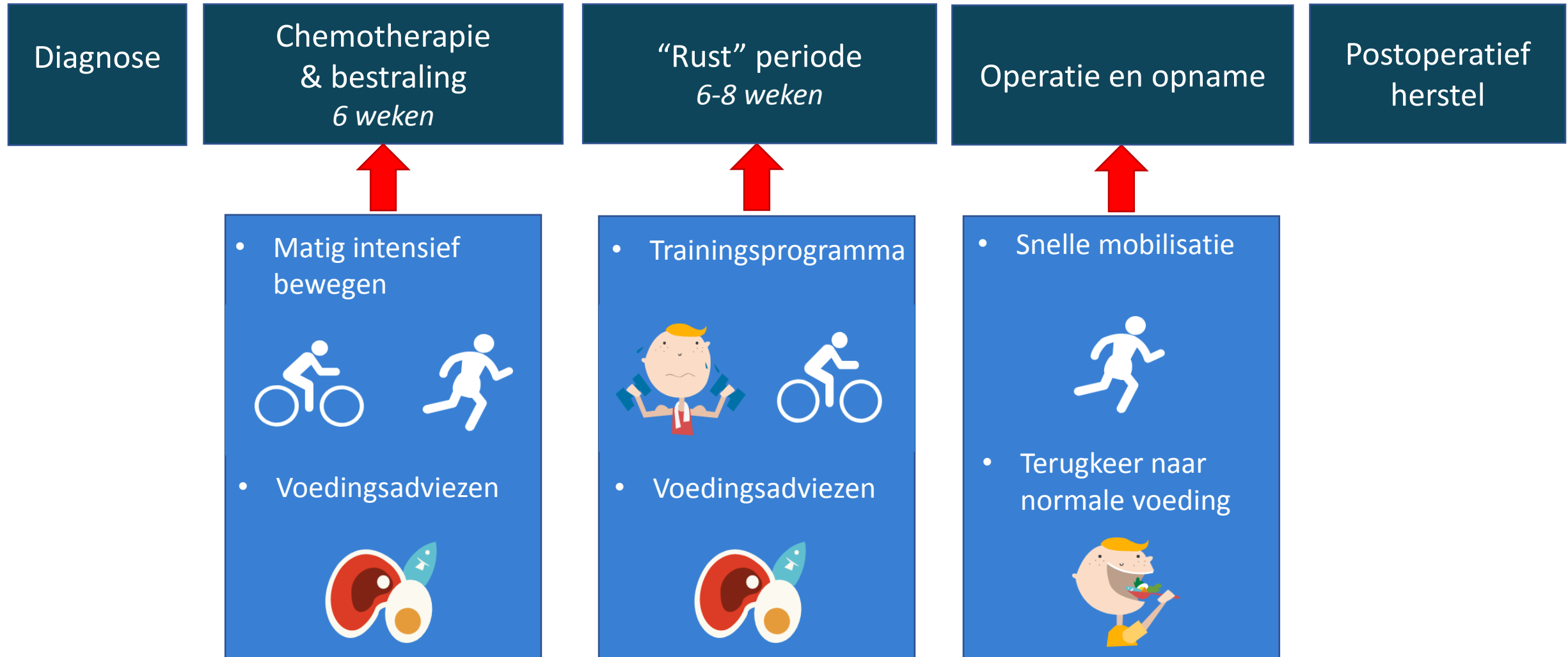


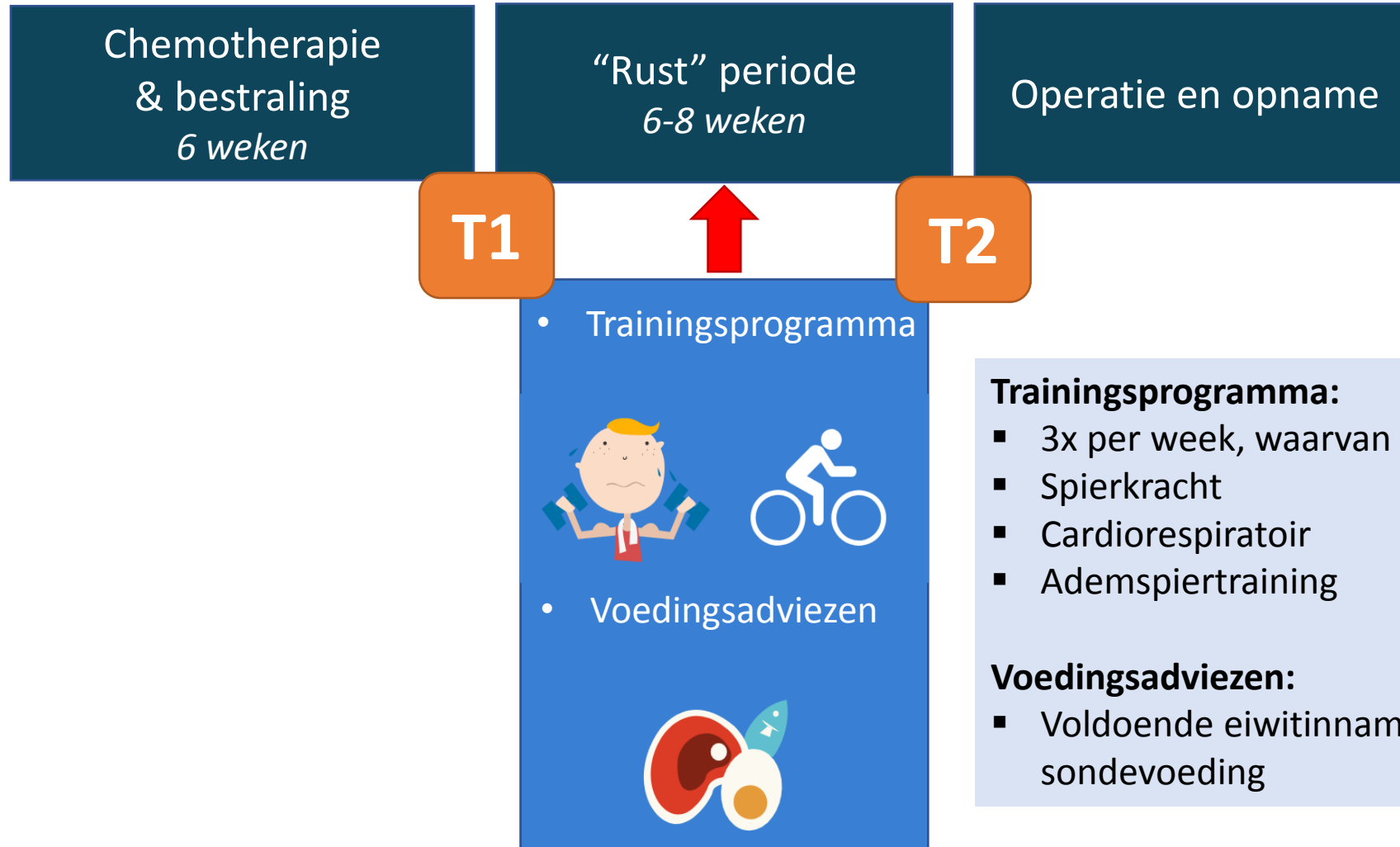
Curatieve behandeling: chemoradiatie + slokdarmresectie



