

Exploring the perspectives of clinicians on solutions to tackling physical inactivity and sedentary behaviour in older hospital patients

Unyime Jasper^{1,2}  | Renuka Visvanathan^{1,2,3} | Joanne Dollard^{1,2} | Solomon Yu^{1,2,3} | Agathe Daria Jadczyk^{1,2}

¹Adelaide Geriatrics Training and Research with Aged Care (GTRAC) Centre, Adelaide Medical School, Faculty of Health and Medical Sciences, University of Adelaide, Adelaide, South Australia, Australia

²Basil Hetzel Institute for Translational Health Research, Central Adelaide Local Health Network, Adelaide, South Australia, Australia

³Aged & Extended Care Services, The Queen Elizabeth Hospital & Basil Hetzel Institute for Translational Health Research, Central Adelaide Local Health Network, Adelaide, South Australia, Australia

Correspondence

Unyime Jasper, Basil Hetzel Institute for Translational Health Research, The Queen Elizabeth Hospital, 37 Woodville Rd, Woodville, SA 5011 Australia.
Email: unyime.jasper@adelaide.edu.au

Funding information

The University of Adelaide; The Hospital Research Foundation

Abstract

Objective: Despite growing research on sedentary behaviour and physical activity among hospitalised older people, there is little evidence of effective intervention strategies. This study sought input from clinical staff from various health professions on strategies to increase physical activity and reduce sedentariness for hospitalised older people.

Methods: A 60-minute focus group discussion involving two physiotherapists, two occupational therapists, one doctor, one nurse and one social worker was conducted. Participants were recruited from a subacute geriatric ward and an acute orthopaedic ward with an orthogeriatric service at a general hospital. Data were thematically analysed.

Results: Six strategies to reduce sedentary behaviour and increase physical activity were identified: clear and positive communication for patients and family/carers; educating patients and family/carers; involving family/carers and volunteers; setting physical activity goals; utilising group activities and activities of daily living (ADL); and making the hospital environment activity-friendly.

Conclusions: This research has revealed novel strategies to increase physical activity and reduce sedentary behaviour in hospital. The next step is to design interventions for testing.

KEYWORDS

frailty, hospital, older people, physical activity, qualitative, sedentary behaviour

1 | INTRODUCTION

While physical activity after illness or injury is more often promoted in hospitals than a decade ago, multifaceted issues contributing to physical inactivity in hospital settings remain, and increased activity does not necessarily translate into reduced sedentariness.¹ Sedentary

behaviour (SB), which refers to low energy expenditure activities, such as reading or watching television or participating in social media, conducted when sitting or lying while awake,² is typical of a hospital stays. However, there is no medical reason patients should remain sedentary as people recover, and it is well understood that prolonged sedentariness predisposes older people to a progressive loss of muscle

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2022 The Authors. *Health Promotion Journal of Australia* published by John Wiley & Sons Australia, Ltd on behalf of Australian Health Promotion Association.

strength, loss of physical independence and agency and, ultimately, to institutionalisation.³⁻⁵ A better outcome for almost all patients could be achieved by increasing physical activity during inpatient treatment.

However, research is required as to how best to achieve this in acute and sub-acute settings, especially for older people, a large proportion of whom are frail⁶ when admitted. One study in a tertiary hospital found that half of the inpatient participants were frail at admission, complicating treatment and rehabilitation efforts.⁷ Therefore, gaining the perspectives of clinicians that manage these patients are important.

