Indiana’s Bold Aim

To make Indiana the safest place to receive health care in the United States... 

*if not the world*
Agenda

- Welcome and Introductions
- Get UP Campaign
- Guest Speaker Theresa Murray, RN, MSN, CCRN, Critical Care Clinical Nurse Specialist
- Resources and Support
- Get Up Webinar Series
Polling Question #1

What is your role within your organization?

- Infection Preventionist
- Nursing Professional
- Laboratory Professional
- Medical Staff
- Physical Therapy Professional
- Environmental Services/Housekeeping Professional
- Other
UP Campaign
Early Progressive Mobility

- Falls
- Pressure Ulcer and Injury
- Delirium
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Ventilator-Associated Events (VAE)
- Venous Thrombo-Embolism (VTE)
- Readmissions

GET UP

IHAnet.org/Quality-Patient-Safety
UP Campaign

**Goal**: Simplify safe care and streamline cross-cutting interventions to reduce the risk for multiple patient harms
Up Campaign Schedule

- Supports Hospital Improvement Innovation Network (HIIN) harm reduction efforts
- Strategic Deployment of Three Campaigns:
  - SOAP UP
  - GET UP
  - WAKE UP

IHAconnect.org/Quality-Patient-Safety
Did you know.....

Potential Complications of Immobility

Respiratory: pneumonia, atelectasis, and pulmonary embolism

Neurological: depression and anxiety

Cardiovascular: postural hypertension, cardiac muscle atrophy, and deep vein thrombosis

Musculoskeletal: osteoporosis, muscle atrophy and weakness, contractures

Metabolic: glucose intolerance and negative nitrogen balance

Renal: calculi and nephritis

Skin: pressure ulcers

Gastrointestinal: constipation and fecal impaction
Results of Falls Checklist Survey

Q5 To help us better understand the Fall Prevention work in Indiana, please check all that are currently underway in your organization. Please include any work that doesn’t fit into one of the listed categories in the "other" box.

Answer Choices

- Have a multidisciplinary falls team with an executive sponsor, front-line staff from nursing and rehab, management support, physical therapy, physician and pharmacy representatives to oversee the strategic plan for the fall injury prevention program.
- Engage all levels of staff and disciplines in creating a safe environment that is free of tripping and slipping hazards and is responsive to patient needs, i.e., “no pass zone” and environmental rounds. Review all falls in leadership huddles to raise awareness of hazards and contributing factors.
- Identify high-risk/vulnerable populations upon admission to receive a multifactorial falls assessment. Do not rely on a risk score alone. Examples: patients admitted with a fall, patients with a history of fall in the past six months, patients over 65, ABSC criteria, depending upon the population served.
- Provide multifactorial assessments and targeted interventions for high risk or vulnerable elderly patients. Assess for and address risk factors associated with fall, balance and mobility, medications, cognitive assessment, heart rate and rhythm, postural hypotension, feet and footwear and home environment hazards.
- Communicate risk across the team: EMR Banners, hand-offs, visual cues, huddles and whiteboards.
- Round every one to two hours on patients; address the five P’s – pain, position, personal belongings, pathway and potty. Escalate rounding frequency to meet patient needs.
- Implement mobility plans for all patients to preserve function and prevent hazards of immobility: rehab referral and collaboration for a progressive activity and ambulation program.
- Review medications – avoid unnecessary hypnotics and sedatives and remove culprit medications from order sets. Target high-risk or vulnerable patients for pharmacist medication review.
- Include patients, families and caregivers in efforts to prevent falls. Provide structured education apart from admission orientation. Educate using teach-back regarding fall prevention measures and encourage family members to stay with high-risk, vulnerable patients.
- Conduct post-fall huddles at the bedside with patient and family immediately after the fall to analyze how and why the fall occurred, and implement change(s) to prevent future falls. Include a pharmacist and rehab staff member in the post-fall huddle or case review.
- Other (please specify)

Total Respondents: 22
Guest Speaker

Theresa Murray MSN,RN, CCRN,CCNS
Community Health Network
Indianapolis, IN
Start Walking: Improving Outcomes Through Use of an Early Progressive Mobility Program

Theresa Murray MSN,RN, CCRN,CCNS
Community Health Network
Indianapolis, IN
Challenge, Journey, Evolution