- Hoog risico op postoperatieve complicaties
→ Pulmonale complicaties 2-40%
- Fysieke fitheid ↓

Blencowe et al. 2012





Trainingsprogramma:

- 3x per week, waarvan 2x onder supervisie fysiotherapeut
- Spierkracht
- Cardiorespiratoir
- Ademspiertraining

Voedingsadviezen:

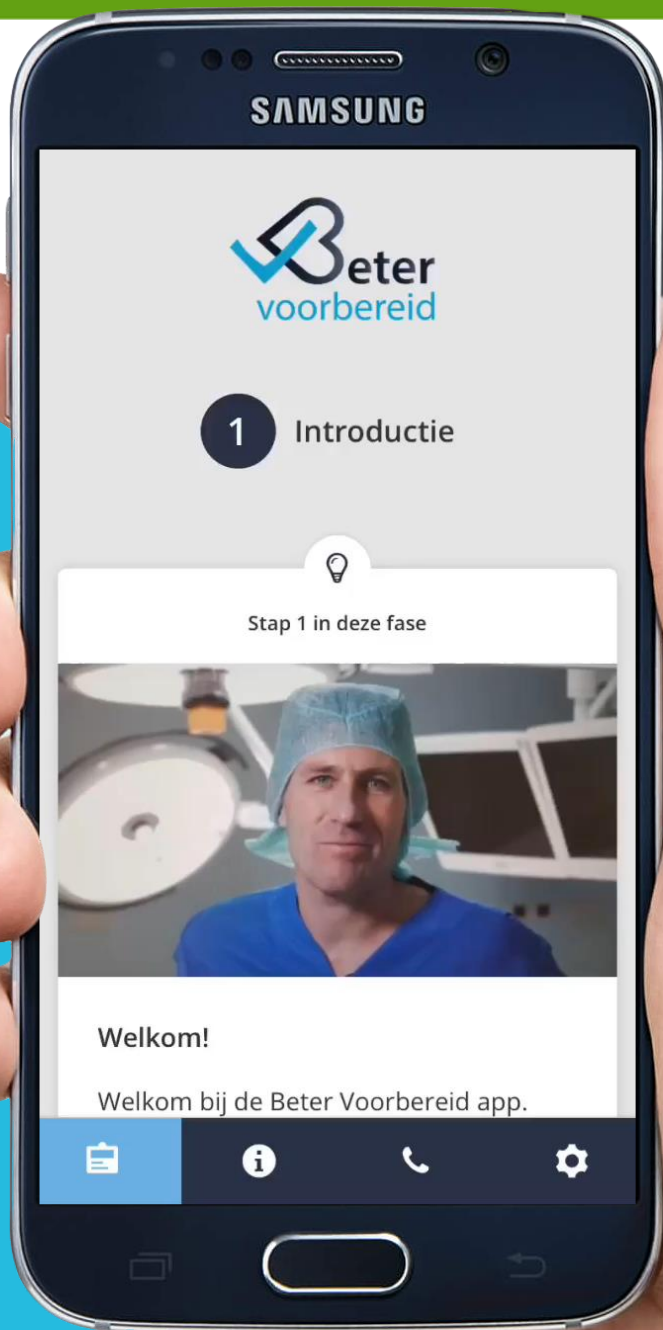
- Voldoende eiwitname, zo nodig extra drink- en/of sondevoeding

- Achteruitgang fysieke fitheid tijdens chemoradiatie
- Vooruitgang tijdens trainingsperiode
- Patiënten: 'mijn goede conditie heeft me geholpen om goed door de operatie te komen'
- Training is haalbaar voor doelgroep



- Uitdagingen:
 - Logistiek binnen het ziekenhuis
 - Welke eerstelijns fysiotherapeuten?
 - Financiering mn van eerstelijns deel
 - Wie wel/wie niet?
 - Pre-operatieve zorg als standaard zorg? En zo niet, wie wijst patiënt erop?
- Geen controle groep