A recently published meta-ethnographic synthesis of qualitative research to February 2019 explored the views of patients, family/carers and healthcare professionals on physical activity behaviour in hospital.⁸ Only three of the eleven studies reviewed focused on older people. Of those, only one sought the views of nurses and physicians but did not explore the views of allied health. This older (2007) study by Brown conducted in medical wards identified that barriers to physical activity for older people included patient features such as pain, symptoms, fear of falls, patients lacking motivation and wellness, treatment interventions including urinary catheter, intravenous lines, staff lack of time, insufficient ambulatory devices.⁹ A recent scoping review has also revealed that the perspective of clinicians about SB among older inpatients is unknown.⁶

Given population ageing and the fact that older patients are already and will increasingly be major consumers of hospital care, it is essential that research focused on older people is encouraged. Clinicians would be key to implementing the multifaceted interventions required to manage the challenge of physical inactivity and sedentariness in older people, and their views are critical for translatable and effective interventions to be designed.⁸

Therefore, this study aimed to explore the perspectives of clinical staff from medical, nursing and allied health professions on implementable strategies to mitigate SB and increase physical activity.

2 | MATERIALS AND METHODS

2.1 | Ethics

The study received ethics approval from the Central Adelaide Local Health Network Human Research Ethics Committee (HREC/18/CALHN/118) and adheres to the CONSolidated criteria for REporting Qualitative research (COREQ) guidelines¹⁰ (Supporting Information S1) for reporting qualitative studies.

2.2 | Study design

This study used an exploratory qualitative approach, conducting a focus group discussion (FGD) to elicit from clinical staff their insights and ideas about the sedentariness and physical activity of hospitalised older people. A focus group was chosen to search for interactive data that could reveal consensus, as well as divergent perceptions. Focus

groups are beneficial for developing knowledge around less understood issues.¹¹

2.3 | Setting

The study was conducted in a metropolitan general hospital in South Australia, and purposively sampled clinical staff working in a Geriatric Evaluation and Management Unit (GEMU) and an acute orthopaedic unit where an orthogeriatrics service supports the management of hip fracture patients. The GEMU is a subacute unit that admits patients for comprehensive geriatric assessment and rehabilitation/restorative care following a brief acute inpatient stay.¹²

2.4 | Participants and recruitment

Purposive sampling was used to recruit medical doctors, allied health staff (physiotherapists, occupational therapists and social workers) and nurses who had worked in the GEMU or the orthopaedic ward for at least 6 months. A researcher approached nine clinical staff in April 2020 and explained the aims of the focus group. Participating staff provided written informed consent. At least one experienced clinician was recruited from both the geriatric and the orthopaedic wards and included each discipline of medical, nursing and allied health.

2.5 | Data collection

The focus group took place in a seminar room located adjacent to the GEMU. Participants completed a demographic questionnaire to record age, gender, ward, educational qualification and years of work experience. The focus group lasted 60 minutes, was audio-recorded and transcribed verbatim. The focus group guide (Supporting Information S2) was informed by previous interviews conducted with patients, carers and staff during a related interview study (unpublished).

One researcher moderated the focus group and encouraged interaction between participants, while a second researcher wrote notes. The focus group began with a discussion about why hospitalised older people were sedentary and then explored strategies to increase their physical activity and reduce sedentariness. To enrich the data, the moderator encouraged convergence and divergence about suggested strategies and field notes were taken.

2.6 | Data analysis

Data were analysed using Braun and Clark's (2006) systematic approach to thematic analysis,¹³ using an inductive approach (data analysis driven by data, not based on researcher's preconceived ideas or coding frame).¹³ To reduce bias, the coding framework, codes and themes were discussed with other co-authors until consensus was

reached, and themes were embedded in the data.¹⁴ NVivo version 12 software was used to manage data analysis. Quotations have been provided to support the themes, and participant number and discipline identify each participant.

3 | RESULTS

Ten staff were approached but one doctor and two nurses declined participation due to time constraints. Seven staff participated in the focus group, four from the GEMU and three from the orthopaedic ward. Two physiotherapists, two occupational therapists, one doctor, one nurse and one social worker (age range 31–58 years; four female participants) made up the participants.

Six themes were identified: (1) clear, positive and consistent communication from staff is critical, (2) educating patients and family/carers on SB and physical activity, (3) involving family/carers and volunteers, (4) setting PA goals, (5) utilising group activities and ADLs and (6) making the hospital environment activity-friendly.

