Early Mobility: Partnering to Ensure Safety in the Med-Surg Environment

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Disclosures for Kathleen Vollman

- Consultant-Michigan Hospital Association Keystone Center
- Consultant/Faculty for CUSP for MVP—AHRQ funded national study
- Subject matter expert for CAUTI and CLABSI for CMS/HEN 1.0 & 2.0
- Consultant and speaker bureau for Sage Products LLC
- Consultant and speaker bureau for Hill-Rom Inc.
- Consultant and speaker bureau for Eloquest Healthcare
- Niveus medical
Cross Cutting Approach to Harm Reduction

Wake Up
Get Up
Soap Up
Script Up
Revaluing Fundamental Care Practices
Notes on Hospitals: 1859

“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.”

Florence Nightingale

Advocacy = Safety
Protect The Patient From Bad Things Happening on Your Watch

Implement Interventional Patient Hygiene
Interventional Patient Hygiene

Hygiene...the science and practice of the establishment and maintenance of health

Interventional Patient Hygiene....nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence based hygiene care strategies

Hand Hygiene

Comprehensive Oral Care Plan

Incontinence Associated Dermatitis Prevention Program

Catheter Care

Bathing & Assessment

Pressure Ulcer Prevention
INTerventional Patient Hygiene (IPH)
Achieving the Use of the Evidence

Factors Impacting the ability to Achieve Quality Nursing Outcomes at the Point of Care

Skills & Knowledge

Resources & System

Value

Attitude & Accountability

Progressive mobility is defined as a series of planned movements in a sequential matter beginning at a patient's current mobility status with goal of returning to his/her baseline (Vollman 2010).

What is progressive mobility?

- Elevate HOB
- Manual turning
- PROM
- AROM
- CLRT and Prone positioning
- Upright / leg down position
- Chair position
- Dangling
- Ambulation

Cumulative Impact on Quality of Life

“New Walking Dependence” occurs in 16-59% in older hospitalized patients (Hirsh 1990, Lazarus 1991, Mahoney 1998)

65% of patients had a significant functional mobility decline by day 2 (Hirsh 1990)

27% still dependent in walking 3 months post discharge (Mahoney 1998)
Missed Nursing Care

“Any aspect of required patient care that is omitted (either in part or whole) or significantly delayed.”

A predictor of patient outcomes

Measures the process of nursing care
Hospital Variation in Missed Nursing Care

Figure 2. Elements of care most and least frequently missed. The solid bars represent the means across all 10 hospitals, and the range lines indicate the standard deviations.
Reasons for Missed Nursing Care

- Too few staff
- Poor use of existing staff resources
- Time required for nursing intervention
- Poor teamwork
- Communication problems
- An effective delegation
- Habit and denial

Systematic Review of Inpatient Mobilization

• Literature review of research studies that provides evidence to the consequences of mobilizing or not mobilizing hospitalized adult patients

• 36 studies were included, will study showed strong quality

• Finding in four theme areas:
  ◦ Physical outcomes include pain relief, reduced deep vein thrombosis, less fatigue, less delirium, less pneumonia, improved physical function (no relationship to falls)
  ◦ Psychological outcomes include less anxiety, ↓depressive mood, ↓distress symptoms, ↑comfort and ↑satisfaction
  ◦ Social outcomes include ↑quality of life and more independence
  ◦ Organizational outcomes include ↓length of stay, ↓mortality and ↓cost

Evidence to Support Success

- Implement and evaluate evidence based intervention targeting staff to promote early mobility in the med-surg area.
- Pragmatic quasi experimental interrupted time series design: 3 periods pre-intervention (10 weeks), intervention (8 weeks), post-intervention (20 weeks).
- 14 academic center in Ontario Ca, 12, 490 patients.
- Targeted patients > 65 yrs of age & admitted between Jan 2012 to Dec 2013.
- Intervention: Multidisciplinary team, multimodal strategies, tools provided including, education modules, checklist, mobility algorithms.
- Three consistent messages
  - Assessed for mobilization status within 24 hr of admission.
  - Mobilization should occur 3x daily.
  - Mobility should be progressive and scaled to patients abilities.