Beter vorbereid

voor een sneller herstel

Leefstijl risicofactoren



15%



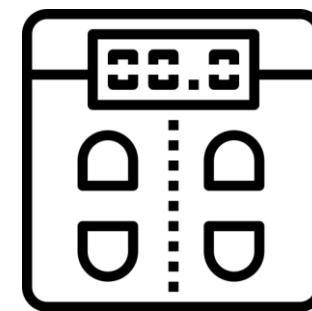
10%



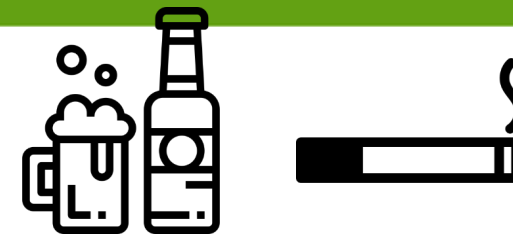
78%



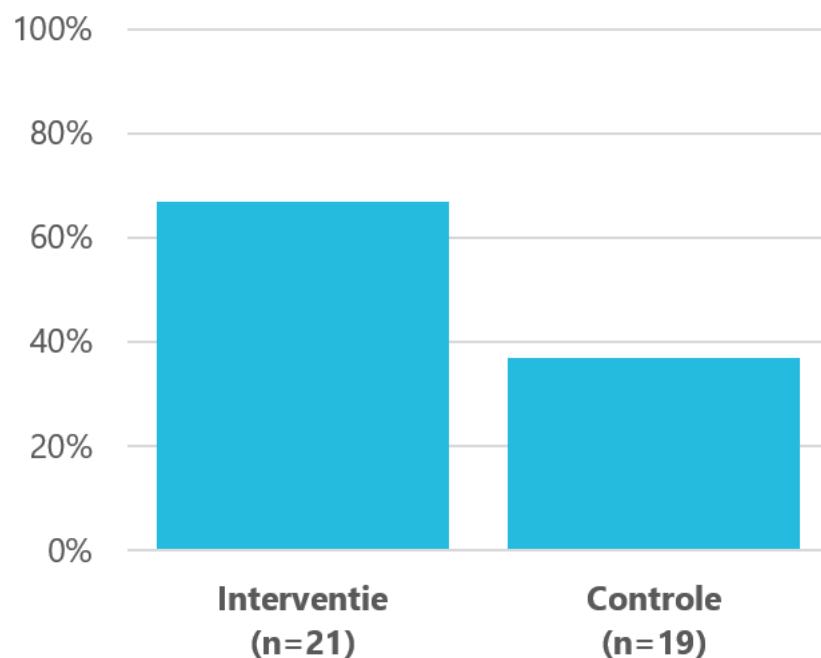
70%



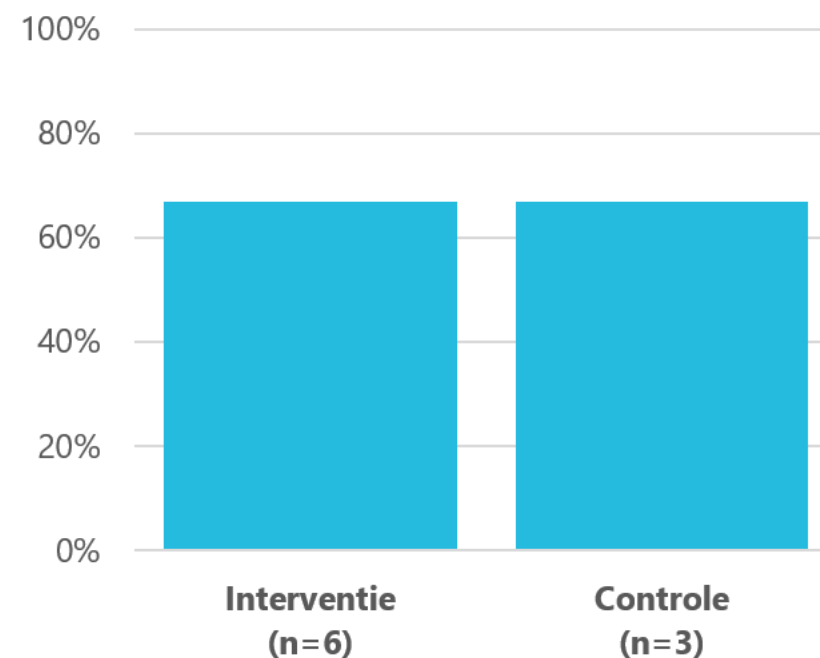
10%



**% participanten dat preoperatief zijn
alcoholgebruik heeft verminderd**

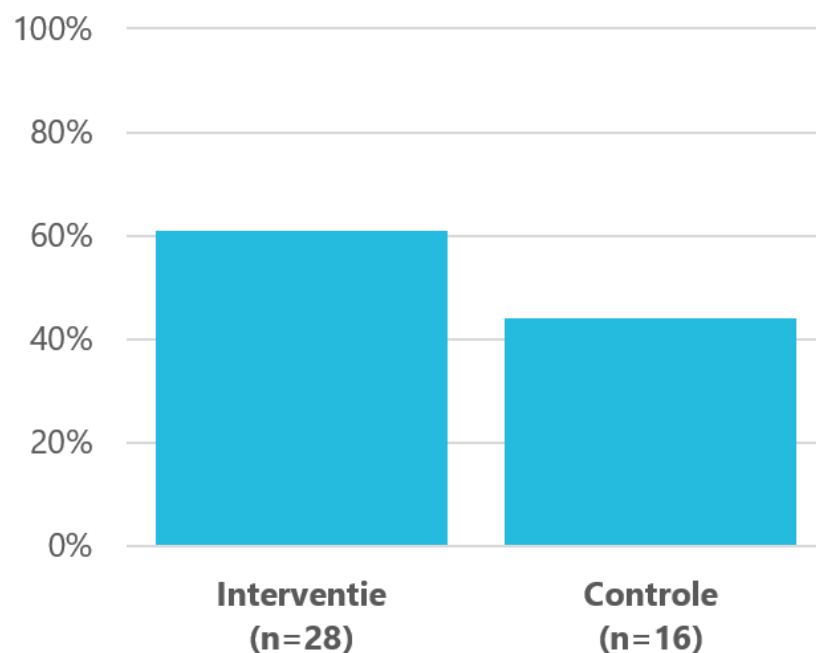


**% participanten dat preoperatief zijn
rookgedrag heeft aangepast**

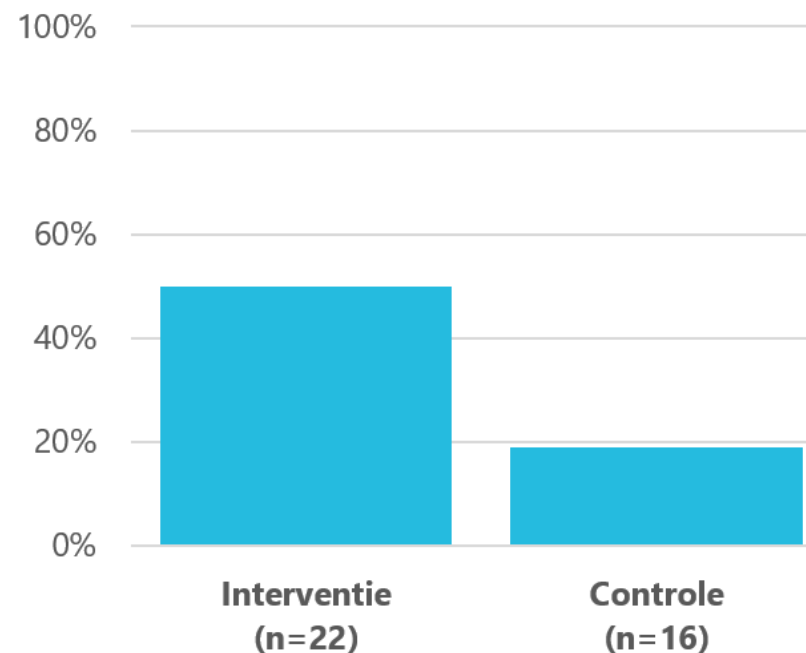




% participanten dat preoperatief meer is gaan bewegen



% participanten dat preoperatief meer spierkrachtoefeningen is gaan doen

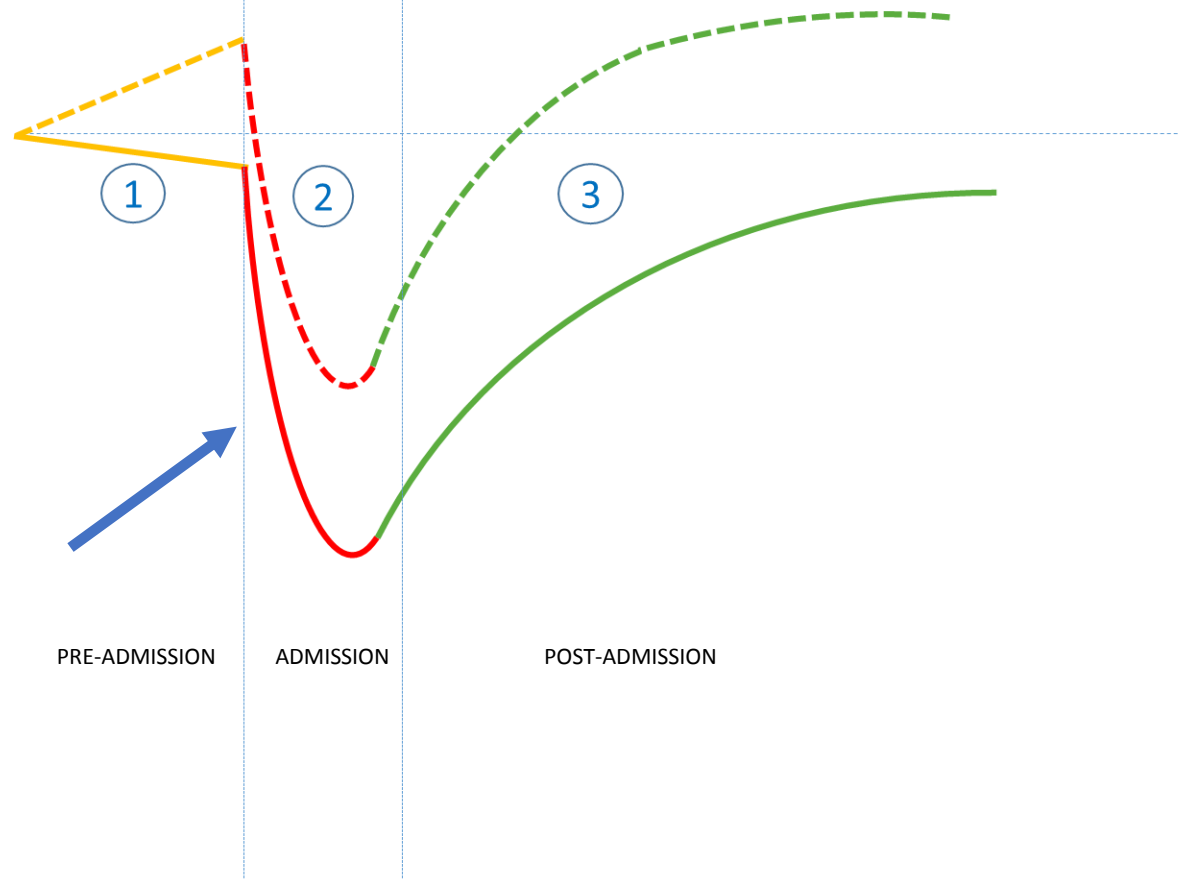


Uitdagingen:

- Aanbieden van app
- Focus op extra begeleiding kwetsbare/niet fitte groep
- Uitbreiding content
- Hoe samenwerking met eerstelijns?



Pre-operatieve / Pre-opname traject





Actie plan – per afdeling

Multidimensionale aanpak



Voorlichting



Integreren in de zorg



Stimulerende omgeving



Betrekken van derden



Technologische support



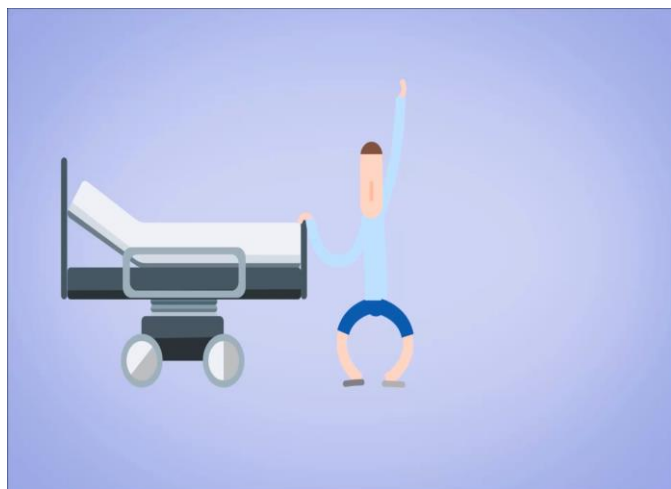
Beweegdoelen



UMC UTRECHT IN BEWEGING – menukaart

Voorlichting	Bewegen als ketenzorg	Beweegvriendelijke omgeving	Hulp van derden	Technologie	Beweegdoelen
Voorlichting aan patiënt over belang van bewegen tijdens opname	Agenda van de dag is duidelijk voor de patiënt; patiënt weet wanneer hij 'vrij' heeft en de kamer & afdeling af mag	Een ruimte voor patiënten op de afdeling speciaal ingericht voor gezamenlijk lunchen en meer bewegen	Dagelijks vrijwilligers aanwezig	Digitale 7 minuten workouts beschikbaar online en op de schermen op de patiëntkamer	Individuele beweegdoelen opstellen door verpleegkundige/ fysiotherapeut en patiënt.