3.1 | Theme 1: Clear and positive communication from staff

Participants emphasised that clear, straightforward and easy to understand communication from staff to patients and family/carers was vital. If patients could be active but required assistance, patients and their families needed to be shown the type of assistance and advised about how much activity and from whom.

‘...clear communication so that they know that they are allowed to walk without someone’. (#1, Doctor)

Clinicians recommended that communication with patients and family/carers emphasise the positives instead of focusing purely on deficits. As the patients' acute illness improves, patients should be encouraged to be physically active as it would contribute to further improvements in their wellbeing.

‘...not harping on how terrible the fracture was but how well it's fixed up now and safe it is to move’. (#3, Physiotherapist)

3.2 | Theme 2: Educating patients and family/carers on sedentary behaviour and physical activity

Patients and family/carers needed to be educated about the detrimental effects of SB and the benefits of physical activity, either verbally or in written format. Such education should commence on admission. Patients' expectations and strategies to reduce sedentaryness whilst increasing physical activity should be part of the information provided.

‘I think we need to educate people what their role is in being a patient in hospital, and what their role is in getting home. So, what they are expected to do, what they need to do, and what they're allowed to do as if giving them permission’. (#3, Physiotherapist)

Participants highlighted the need to personalise the advice to the patient, taking into account the patient's health condition, including pain levels and the need for patients to be safe.

‘I guess a lot of it is trying to educate them about the pain itself. It's [physical activity] not harmful. Moving and walking is not going to create harm or damage to the operation. It's going to help strengthen it’. (#4, Physiotherapist)

Allied health staff were keen that doctors were more involved in providing advice or encouragement to patients.

‘So, even if there was a ward round where the doctors did their examinations and their discussions...a second round where the interns target the specific things they want to tell the patient...that might help them take on that information a lot easier’. (#6, Occupational Therapist)

Staff emphasised that information needed to be visible and straightforward and could either be printed on paper or written on a whiteboard to make it visible to all team members who could reinforce the information.

‘...like encourage them through both written up things on posters that sometimes they can look at them and remember to walk or something’. (#1, Doctor)

3.3 | Theme 3: Involving family/carers and volunteers

Staff perceived that the involvement of family/carers and hospital volunteers could offer support in increasing physical activity, especially with those who were more independent, required support and in unsafe circumstances.

‘Yeah, I think volunteers would very much motivate that category (older patients). But then volunteers could provide an endpoint for people. Staff could walk standbys (those that need assistance), and then one assists to the spot where the volunteers were doing a seated activity’. (#5, Nurse)

Where patients needed assistance, family/carers and volunteers could be involved with staff supervision.

'...family can or volunteers maybe. I'm not sure if there's policies around that in this hospital'. (#1, Doctor)

Staff emphasised, however, that patient safety was important, and family/carers and volunteers would need education about how to minimise risk to the patients. Staff also preferred family/carers and volunteers to seek permission from staff before attempting to encourage patients to move.

'So, getting the family/carers onboard is important... even if they're not actually helping to get them moving, they're not stopping it from happening'. (#2, Occupational Therapist)

3.4 | Theme 4: Setting physical activity goals

According to clinical staff, clear and easy-to-understand physical activity goals could help older patients stay motivated while preparing them mentally and physically for physical activity. In addition, clinicians could provide pain relief and reassurance for patients before they engage in physical activity. Physical activity goals should incorporate activities for daily living, be written down and visible to staff and family/carers, who could then offer encouragement.

'If the goal is in front of them and clear and simple and they can obviously, they know what they are coming against, so they can anticipate what needs to be done, which might help prepare them for their pain as well, I guess'. (#3, Physiotherapist)

Clinical staff also reiterated that goal setting needed to be followed by feedback to the older patient, as they may underestimate their ability and otherwise not appreciate what they have accomplished. Feedback provides patients with positive reinforcement and supports the process of goal setting.