Lu, B, et al. Age and Aging, 2017;0:1-7
Results of MOVE ON Study

4.28% more patients out of bed
3.12% more patients out of bed
10.56% more patients out of bed

Figure 1. Overall weekly visual audit results for proportion of patients out of bed.

A decrease of 0.1 days in median LOS compared to pre-intervention
A 3.45 decrease in median LOS
A decrease of 2.03 in median LOS

Lu, B, et al. Age and Aging, 2017;0:1-7
Mobility interventions are regularly missed

- Nursing perceptions
  - Lack of time
  - Ease of omission
  - Belief it is PTs responsibility
- Survey results
  - Concern for patients level of weakness, pain and fatigue
  - Presence of devices – IVs and Urinary Catheters
  - Lack of staff to assist

Complication Related to Immobility in Medical-Surgical Patient

- Bedrest contributes to;
  - delirium
  - pressure injuries
  - Pneumonia
  - muscle atrophy
  - increase risk for falls

- Bedrest-1-5% daily loss of muscle strength

Assessing Readiness:

Consider a Physiological Safety Screen

<table>
<thead>
<tr>
<th>Test</th>
<th>Task</th>
<th>Response</th>
<th>Fail = Choose most appropriate equipment/device(s)</th>
<th>Pass = Passed Assessment Level 1 = Proceed with Assessment Level 2.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Level 1</strong></td>
<td><strong>Sit and shake:</strong> From a semi-reclined position, ask patient to sit upright and rotate to a seated position at side of bed; may use bedrail. Note patient’s ability to maintain seated balance for 2 minutes (without caregiver assistance).</td>
<td><strong>Sit:</strong> Patient is able to follow commands, and maintain balance for 2 minutes (without caregiver assistance). <strong>Shake:</strong> Patient has significant upper body strength, awareness of body in space, and grasp strength.</td>
<td><strong>MOBILITY LEVEL 1</strong>&lt;br&gt;- Use total lift with sling and/or repositioning sheet and/ or straps.&lt;br&gt;- Use lateral transfer devices, such as roll board, friction-reducing device (slide sheets/ tube), or air-assisted device.&lt;br&gt;<strong>Note:</strong> If patient has strict bed rest or bilateral non-weight-bearing restrictions, do not proceed with the assessment; patient is MOBILITY LEVEL 1.</td>
<td>Passed Assessment Level 1 = Proceed with Assessment Level 2.</td>
</tr>
<tr>
<td><strong>Assessment Level 2</strong></td>
<td><strong>Stretch and point:</strong> With patient in seated position at side of bed, have patient place both feet on floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten knee, then bend ankle/inflate and point toes. If appropriate, repeat with other leg.</td>
<td>Patient exhibits lower extremity stability, strength, and control. May test only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).</td>
<td><strong>MOBILITY LEVEL 2</strong>&lt;br&gt;- Use total lift for patient unable to weight-bear on at least one leg.&lt;br&gt;- Use sit-to-stand lift for patient who can weight-bear on at least one leg.</td>
<td>Passed Assessment Level 2 = Proceed with Assessment Level 3.</td>
</tr>
<tr>
<td><strong>Assessment Level 3</strong></td>
<td><strong>Stand:</strong> Ask patient to elevate off bed or chair (seated to standing) using assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of three. May repeat once.</td>
<td>Patient exhibits upper and lower extremity stability and strength. May test with weight-bearing on only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).</td>
<td><strong>MOBILITY LEVEL 3</strong>&lt;br&gt;- Use non-powered robotic/stand aid; default to powered sit-to-stand lift if no stand aid is available.&lt;br&gt;- Use total lift with ambulation assistance.&lt;br&gt;- Use assistive device (cane, walker, crutches).&lt;br&gt;<strong>Note:</strong> Patient passes Assessment Level 3 but requires assistive device to ambulate or cognitive assessment indicates poor safety awareness; patient is MOBILITY LEVEL 3.</td>
<td>Passed Assessment Level 3 AND no assistive device needed = Proceed with Assessment Level 4. Consult with physical therapist when needed and appropriate.</td>
</tr>
<tr>
<td><strong>Assessment Level 3</strong></td>
<td><strong>Walk:</strong> Ask patient to march in place at bedside. Then ask patient to advance stop and return each foot. Patient should display stability while performing tasks. Assess for stability and safety awareness.</td>
<td>Patient exhibits steady gait and good balance while marching and when stepping forward and backward. Patient can maneuver necessary turns for in-room mobility. Patient exhibits safety awareness.</td>
<td><strong>MOBILITY LEVEL 3</strong>&lt;br&gt;- If patient shows signs of unsteady gait or falls Assessment Level 4, refer back to MOBILITY LEVEL 3; patient is MOBILITY LEVEL 3.</td>
<td>Passed Assessment Level 3 AND no assistive device needed to ambulate; use your best clinical judgment to determine need for supervision during ambulation.</td>
</tr>
</tbody>
</table>

Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt about the patient’s ability to perform the task.
GET-UP MUST DO’S!

1. Walk in, walk during, walk out!
2. Grab and Go Mobility Aids!
3. (3) laps a day keeps the nursing home at bay!
Tips for Promoting Mobility

Order Modifications
- Delete orders for
  - Bedrest
  - Ad lib
- Replace with specific orders
  - Times, activities, distance

Promote Team Mobility Management
- Delegation of patient mobility
  - Replace sits with a mobility aide
- Define patients mobility abilities on whiteboard
- Rehab and Nursing face-to-face bedside handoffs
Developing our Culture of Mobility: A Journey by Franciscan Health Michigan City, Indiana

PRESENTED BY: BROOKE NACK, PT
INPATIENT THERAPY MANAGER
MOBILITY PROGRAM MANAGER
Our Mobility Committee

“We have an idea…”
Motivation to move... our lit review

“A study of 45 elderly patients on a general medical unit, who had neither delirium or dementia and were able to walk prior to admission, found that they spent 20 out of every 24 hours in bed over the mean 5.1 days they were in the hospital.”

Wood et al. A mobility program for an inpatient acute care medical unit. AJN. 2014; 114(10)34-40.
What does a Culture of Mobility look like?

THE PROVIDER APPROACH

• All providers set patient/family expectations to MOVE
• Barriers to mobility are recognized and removed
• Providers hold each other accountable to achieve highest level of mobility
• Providers help each other mobilize patients
• All providers advocate for patient mobility
• Systematic use of mobility data and language
• Direct care providers know pre-admission and current mobility levels
• Medical and pharmacological management supports mobility

THE PATIENT EXPERIENCE

• Patients eat all meals in a chair unless they can’t
• Mobile patients walk out of their room every day, including day of admission
• Necessary mobility equipment is at every bedside
• Families participate in patient mobility
• Mobility status, precautions, and projected discharge date is visible at bedside
Who owns mobility?

- Physicians?
- Nurses?
- Patients?
- Therapists?
- Families?
- Administration?
What a team approach to mobility looks like

Patient performs highest mobility at least 3x/day with assistance of appropriate provider.

Therapy Orders generated by Mobility Reconciliation.

Nurse Assesses Mobility.
# Common early mobility scales and team goals

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Team Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One</td>
<td>Minimally Conscious/Bedbound</td>
<td>Stability and Range of Motion</td>
</tr>
<tr>
<td>Level Two</td>
<td>Bed Mobility</td>
<td>Trunk strength and Readiness to bear weight</td>
</tr>
<tr>
<td>Level Three</td>
<td>Mobility in Room</td>
<td>Weight bearing and Transfers to a chair</td>
</tr>
<tr>
<td>Level Four</td>
<td>Ambulation and Self Care</td>
<td>Increase gait distance and Resume ADL’s</td>
</tr>
</tbody>
</table>
Rate your patient’s Mobility Level

**Level Zero (0):**
Vital signs unstable, patient may not be conscious

**Level One (1):**
Needs two assist to sit patient on edge of bed

**Level Two (2):**
Dangles on edge of the bed with assist x 1; holds at least one leg up, indicating strength to stand

**Level Three (3):**
Stands with assist or device for 2 minutes OR walks in room with assist or device

**Level Four (4):**
Walks in the hallway ("out the door") with or without assistance or a device
Mobility scale trial data