Uitreken informatiefolder 'Bewegen tijdens uw ziekenhuisopname'	Artsen nemen bewegen mee tijdens hun visite	Beschikbaarheid van trainingsmateriaal op de verpleegafdeling	Voorlichting aan vrijwilligers over hun mogelijke aandeel om patiënten te ondersteunen bij meer bewegen.	Implementatie beweegsensor in de dagelijkse zorg	John Hopkins Highest Level of Mobility Scale (of vergelijkbaar) implementeren
Informatieposters op elke kamer	Het thema bewegen wordt een vast onderdeel van de teamvergadering	Goede en voldoende stoelen aanwezig	Inzet van de voedingsassistent voor het gezamenlijk lunchen en stimuleren van eten aan tafel	Mobilisatie advies van de fysiotherapeut wordt opgenomen in verpleegkundig actieplan.	FitBit of vergelijkbaar beschikbaar
Voorlichtingsvideo (animatie) beschikbaar online en op de schermen op de patiëntkamer	Het belang van bewegen wordt vast onderdeel van het onderwijs van AIOS	QR Themaroutes	Stimuleren van bezoek om samen met hun naasten oefeningen te doen, te wandelen of de afdeling af te gaan	HoloLens	
Beweegbox met daarin verschillende folders en materialen om bewegen te stimuleren	Korte onderwijsmomenten over het belang van bewegen voor de verpleging	Kunstwandeling (begeleid of onbegeleid)		Hometrainer met interactief scherm of andere digitale trainingstoepassing	
Inzet van oefengidsen met oefeningen voor op bed, zittend en/of staand	Dagelijkse/wekelijkse beweeggroep op de afdeling			Beweeg app(s)	
	Gezamenlijk lunchen implementeren				