• Everest is 29,035 ft. = 5 ½ miles
• 7,001 summits through August 2015
  • 1923-1999: 1,169 summits; 170 deaths; 14.5% mortality rate
  • 2000-2015: 5,832 summits; 112 deaths; 1.9% mortality rate

• Mortality rates in patients admitted to adult ICUs average 10% to 29%
• Study shows decrease in ICU length of stay, falls post ICU, and hospital length of stay
• Ultimately reduce readmissions and the mortality rate based on ICU stay
Study Purpose and Objectives

- This randomized, IRB approved study, looked at active progressive mobility with the goal to prevent deconditioning and the resultant negative outcomes (12 bed ICU)
  - falls
  - increased length of stay
  - readmission
- This progressive mobility program followed the patients throughout their hospital stay.
Study Investigative Team

• Study Principle Investigator: Theresa Murray
• Co Investigators: Marianna Schneider, Sue Heinzman, Deb Ferguson
• Rehabilitation Study Team: Wilfredo Geronimo PT, Janet Dawes OTR, Marcia Shumaker OTR (labor team)
• Erin Gill RN, Miranda Bailey RN, Ebony Brown RN
• Physician Champion: Bassam Helou MD
• All CHE inpatient staff
• Kanitha Phalakornkule – Statistical researcher
Patient Risk Factors

• Immobility
• Number of days on mechanical ventilation/VAE’s
• Length of stay in the ICU
• Heavy sedation
• Delirium *mobility
Early ICU Mobility Therapy

• Baseline characteristics similar in both groups

• Protocol group:
  • Received as least 1 PT session vs. usual care (80% vs. 47%, p ≤ .001)
  • Out of bed earlier (5 vs. 11 days, p ≤ .001)
  • Reduced ICU LOS (5.5 days vs. 6.9 days, p=.025)
  • Reduced Hospital LOS ( 11.2 days vs. 14.5 days, p = .006)
  • No adverse outcomes;
    • Most frequent reason for ending mobility session was patient fatigue
  • Cost
    • Average cost per patient was $41,142 in the protocol group
    • Average cost per patient was $44,302 in the control group

Determining Readiness

- Perform Initial mobility screen w/in 8 hours of ICU admission & Reassess mobility level at least q 24 hrs (recommended at shift change)

- PaO2/FiO2 ≥ 250
- Peep <10
- O2 Sat ≥ 90%
- RR 10-30
- No new onset cardiac arrhythmias or ischemia
- HR >60 <120
- MAP >55 <140
- SBP >90 <180
- No new or increasing vasopressor infusion
- RASS ≥ -3

Patient Stable, Start at Level II & progress

Patient is unstable, start at Level I & progress

The Progressive Mobility Continuum

<table>
<thead>
<tr>
<th>Patient Assessment</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
<th>Level V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes samples/selected, hemodynamically unstable and stable (selected patients); may include non-selected</td>
<td>RASS -3 to -3</td>
<td>RASS 3 up</td>
<td>RASS 1 up</td>
<td>RASS 0 &amp; up</td>
<td>RASS 0 &amp; up</td>
</tr>
<tr>
<td>Includes intubated, non-selected hemodynamically stable (selected patients); no contraindications</td>
<td>RASS 3 up</td>
<td>RASS 1 up</td>
<td>RASS 0 &amp; up</td>
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**START HERE**
Perform initial mobility screen within 6 hours of ICU admission.

Date:

**Resumes mobility level at least 6/24hs. (recommendation: 1hr change)**

**MOBILITY SCREEN**

**MOBILITY SCREEN**

- **Score 0**
- **Score 1**
- **Score 2**

**Patient Assessment**

- **Progress to Level II**
- **Progress to Level III**
- **Progress to Level IV**
- **Progress to Level V**

**Mobility is the responsibility of the RT with assistance from the ITA, IAP, and PT/OT. PT/OT may assist the team with placement to the appropriate mobility level, always prioritizing patient and provider safety. Placement is based on clinical judgement.**
Level I
RASS -5 to -3

Goal: Clinical Stability, Passive ROM, (PT/OT consult PRN)

Maintain HOB > 30°

*PROM 2X/d performed by RN, or UAP

CLRT/Pronation initiated if patient meets criteria based on institutional practice OR
Q 2 hr turning with assist device
### Level II

**RASS -3 & Up**

**Goal:** Upright sitting; increase strength & moves arm against gravity

PT/OT consult prn

<table>
<thead>
<tr>
<th>ACTIVITY:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 2 hr turning with assist device</td>
<td></td>
</tr>
<tr>
<td>*Passive /Active ROM 3x/d</td>
<td></td>
</tr>
</tbody>
</table>

**Progressive Bed Positioning**

1. HOB 45° X 15 min.
2. HOB 45°, Legs in dependant position X 15 min.
3. HOB 65°, Legs in dependant position X 15 min.
4. Step (3) & full chair mode X20 min

Or Full assist into cardiac chair with turn/assist or air transport device 2X/day

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**MOBILITY SCREEN**

- **HOB:**
  - 45°: X 15 min.
  - 65°: X 15 min.