'So, having that feedback and saying "oh actually, like yeah, you did well with that. But I actually think you could be doing this much" is helpful because their perception of where they should be is often quite different to where we think they could be'. (#6, Occupational Therapist)

3.5 | Theme 5: Utilising group activities and ADLs

According to clinical staff, establishing and increasing the use of incidental activities, such as walking to the lounge room to socialise, was crucial for breaking older patients' SB in hospital. Clinical staff thought incidental activities might encourage physical activity more than planned activity with physiotherapists or nurses. Group activities,

such as art and diversional therapy, and group exercise, could reduce SB and increase physical activity because patients value the opportunity to socialise with others.

'But I know that they work and we've had our physio sessions in the afternoon, which we don't have anymore, and that was really great in getting people moving because it was a group thing. Most people are sociable, they like to be sociable and they don't get that opportunity if they're just sitting in their room'. (#4, Physiotherapist)

How best to deliver activity depends on context with post-surgical patients perhaps preferring purposeful movement rather than group activities because of health issues, such as pain.

'I think they [patients in pain] have to see the benefit and it has to be purposeful. They have to know why they're doing it and what it achieves really'. (#3, Physiotherapist)

Staff suggested that meals should not be provided at the patient's bedside, as this fostered the 'sick role'. Instead, patients should be encouraged to walk to communal areas for meals, either assisted or independently. Clinicians perceived that encouraging participation in the activities of daily living at admission and modifying nurses' roles from being the providers of all aspects of day-to-day living to supervising patients to be as independent as possible would encourage physical activity. It was further suggested that occupational therapists could engage older people in activities such as preparing meals.

'For a patient if they are able to mobilise a little bit, instead of giving their food in the bedside, why can't you think about getting maybe a wall-mounted tray where it can fold out or lift it up and for lunch, they have to go up there to have their lunch...'. (#7, Social Worker)

3.6 | Theme 6: Making the hospital environment activity-friendly

Staff identified that spaces, such as ward lounge rooms, should be clearly identified, easily accessible and aesthetically appealing. Clinicians felt that this could increase the likelihood of patients being attracted to walk to and utilise such spaces.

'If those spaces are available, that does increase the opportunity for people to be able to just get up and move with more purpose as well rather than just like, it's time to get up with the physios and nurses today. Let's walk here and then walk back'. (#4, Physiotherapist)

Clinical staff pointed out that patients may remain in their rooms because they fear becoming lost on the ward. Therefore, staff suggested that clear room and ward numbering and coloured lines on the ground could help orient older patients.

'So sometimes using that as a marker like, "if you want to go walking yourself, just walk to the green wall and back and you'll find your room." Or "follow the numbers" or sort of just giving them some sort of directions so they will do it, have confidence in doing it'. (#5, Nurse)

There was also a suggestion that a quieter and uncluttered environment might make patients feel safer and more confident.

'I've seen some wards do quiet time in the afternoon... all the staff quietened down as well and the staff were encouraged to be a bit quieter in their voice and in their walking and shuffling around and things. So that - I don't know, maybe later in the evening or something, maybe'. (#2, Occupational Therapist)

4 | DISCUSSION

To the best of our knowledge, this is the first qualitative study to focus on possible strategies for reducing sedentariness and increasing physical activity, focussing on older inpatients and reporting on the perspectives of allied health team members in addition to medical and nursing clinicians. The findings of this study are significant as they represent the perspectives of clinicians who best understand their workflows, patients' needs and what strategies might be translatable. Explicit strategies suggested by clinicians in this study included (1) clear communication to both the patients and family/carers on physical activity expectations in hospital commensurate with the older patient's recovery; (2) specific and individualised education by clinical staff on SB and physical activity commencing from admission, including the importance of physical activity, the consequences of SB and possible barriers to activity; (3) integrating ADLs and incidental activities into the older patient's physical activity plans; (4) establishing personalised physical activity goals for older patients and providing timely feedback (5) introducing 'quiet times' in the wards to improve older patients' confidence; (6) involving family/carers to encourage, motivate and support older patients to be physically active and (7) making the hospital environment physical activity-friendly.