ACTIVITY LEVEL AT HOME

Home Function by Self-Report

ACTIVITY LEVEL USING CARE MAP

Current Function by Nursing Assessment Using Care Map
Implementation Timeline

Culture of Mobility

- Administrative Approval and Position Requests
- Staff Surveys: Mobility Needs and perceptions.
- Mobility Team
  1. Policies
  2. Job Descriptions
  3. Create Staff and patient Education Materials
- MOBILITY CARE MAP GO-LIVE
- Med Exec approval then Announce and Interview for Positions
- 7-6-15 Patient Engagement Video Shoot
- 9-1-15 MOBILITY CARE MAP GO-LIVE
- 10-1-15 MOBILITY TEAM GO-LIVE
- Analyze 4th Quarter 2015 Results
- 4-1-16 Assess performance
### Cost savings through reduced adverse events

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Current Rate</th>
<th>Target (every year for 5 years)</th>
<th>Cost per Event</th>
<th>Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers</td>
<td>Per 1000 patients</td>
<td>↓ 10%</td>
<td>Facility Specific</td>
<td></td>
</tr>
<tr>
<td>Hospital-Acquired pneumonia</td>
<td>Per 1000 patients</td>
<td>↓ 10%</td>
<td>Facility Specific</td>
<td></td>
</tr>
<tr>
<td>DVT</td>
<td>Per 1000 patients</td>
<td>↓ 10%</td>
<td>Facility Specific</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>Per 1000 patients</td>
<td>↓ 10%</td>
<td>Facility Specific</td>
<td></td>
</tr>
</tbody>
</table>

“If he has a bedsore, it’s generally not the fault of the disease, but of the nursing”

- Florence Nightingale, 1859

Nightingale F. Notes on nursing. Philadelphia: Lippincott; p. 1859
Cost savings through employee safety and engagement

<table>
<thead>
<tr>
<th>Metric</th>
<th># of Employees</th>
<th>Target (every year for 5 years)</th>
<th>Cost per Event</th>
<th>Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers’ Compensation: Low Back Pain</td>
<td>Facility Count per targeted unit(s)</td>
<td>↓ 10%</td>
<td>Facility Specific stratified by event type</td>
<td></td>
</tr>
<tr>
<td>Worker Retention Rate (RN/CNA/other)</td>
<td>Facility Count per targeted unit(s)</td>
<td>↑ retention by 5%</td>
<td>Replacement of position cost</td>
<td></td>
</tr>
</tbody>
</table>
Evidence-based goals for mobility program ROI

<table>
<thead>
<tr>
<th>Factor</th>
<th>Early Mobility in ICU</th>
<th>Medical-Surgical Culture of Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay</td>
<td>↓ ICU LOS by 22%</td>
<td>↓ Total LOS by .4 days</td>
</tr>
<tr>
<td></td>
<td>↓ Total LOS by 20%</td>
<td></td>
</tr>
<tr>
<td>30 Day Readmissions</td>
<td></td>
<td>↓ probability 10—20%</td>
</tr>
<tr>
<td>Hospital Mortality Rate</td>
<td>↓ 10%</td>
<td></td>
</tr>
<tr>
<td>Sources:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evidence-based goals for mobility program ROI

<table>
<thead>
<tr>
<th>Factor</th>
<th>Early Mobility in ICU</th>
<th>Medical-Surgical Culture of Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall rate</td>
<td>Early mobility is not associated with higher risk of adverse events</td>
<td>Reduced fall rate from 6 falls to 1 fall every 2 months on a Gero-psych unit</td>
</tr>
</tbody>
</table>
Nursing opinion survey

Please rate your response about the **CURRENT** barriers related to patient mobility:

1. I always get enough information about how each patient moves

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

2. I have had enough training in safe mobilization techniques

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

3. I have enough equipment to move patients safely

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

4. I believe that if I help patients get up more they are more likely to fall

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please rate your response about the **FUTURE** benefits related to Mobility Master teams:

6. I believe that having Mobility Masters would improve my job satisfaction.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