- **Full Chair Mode:**
  - Step (3) & full chair mode X20 min

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**START HERE**

- Perform initial mobility screen within 6 hours of ICU admission.
- Reassess mobility level at least (24hr, recommended at shift change).

**Goal:**

- Increase distance in ambulation and ability to perform some ADLs
- Self or assisted QHR turning
- Up to regular shall lift 3x per day with SPO & chair alarm
- Meals will be consumed while hanging on side of bed or in wheelchair with IV's and chair alarm
- Ambulate with gait belt progressively longer distance with less assistance 2x per day with IV/PW or UAP.

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**Mobility is the responsibility of the TH w/assistance from the STA, UAP, and PT/OT. PT/OT may assist the team with placement to the appropriate mobility level, always prioritizing patient and provider safety. Placement is based on clinical judgement.**
Level III
RASS -1 to up

Goal: Increased trunk strength, moves leg against gravity and readiness to weight bear

PT: active resistance 1x per day, strength exercises; OT: consult PRN

**ACTIVITY:**
- Q 2 hr turning by self or with assist device
- Sitting on edge of bed w/RN, PT, RT assist X 15 min.
  Or
  Pivot to regular chair 2X/d with gait belt, SPD and chair alarm
## Level IV
### RASS 0 & up

**Goal:** stands w/ min. to mod. assist, able to march in place, weight bear and transfer to chair

**PT & OT each daily**

### ACTIVITY:

**Q 2 hr turning by self or with assist device**

**Sitting on edge of Bed with RN, PT, RT present and stand with gait belt assist 3x daily or**

**Regular chair 3x per day with gait belt, SPD and chair alarm**
**Goal:** Increase distance in ambulation & ability to perform some ADLs

**PT & OT each daily**

**ACTIVITY:**

Self or assisted Q 2 hr turning

Up to regular chair

Min. 3X/day with SPD & chair alarm

Meals will be consumed while dangling on edge of bed or in regular chair with SPD & chair alarm

Ambulate with gait belt progressively longer distances with less assistance x3/day with RN/PT/RT

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**Level V**
RASS 0 & up

<table>
<thead>
<tr>
<th>Patient Assessment</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
</tr>
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<tbody>
<tr>
<td>NRS 3-5</td>
<td>NRS 2 &amp; Up</td>
<td>NRS 0 &amp; Up</td>
<td></td>
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</tbody>
</table>

**MOBILITY SCREEN**

- **Mobility Scale**
  - 0-4: 50%
  - 5: 1-10%
  - 6: 10%

- **New motoric score**
  - 7: 40%
  - 8: 20%
  - 9: 10%

- **New strength score**
  - 0: 50%
  - 1: 25%
  - 2: 10%

- **New sensory score**
  - 0: 50%
  - 1: 25%
  - 2: 10%

- **New cognition score**
  - 0: 50%
  - 1: 25%
  - 2: 10%

- **New communication score**
  - 0: 50%
  - 1: 25%
  - 2: 10%

<table>
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<tr>
<th>Mobility Score</th>
<th>Progress to level II</th>
<th>Progress to level IV</th>
<th>Progress to level V</th>
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<td>NRS 3-5</td>
<td>NRS 2 &amp; Up</td>
<td>NRS 0 &amp; Up</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>NRS 3</td>
<td>NRS 2 &amp; Up</td>
<td>NRS 0 &amp; Up</td>
<td></td>
</tr>
<tr>
<td>Level III</td>
<td>NRS 2</td>
<td>NRS 0 &amp; Up</td>
<td>NRS 0 &amp; Up</td>
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</table>

Mobility is the responsibility of the RN unless the patient is RASS 0 & up, or PT/OT. PT/OT may assist the team with placement to the appropriate mobility level, always prioritizing patient safety.
Progressive Mobility: Use of Supports For In-Bed & Out of Bed Mobility

Progression to tolerating turning, upright position, sitting, SOSOB, marching, standing, walking, and out of bed chair sitting can occur quicker through the use of supports.
“Four Cornerstones for Success”

- Evidence Based Practice
- Inter-Professional Teams
- Reduction of Practice Variation
- System Collaboration
Patients in the study

- Control Group
  - 50 patients
    - 34 vents

- Intervention group
  - 47 patients
    - 32 vents

Both groups had similar age ranges, admitting diagnoses, sex
What about falls during the study?