Consistent with previous literature, participants in this study agreed that all healthcare professionals should provide timely and tailored physical activity expectations, information, encouragement and education.⁸ Clinical staff in this study emphasised that doctors played a central role in the delivery of physical activity education because patients value doctors' advice¹⁵ and are more likely to comply with it.¹⁶ According to Geelen et al., physicians agree on the need to encourage physical activity participation.¹⁷ However, they may lack the necessary time and

knowledge or perceive that providing advice and encouragement is secondary to their role in managing medical illnesses.¹⁶ With patients more likely to engage in physical activity if advised by physicians^{18,19} and other staff adhering to physical activity goals when they are suggested and followed up by a physician,²⁰ there is a need to explore how doctors can better integrate the provision of education about improving physical activity and reducing SB within their routine workflows.

Viewing the conduct of activities of daily living such as bathing and toileting as a form of physical activity rather than just focusing on mobility is another way to better prepare patients for their return home whilst mitigating the risks arising from sedentariness in hospitals. Hospitalised older people are, on the whole, keen to participate in their activities of daily living where safe to do so.²¹ However, they may face barriers due to attitudes, staff time pressures and risk-averse ward cultures, translating to the situation where, more often than not, things are done *to* patients rather than *with* patients.²¹ It is important to be mindful that some patients prefer to be cared for by staff during hospitalisation and that things be done for them.²¹ In such scenarios, it will also be important to shift patient attitudes.

Goal setting with daily objective feedback via activity monitors has been demonstrated to increase walking times in older people both in and out of therapy periods.²² Clinicians in this study felt that broadening the range of activities coupled with more frequent reviews of goals following feedback was more likely to be effective. Technology advancement may eventually make it more possible for real-time and frequent objective feedback to be achieved as sensor technology becomes more common in clinical practice.

This study re-emphasised the valuable role family/carers and volunteers could play in helping older patients recover. The SoMoVe™ feasibility study investigated a volunteer-led intervention to improve older patients' mobility in acute medical wards, reported positive trends in older patients' step count and length of stay.²³ The study emphasised that clinical staff (ie, nurses and allied health) and older patients considered engaging volunteers a safe and acceptable strategy.²³

Interestingly, a synthesis of qualitative papers before February 2019⁸ and the more recent SoMoVe™ feasibility study²³ reveals a lack of exploration of the carer perspective, a gap in the literature that requires action. Research in the community setting reveals that where family/carers understand the benefits of physical activity and support patients with physical activity, they are more likely to influence older patients to collaborate with clinicians and undertake physical activity.²⁴ The family/carer is a valuable resource that should be utilised more often within the inpatient clinical setting.

Creating a safe ward environment and processes ensures that older people are willing to be physically active. Bungay et al. demonstrated that older people who attended a dance group session in acute care valued social interaction.²⁵ Social relationships resulting from group exercises can buffer stress and maintain or improve patients' mental health during hospitalisation.²⁶ Research has demonstrated that ease of navigation and variation in the physical environment of stroke units influenced patients' physical activity levels positively.²⁷ Other research has revealed that improved way-finding enhances patients' wellbeing.²⁸ Participants in our study noted that

the busy ward environment, including clutter, could discourage older patients from participating in physical activity. They suggested that 'quiet time' when staff and equipment movement is limited on the ward might be an intervention strategy that could improve older patients' participation in physical activity during non-therapy periods when safe to do so.

5 | STRENGTHS AND LIMITATIONS

A strength of this study was the inclusion of a range of health professionals with clinical experience in the care of older people from both the medical and surgical areas of a hospital. Whilst this research focused on inpatient settings where geriatrics services are involved, the strategies uncovered through this research are likely to be relevant to other areas in the hospital where older people are managed. Nevertheless, it would be beneficial to explore clinicians' views in other health jurisdictions, and other specialty environments as this could add further valuable insight into identifying solutions to reduce SB and increase physical activity, strengthening the case for and methods to support change in clinical practice. Due to competing workplace pressures for clinicians, we could not approach staff to conduct member checking, another limitation of this study.