Voorlichting



Voorlichting

Voorlichting aan patiënt
over belang van
bewegen tijdens
opname

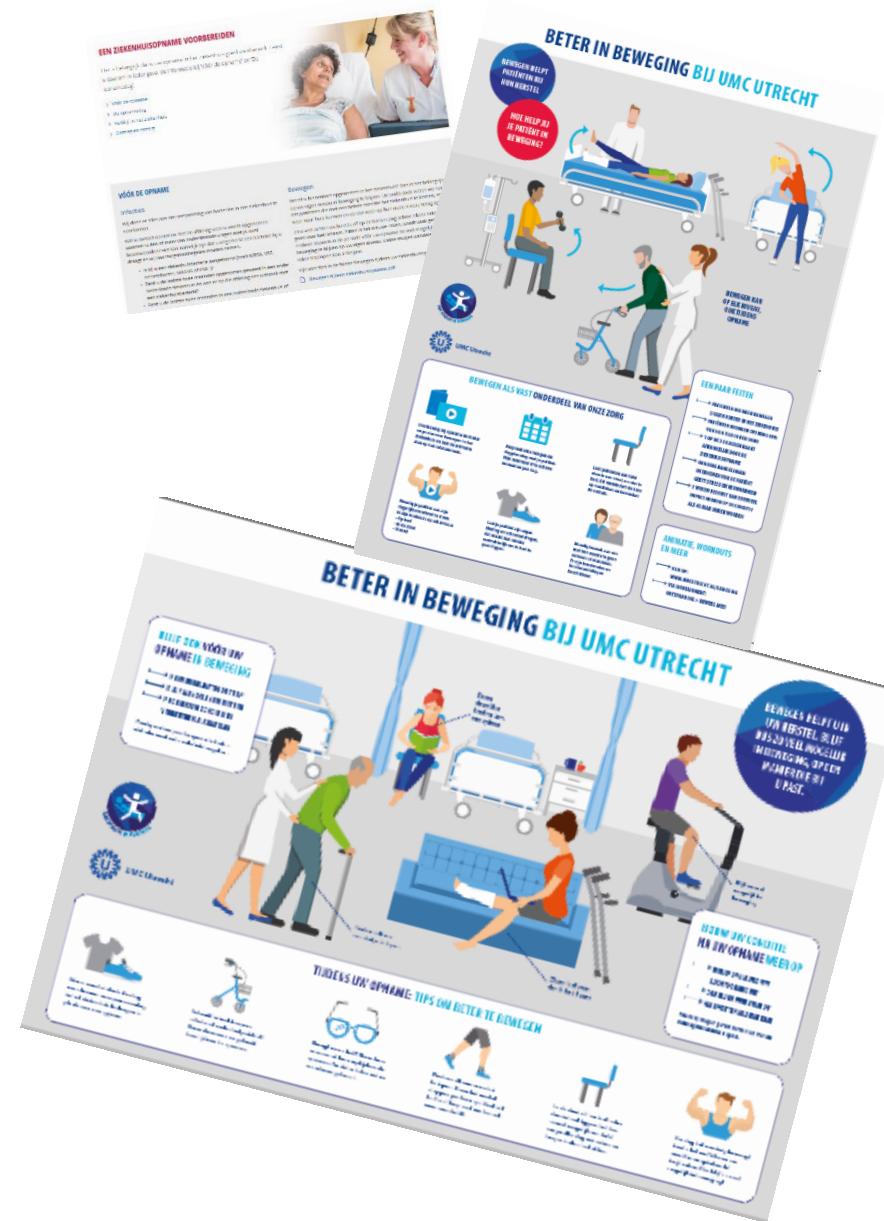
Uitreiken
informatiefolder
'Bewegen tijdens uw
ziekenhuisopname'

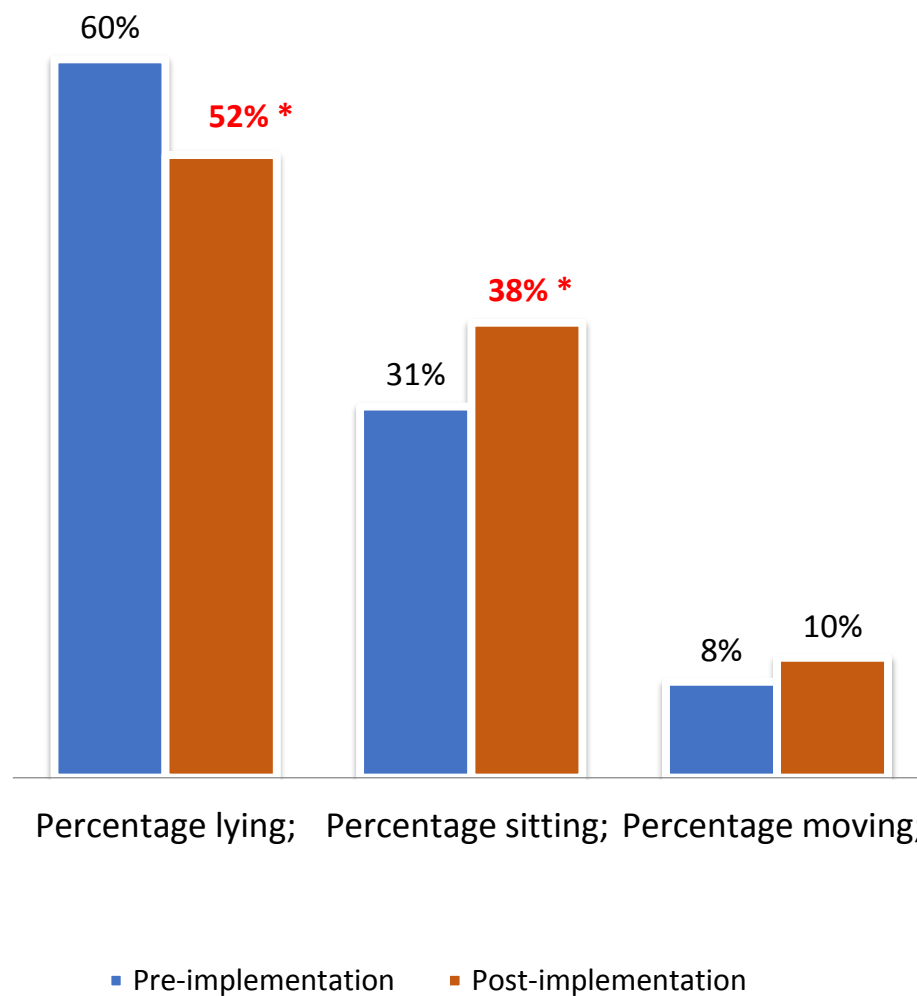
Informatieposters op
elke kamer

Voorlichtingsvideo
(animatie) beschikbaar
online en op de
schermen op de
patiëntkamer

Beweegbox met daarin
verschillende folders en
materialen om bewegen
te stimuleren