47.0%

Total Falls of Patients who have been transferred from the ICU

Only 2 patients in the study group fell.
Length of Stay Aspects
Control group vs. Study group

- ICU LOS
  - Control: 5.8
  - Study: 7.1

- Vent LOS
  - Control: 7.3
  - Study: 5.3

- Hospital LOS
  - Control: 10.5
  - Study: 8.3
Discharge Disposition

![Discharge Status Chart](chart.png)

**Discharge Status**

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Home with help</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Acute Rehab</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>LTAC/OSH</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>ECF</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>RHC</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>
Readmissions

Graph showing the distribution of discharge admit day for control and intervention groups.

Bar chart indicating the number of patients readmitted within different time frames:
- <5 days: 1 patient
- <10 days: 1 patient
- <15 days: 3 patients
- 16-30 days: 4 patients
- >30 days: 2 patients

The graph on the right shows the distribution of discharge admit day with histograms for control and intervention groups, along with superimposed normal and kernel distributions.
Conclusions

• A progressive mobility program is possible and is found to have beneficial outcomes for all patient types; especially related to prevention of deconditioning (falls), ability to discharge to acute rehab, and less death

• Following the patient throughout the entire LOS engages all levels of caregivers to improve patient outcomes

Opportunities

• Engagement of all members of the care team is necessary

• Meeting with the group at the sharp end regularly to get their feedback on the process is essential

Thank you
Get Up Resources
How Can IHA Help?

• What resources do you need to help with your improvement efforts?
PREVENTING HARM FROM INJURIES FROM FALLS AND IMMOBILITY

FALLS WITH INJURY CHANGE PACKAGE

2017 UPDATE

1. Awareness: A multiphase falls team with an executive sponsor from the chief nursing and retail, management support, physical therapy, physician, and pharmaceutical representatives to oversee the strategic plan for the fall injury prevention program.

2. Engage all levels of staff and抱歉，未能完成。
HRET Change Package-Pressure Ulcers/Injuries

http://www.hret-hiin.org/resources/display/hospital-acquired-pressure-ulcersinjuries-change-package
Teach-Back Tool

http://www.hret-hiin.org/resources/display/hret-hiin-teachback-tool-for-falls-prevention
AHRQ Toolkit-Pressure Injuries

AHRQ Toolkit - Falls

https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html
# AHRQ VAE Guide

**AHRQ Safety Program for Mechanically Ventilated Patients**

**Early Mobility Guide for Reducing Ventilator-Associated Events in Mechanically Ventilated Patients**

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**Daily Data Collection Tools**

Local data should drive all quality improvement efforts. The Daily Early Mobility and Daily Care Processes data collection tools can be used for collecting data on daily patient care activities.

<table>
<thead>
<tr>
<th>Tools</th>
<th>How To Use Them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Early Mobility Data Collection Tool</td>
<td>This tool helps track compliance with each of the evidence-based recommendations for promoting early mobility as well as capturing perceived barriers to early mobilization, events that may occur during the mobilization process, and the level of PT and OT involvement.</td>
</tr>
<tr>
<td>Daily Care Processes Data Collection Tool</td>
<td>This tool helps track the compliance with each of the recommended daily care measures shown to reduce the harms associated with mechanical ventilation.</td>
</tr>
</tbody>
</table>

Social Media Messaging

- IHA has created messaging for both general public, health care providers

- Messaging provided for formats:
  - Twitter
  - Facebook
  - LinkedIn
How are you incorporating GET UP within your organization?

http://www.hret-hiin.org/engage/up-campaign.shtml
GET UP Webinar Series

Nov. 14-HAPU Prevention with Early Mobility

Dec. 12-Multi-disciplinary Approach to Early Progressive Mobility
Our IPSC Team

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