6 | CONCLUSION

This study focused on both improving physical activity and reducing SB in older inpatients. Ideas and insights were sought from clinicians from the medical, nursing and allied health professions to provide new insights into strategies that could potentially be implemented into clinical practice. Interventions that consider end-users perspectives are more likely to translate into beneficial effects due to improved engagement. The next steps would be further qualitative research in other health jurisdictions and co-designing interventions for testing and refinement. Recommendations include the need for a multidisciplinary effort and collaboration to incorporate physical activity into current workflows, and hospital policies and goals of care should include hospital expectations and clinician accountability to improve patients' physical activity as that could encourage collaboration and efforts by clinicians to encourage and support older patients to be active.

ACKNOWLEDGEMENTS

We acknowledge the support provided by clinical staff who participated in this study. We also acknowledge the funding support received from The Hospital Research Foundation and The University of Adelaide. Open access publishing facilitated by The University of Adelaide, as part of the Wiley - The University of Adelaide agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

Professor Visvanathan whilst the Head of Unit of the geriatrics service at this general hospital which operates the GEMU and delivers the

orthogeriatrics service, played no role in recruiting participants to this research or interviewing participants.

ORCID

Unyime Jasper  <https://orcid.org/0000-0002-7005-9927>

REFERENCES

1. Barone Gibbs B, Brach JS, Byard T, Creasy S, Davis KK, McCoy S, et al. Reducing sedentary behavior versus increasing moderate-to-vigorous intensity physical activity in older adults: a 12-week Randomized Clinical Trial. *J Aging Health*. 2017;29(2):247-67.
2. Tremblay M, Aubert S, Barnes J, Saunders T, Carson V, Latimer-Cheung A, et al. Sedentary behavior research network (SBRN)—terminology consensus project process and outcome. *Int J Behav Nutr Phys Act*. 2017;14(1):75.
3. Tasheva P, Vollenweider P, Kraege V, Roulet G, Lamy O, Marques-Vidal P, et al. Association between physical activity levels in the hospital setting and hospital-acquired functional decline in elderly patients. *JAMA Netw Open*. 2020;3(1):e1920185.
4. Coker RH, Hays NP, Williams RH, Wolfe RR, Evans WJ. Bed rest promotes reductions in walking speed, functional parameters, and aerobic fitness in older, healthy adults. *J Gerontol A Biol Sci Med Sci*. 2015;70(1):91-6.
5. Chodos A, Kushel M, Greysen S, Guzman D, Kessell E, Sarkar U, et al. Hospitalization-associated disability in adults admitted to a safety-net hospital. *J Gen Intern Med*. 2015;30(12):1765-72.
6. Jasper U, Yadav L, Jadcak AD, Yu S, Visvanathan R, Dollard J. Sedentary behaviour in hospitalised older people: a scoping review. *Int J Environ Res Public Health*. 2020;17:9359.
7. Richards SJG. Prevalence of frailty in a tertiary hospital: a point prevalence observational study. *PLoS One*. 2019;14(7):e0219083.
8. Koenders N, Marcellis L, Nijhuis-van der Sanden MWG, Satink T, Hoogeboom TJ. Multifaceted interventions are required to improve physical activity behaviour in hospital care: a meta-ethnographic synthesis of qualitative research. *J Physiother*. 2021;67(2):115-23.
9. Brown CJ, Williams BR, Woodby LL, Davis LL, Allman RM. Barriers to mobility during hospitalization from the perspectives of older patients and their nurses and physicians. *J Hosp Med*. 2007;2(5):305-13.
10. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International J Qual Health Care*. 2007;19(6):349-57.
11. Kitzinger J. The methodology of focus groups: the importance of interaction between research participants. *Sociol Health Illn*. 1994;16(1):103-21.
12. Dent E, Chapman I, Howell S, Piantadosi C, Visvanathan R. Frailty and functional decline indices predict poor outcomes in hospitalised older people. *Age Ageing*. 2014;43(4):477-84.
13. Clarke V, Braun V. Thematic analysis. *J Posit Psychol*. 2017;12(3):297-8.
14. Mackieson P, Shlonsky A, Connolly M. Increasing rigor and reducing bias in qualitative research: a document analysis of parliamentary debates using applied thematic analysis. *Qual Soc Work*. 2018;18(6):965-80.
15. Jadcak AD, Dollard J, Mahajan N, Visvanathan R. The perspectives of pre-frail and frail older people on being advised about exercise: a qualitative study. *Fam Pract*. 2018;35(3):330-5.
16. Stutzbach JJ, Taber A, Recicar J, Burke RE, Stevens-Lapsley J. A systems approach is needed for in-hospital mobility: a qualitative meta-synthesis of patient and clinician perspectives. *Arch Phys Med Rehabil*. 2020;102(5):984-98.
17. Geelen SJG, Giele BM, Engelbert RHH, de Moree S, Veenhof C, Nollet F, et al. Barriers to and solutions for improving physical activity