Inzet van oefengidsen
met oefeningen voor op
bed, zittend en/of
staand





Positieve trend:
Length of stay

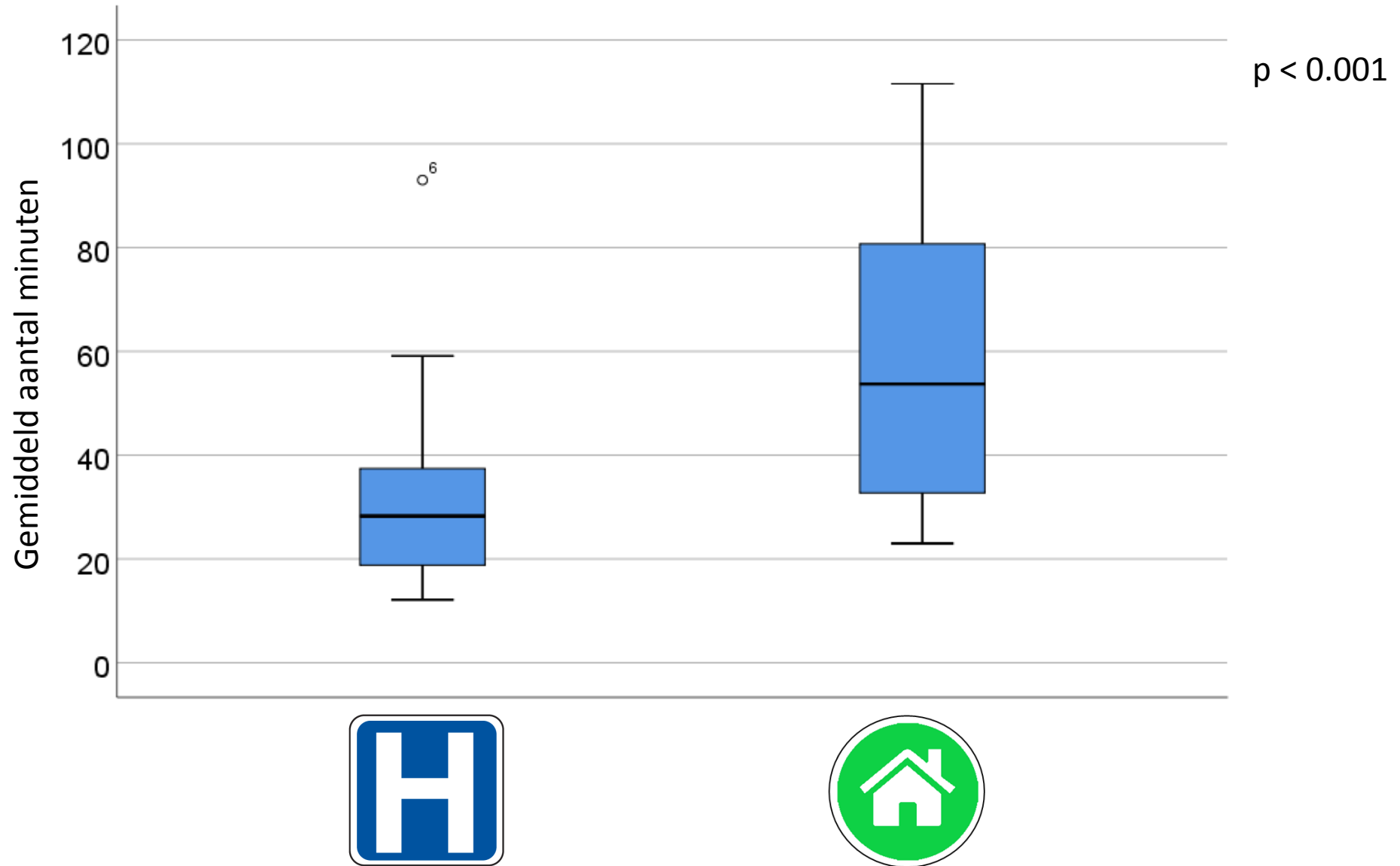
Conclusie: Patiënten meer het bed uit
Volgende stap: meer bewegen

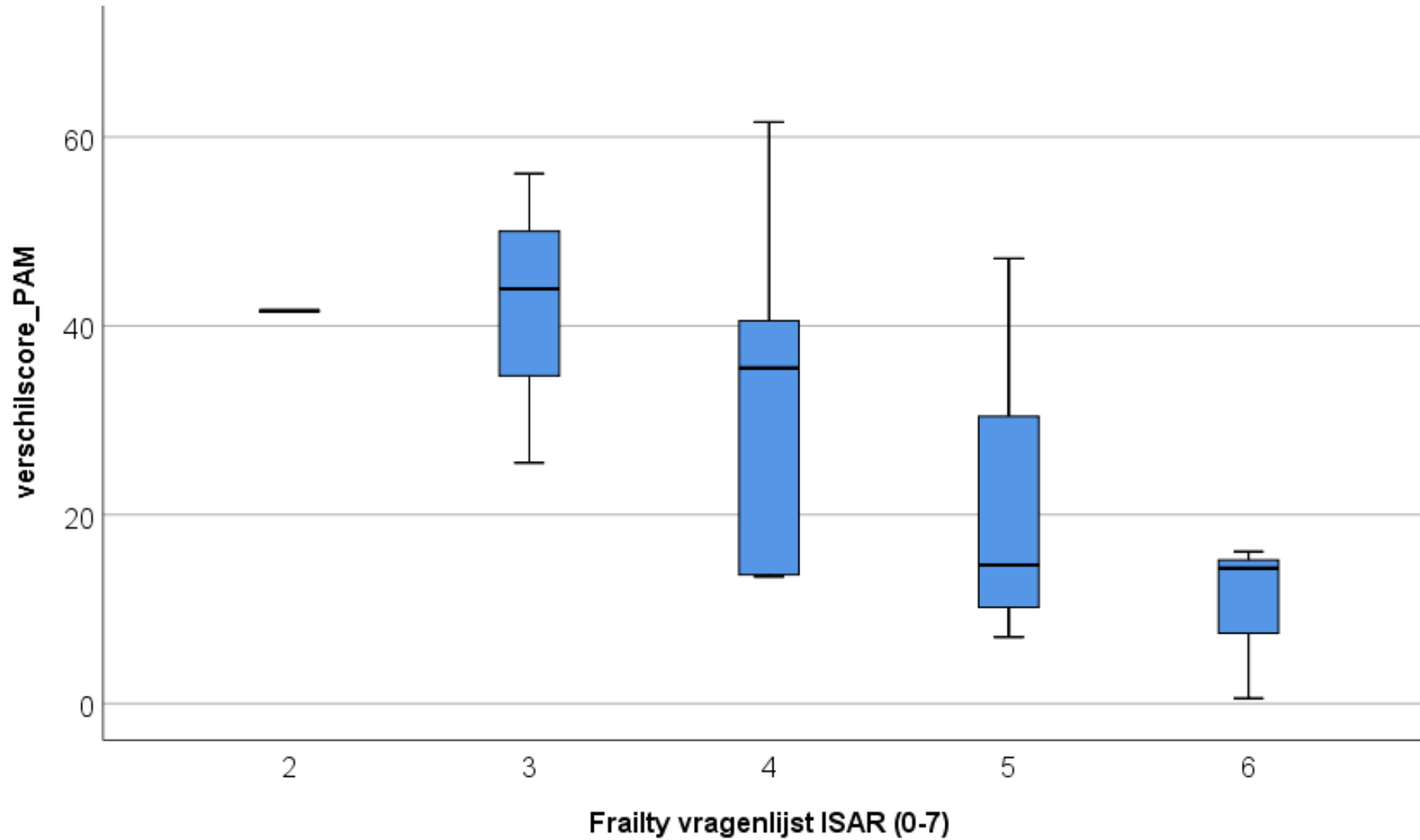
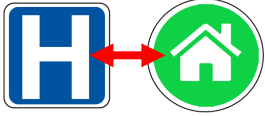