7. If we were to hire “Mobility Masters” to mobilize patients 2 x daily and expect Nursing/unit PCAs to ambulate/mobilize at least one episode a day, which shift time listed below would be the most advantageous for the Mobility Masters to work?

   a) 8:00 am to 4:30 pm
   b) 11:00 to 7:30 pm
   c) 10:00 to 6:30 pm
   d) other (propose a new shift time: ______________________)
### Nursing survey results

<table>
<thead>
<tr>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>Neg Response</th>
<th>4</th>
<th>5</th>
<th>Pos. Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I always get enough information</td>
<td>3</td>
<td>11</td>
<td>14</td>
<td>20</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>I have had enough training</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>18</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>I have enough equipment</td>
<td>2</td>
<td>15</td>
<td>17</td>
<td>16</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>I believe patients are more likely to fall</td>
<td>17</td>
<td>15</td>
<td>32</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>I believe patients are resistant, so low satisfaction</td>
<td>17</td>
<td>16</td>
<td>33</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Mobility Masters = higher job satisfaction</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>15</td>
<td>17</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schedule</th>
<th>8-4:30</th>
<th>11-7:30</th>
<th>10-6:30</th>
<th>Write in 9-5:30</th>
<th>Later: Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>20</td>
<td>12</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best result of Mobility Team:</th>
<th>Job satisfaction</th>
<th>Teamwork</th>
<th>Pt satisfaction</th>
<th>Healthcare Org</th>
<th>Hope</th>
<th>All of the above</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>10</td>
<td>8</td>
</tr>
</tbody>
</table>
“Move Me”: Engaging our peers and our patients...

https://www.youtube.com/embed/e6BOqd0JPwc?rel=0
Key messages within mobility competence programs

**NURSING**

• Promote patient activity level “*within your nursing care*”

• Only rate what actually occurred/what the body experienced

• Keep the patient informed of the mobility goal and the current level

• A mobile patient makes nursing easier

• Apply what you know about one diagnostic group (CABG) to all others

• Trust your clinical decision making using the Care Map

**THERAPY**

• Stop owning mobility

• A team approach to mobility supports therapy, this is not a competition

• Address mobility from a laymen’s perspective

• Use your skills to equip others

• Don’t forget patient lift assist devices (Sara Steady)

• Provide specific examples of skilled vs. unskilled mobility services
Skills-development for progressive mobility...

Having a Little Fun
# Nursing mobility skills assessment

**Method of Instruction Key:**
- **P** = Policy/Procedure Review
- **C** = Classroom/Lecture
- **D** = Demonstration
- **R** = Role-Play/Simulation

**Method of Evaluation Key:**
- **O** = Observation (in clinical setting)
- **RD** = Return Demonstration
- **T** = Written Test
- **V** = Verbalized Understanding

<table>
<thead>
<tr>
<th>Employee Self-Assessment</th>
<th>Never Done</th>
<th>Needs Review/Practice</th>
<th>Competent</th>
<th>Method of Instruction (Use Instruction Key on Left)</th>
<th>Able to Perform Without Cueing or Prompts</th>
<th>Evaluation Method (Use Evaluation Key on Left)</th>
<th>Referred to CNS or Educator for Remediation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides verbal education about benefits of mobility</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Explain procedure to the patient/family</td>
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<tr>
<td>Applies gait belt and uses it safely</td>
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<tr>
<td>Selects medical equipment appropriate for Mobility Level</td>
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<tr>
<td>Recognizes and complies with mobility precautions</td>
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<tr>
<td>Utilizes safe lifting techniques for patient</td>
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<tr>
<td>Utilizes appropriate body mechanics for staff safety</td>
<td></td>
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<tr>
<td>Progresses mobility to highest level on Care Map</td>
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<tr>
<td>Accurately rates mobility on the 1-4 Mobility Scale</td>
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<tr>
<td>Recommends appropriate activity for Mobility Level</td>
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<tr>
<td>Documents mobility appropriately on white board in room</td>
<td></td>
<td></td>
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<tr>
<td>Documents mobility appropriately in medical record (EPIC)</td>
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<tr>
<td>Sets up the patient safely upon completion of mobility</td>
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<tr>
<td>Establishes the patient's expectation for next mobility episode</td>
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</tr>
<tr>
<td>Provides a verbal report including Mobility Level and time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mobility Program:**