- in adults during hospital stay: a mixed-methods study among health-care professionals. *Disabil Rehabil.* 2021;1-10:1–10.
18. Kirk JW, Bodilsen AC, Sivertsen DM, Husted RS, Nilsen P, Tjørnhøj-Thomsen T. Disentangling the complexity of mobility of older medical patients in routine practice: an ethnographic study in Denmark. *PLoS One.* 2019;14(4):e0214271.
 19. Scheerman K, Schoenmakers AHC, Meskers CGM, Maier AB. Physical, motivational and environmental factors influencing physical activity promotion during hospitalization: older patients' perspective. *Geriatr Nurs.* 2021;42(2):599–604.
 20. Pedersen MM, Brodsgaard R, Nilsen P, Kirk JW. Is promotion of mobility in older patients hospitalized for medical illness a physician's job?—an interview study with physicians in Denmark. *Geriatrics.* 2020;5(4):74.
 21. Chan E-Y, Samsudin SA, Lim YJ. Older patients' perception of engagement in functional self-care during hospitalization: a qualitative study. *Geriatr Nurs.* 2020;41(3):297–304.
 22. Peel NM, Paul SK, Cameron ID, Crotty M, Kurrle SE, Gray LC. Promoting activity in geriatric rehabilitation: a randomized controlled trial of accelerometry. *PLoS One.* 2016;11(8):e0160906.
 23. Lim S, Ibrahim K, Dodds R, Purkis A, Baxter M, Rogers A, et al. Physical activity in hospitalised older people: the feasibility and acceptability of a volunteer-led mobility intervention in the SoMoVe™ study. *Age Ageing.* 2019;49(2):283–91.
 24. Chastin SFM, Fitzpatrick N, Andrews M, DiCroce N. Determinants of sedentary behavior, motivation, barriers and strategies to reduce sitting time in older women: a qualitative investigation. *Int J Environ Res Public Health.* 2014;11(1):773–91.
 25. Bungay H, Hughes S, Jacobs C, Zhang J. Dance for health: the impact of creative dance sessions on older people in an acute hospital setting. *Arts Health.* 2020;14:1–13.
 26. Kanamori S, Takamiya T, Inoue S. Group exercise for adults and elderly: determinants of participation in group exercise and its associations with health outcome. *J Phys Fitness Sports Med.* 2015;4(4):315–20.
 27. Anåker A, von Koch L, Sjöstrand C, Heylighen A, Elf M. The physical environment and patients' activities and care: a comparative case study at three newly built stroke units. *J Adv Nurs.* 2018;74(8):1919–31.
 28. Huisman ERCM, Morales E, van Hoof J, Kort HSM. Healing environment: a review of the impact of physical environmental factors on users. *Build Environ.* 2012;58:70–80.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Jasper U, Visvanathan R, Dollard J, Yu S, Jadczyk AD. Exploring the perspectives of clinicians on solutions to tackling physical inactivity and sedentary behaviour in older hospital patients. *Health Promot J Austral.* 2023;34(1):41–7. <https://doi.org/10.1002/hpja.630>