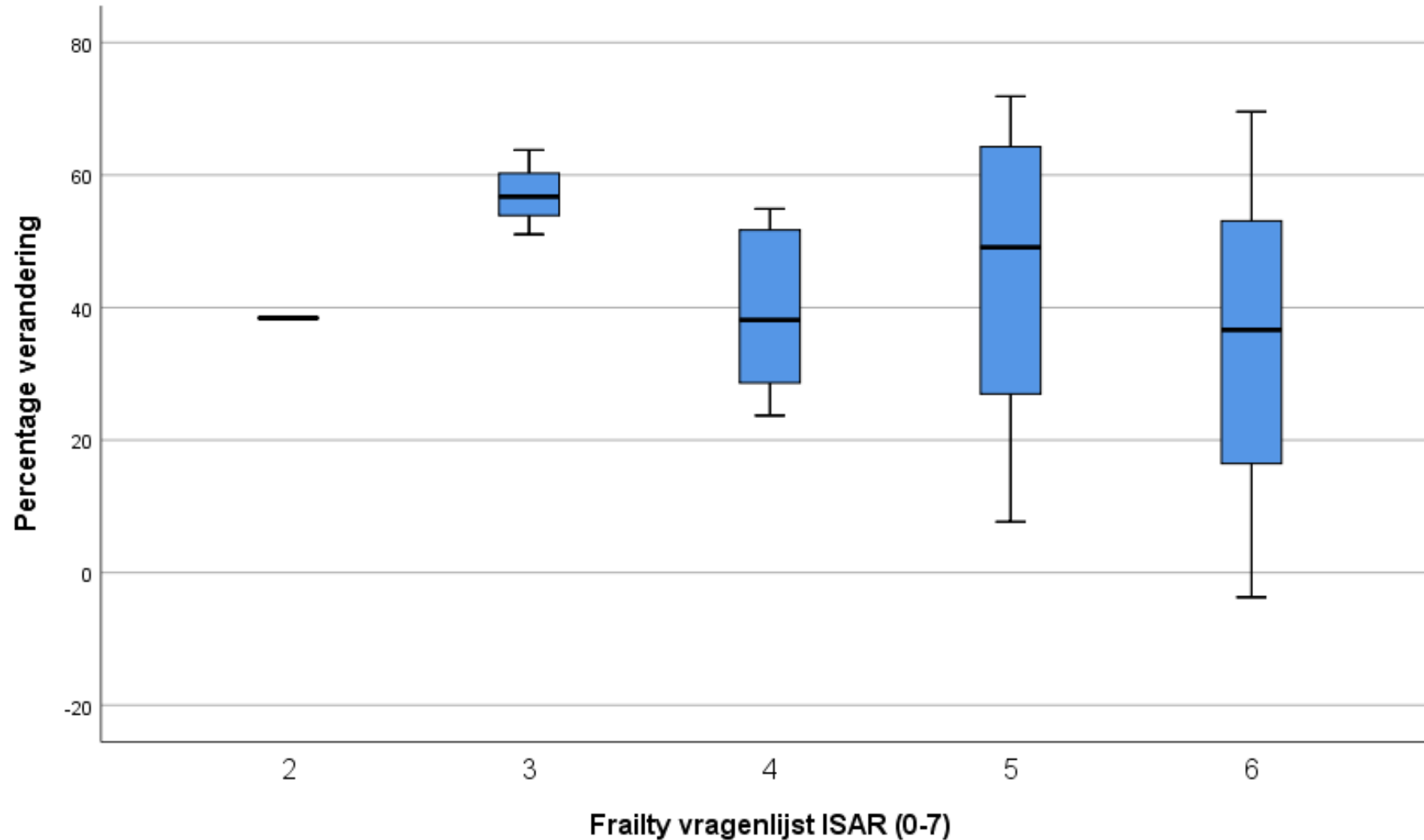
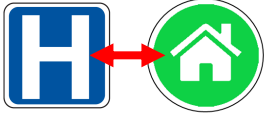
Werken met beweegdoelen



Plus aandacht voor
transitie naar huis

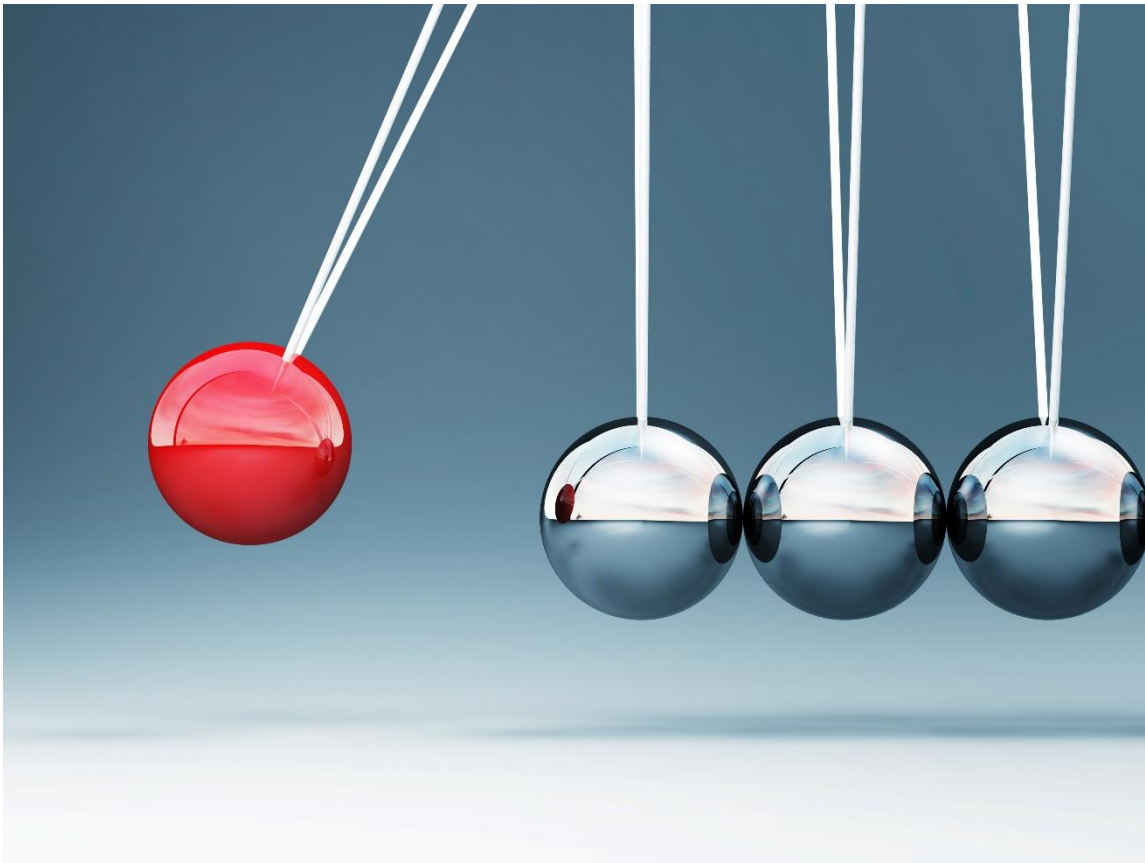








Geleerde lessen: De beweging erin houden is lastiger dan het in beweging krijgen....