<table>
<thead>
<tr>
<th>Date and Initials</th>
<th>Date notified and Initials</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td></td>
</tr>
<tr>
<td>Preceptor/Mentor</td>
<td></td>
</tr>
<tr>
<td>Nurse Manager</td>
<td></td>
</tr>
</tbody>
</table>
From an idea to reality...introducing our mobility team
## Day One Results

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility Level reported in Interdisciplinary rounds</td>
<td>96%</td>
</tr>
<tr>
<td>Mobility Level written on Board in Room</td>
<td>53%</td>
</tr>
<tr>
<td>Mobility Documentation by nursing matches reported Levels and is completed during day shift</td>
<td>63%</td>
</tr>
</tbody>
</table>

### Methods to Promote Compliance

1. Feedback of performance provided to unit managers
2. Transparency of performance across units
3. Celebration of nurses with 100% compliance
4. Leadership presence and rounding on the units
5. Mobility Committee attends interdisciplinary rounds
# MOBILITY PROGRAM RESULTS

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Pilot Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IMCU</td>
</tr>
<tr>
<td>Length of Stay (in days)</td>
<td>-0.2</td>
<td>-0.25</td>
</tr>
<tr>
<td>Hospital Aquired Pressure Ulcers</td>
<td>-10%</td>
<td></td>
</tr>
<tr>
<td>Fall Rate</td>
<td>-10%</td>
<td></td>
</tr>
<tr>
<td>Worker Back Injuries</td>
<td>-10%</td>
<td></td>
</tr>
<tr>
<td>Nursing Turnover Rate</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>CNA Turnover Rate</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>Unspecified</td>
<td>-42.9%</td>
</tr>
<tr>
<td>Discharge to SNF</td>
<td>Unspecified</td>
<td></td>
</tr>
</tbody>
</table>
## Mobility Program Survey Results

<table>
<thead>
<tr>
<th>Question</th>
<th>NURSING STAFF</th>
<th>NON-NURSING PROFESSIONALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree/Strongly Agree (n = 38-41)</td>
<td>Disagree/Strongly Disagree (n = 1-3)</td>
</tr>
<tr>
<td>Patients receive more opportunities to move since Mobility Team</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>My patients are satisfied with the Mobility Team</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>The Mobility Team safely mobilizes patients</td>
<td>97%</td>
<td>3%</td>
</tr>
<tr>
<td>Parts of my job are easier because we have a Mobility Team</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td>The Mobility Team has contributed to my job satisfaction</td>
<td>92%</td>
<td>8%</td>
</tr>
<tr>
<td>The Mobility Team contributes positively to DC planning</td>
<td>93%</td>
<td>7%</td>
</tr>
</tbody>
</table>
Mobility Program Survey Results
April 2016

• I see so many more patients now up in chairs and walking the halls. Great job! I think as the Mobility Team continues to work with our patients the need will increase even more. It will become the norm which is wonderful. Great program! (CNA)

• Early Mobilization and discharge… Patients do get better with early ambulation. (RN)

• Best results are decreased decubiti, decreased aspiration and overall reduced LOS. Excellent idea. Well managed and standardized. Easy to follow process. One of my favorite projects that helped my patients tremendously. (Hospitalist)
Conclusion

It is feasible and effective for both community and university based healthcare organizations to make great strides in developing a Culture of Mobility.

A systematic team approach to mobility is key to a sustainable value and values based approach to preventing hospital acquired conditions.

Franciscan Health Michigan City’s Mobility Program is recognized as the Innovation Award winner by the Indiana Hospital Association at the Safety Summit on June 6, 2017.

For further information on Franciscan’s Mobility Program, contact

Brooke Nack, Inpatient Therapy Manager

Brooke.nack@franciscanallinace.org

219-877-1133


6. Friedman M, Stilphen M. Establishing a Culture of Mobility in the Hospital Setting. Presented at APTA Combined Sections Meeting Indianapolis, IN. 2015 Feb 4-7.
The Sky is the Limit!
Thank You