Uitdagingen:

- Multidisciplinaire karakter
- Niet te veel tegelijk
- Duurzame cultuurverandering
- Wie wel/wie niet
- Financiering
- Transitie naar huis -> herstel van mensen thuis belangrijk
- In ziekenhuis evenveel bewegen als thuis

Overall geleerde lessen



Nog veel vragen over
optimale inhoud

High-intensity training? Bewegen? Voorkomen sedentair gedrag?



Overall geleerde lessen



Nog veel vragen over optimale inhoud



Multidisciplinaire insteek

Overall geleerde lessen



Nog veel vragen over optimale inhoud



Multidisciplinaire insteek



Ketenaanpak is uitdaging



Financiering een uitdaging – met name pre-operatieve traject

Overall geleerde lessen



Nog veel vragen over optimale inhoud



Multidisciplinaire insteek



Ketenaanpak is uitdaging

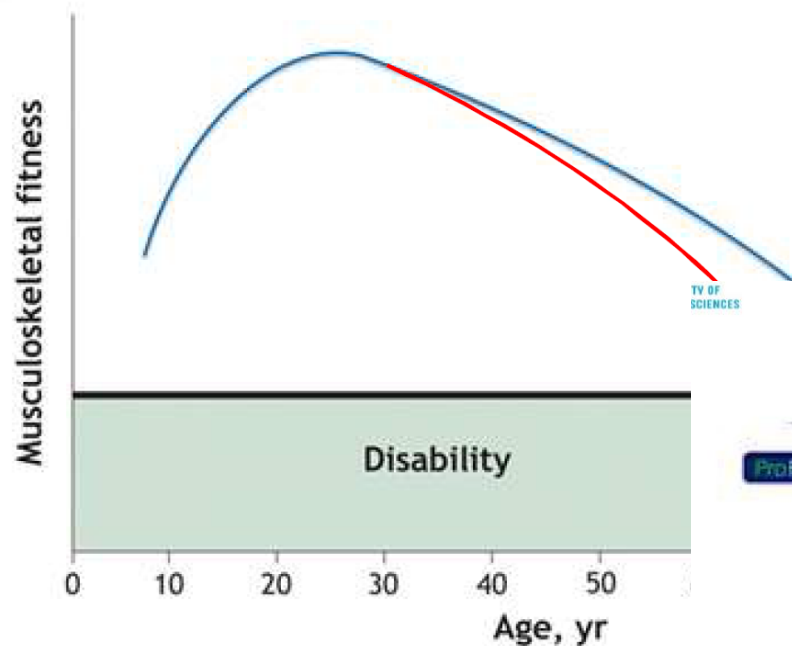


Financiering een uitdaging – met name pre-operatieve traject

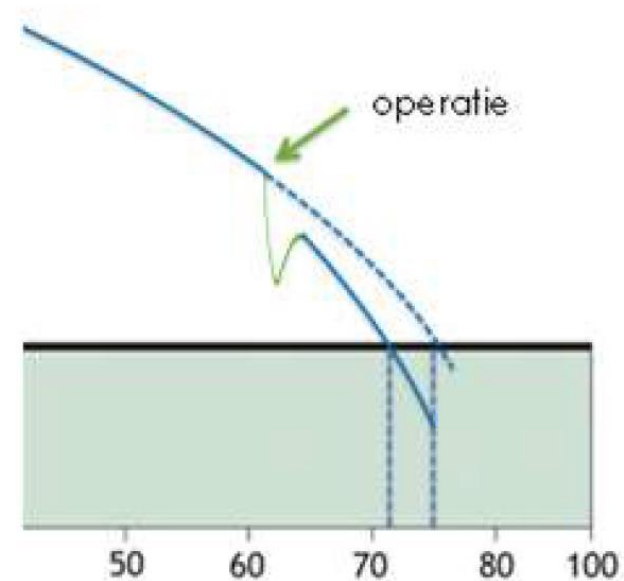
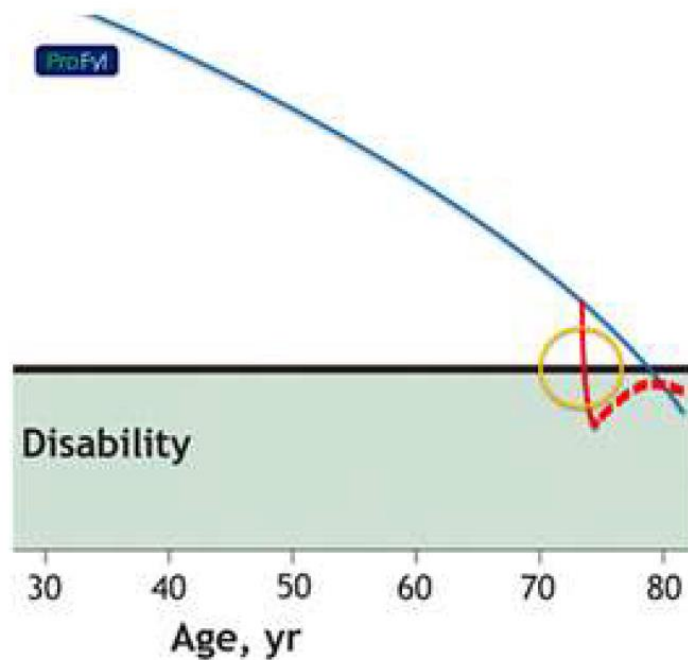


selectie high risk/low risk

Wie trainen?



Wie trainen?



Adapted from Warburton D E et al. CMAJ 2006;174:801-809

Overall geleerde lessen: Peri-operatieve training belangrijk



Nog veel vragen over optimale inhoud



Multidisciplinaire insteek



Ketenaanpak is uitdaging



Financiering een uitdaging – met name pre-operatieve traject



selectie high risk/low risk



Gepersonaliseerde aanpak



Technologie inzet waar mogelijk



Belang van inzet van peri-
operatieve training voor betere
fitheid van patiënten rondom
ziekenhuisopname



