GET UP

December 12, 2017

IHAconnect.org/Quality-Patient-Safety
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
- Brooke Nack, PT MHS, Inpatient Therapy Manager & Bobbi Herron-Foster MS, RN, ACNS-BC, CMSRN
  Franciscan Health Michigan City
- Coming Soon! Wake Up!
- Resources and Support
UP Campaign
UP Campaign

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

[Logo: SafetyMatters]
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

IHAconnect.org/Quality-Patient-Safety
Guest Speakers

Brook Nack, PT MHS, Inpatient Therapy Manager
&
Bobbi J. Herron-Foster MS, RN, ACNS-BC, CMSRN
Franciscan Health Michigan City
Developing our Culture of Mobility

A Journey by Franciscan Health
Michigan City, Indiana

Presented by:
Bobbi Herron-Foster, Clinical Nurse Specialist, Medical Surgical
Brooke Nack, PT Inpatient Therapy/Mobility Program Manager
Mobility matters...Where do we start?
A healthy person loses 3% of his/her muscle strength for each day spent in bed.

Studies show that 83% of a hospital day is spent in bed.
Wood et al. A mobility program for an inpatient acute care medical unit. AJN. 2014; 114(10)34–40.

Post–Hospital Syndrome is an acquired, transient period of vulnerability that is associated with risk for hospital readmission.

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What’s the problem: At Franciscan Health?
We have a long way to go...
Our mobility committee: “We have an idea...”
Getting started…
First steps on our mobility journey

Implementation Process:
1. Interdisciplinary Mobility Committee formed
2. Extensive literature review of current nursing and therapy journals
3. Agreed upon interdisciplinary Mobility Scale
4. Collected baseline data
5. Completed needs assessment
6. Calculated Return on Investment
7. Requested administrative approval to hire Mobility Team and to execute the Implementation Timeline
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.
Who owns mobility?

- Physicians?
- Nurses?
- Therapists?
- Administration?
- Patients?
- Families?
<table>
<thead>
<tr>
<th>Therapy-Driven Model</th>
<th>Nursing Driven Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cost of skilled provider</td>
<td>Only as robust as the nursing staffing grid</td>
</tr>
<tr>
<td>Only as robust as therapy staffing grid</td>
<td>Difficulty balance mobility among other medical priorities</td>
</tr>
<tr>
<td>Limited carryover to other shifts and weekends</td>
<td>High cost provider</td>
</tr>
<tr>
<td>not a 24 hour plan of care</td>
<td>Not considered “the mobility expert”</td>
</tr>
<tr>
<td>Insufficient episodes of mobility to support function</td>
<td></td>
</tr>
</tbody>
</table>
A team approach to mobility

- Patient performs highest mobility at least 3x/day with assistance of appropriate provider
- Nurse assesses mobility
- Therapy orders generated by mobility reconciliation
Team-Driven Model

- Match right skill to right need using lower cost provider to assist mobility when appropriate
- Carryover of routine across shifts/days
- Potential to achieve more frequent episodes of mobility
- Knowledge sharing, support, and engagement
What does a culture of mobility look like?

<table>
<thead>
<tr>
<th>The Provider Approach</th>
<th>The Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>All providers set patient/family expectations to MOVE</td>
<td>Patients eat all meals in a chair unless they can’t</td>
</tr>
<tr>
<td>Barriers to mobility are recognized and removed</td>
<td>Mobile patients walk out of their room every day, including day of admission</td>
</tr>
<tr>
<td>Providers hold each other accountable to achieve highest level of mobility</td>
<td>Necessary mobility equipment is at every bedside</td>
</tr>
<tr>
<td>Providers help each other mobilize patients</td>
<td>Families participate in patient mobility</td>
</tr>
<tr>
<td>All providers advocate for patient mobility</td>
<td>Mobility status, precautions, and projected discharge date is visible at bedside</td>
</tr>
<tr>
<td>Systematic use of mobility data and language</td>
<td></td>
</tr>
<tr>
<td>Direct care providers know pre-admission and current mobility levels</td>
<td></td>
</tr>
<tr>
<td>Medical and pharmacological management supports mobility</td>
<td></td>
</tr>
</tbody>
</table>
You are doing a good job navigating through the wilderness!
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
**Progressive Mobility Continuum**

Nurse performs initial mobility screen during admission assessment to unit.
Nursing staff provide three episodes of the highest mobility level possible per day.

<table>
<thead>
<tr>
<th>Rate of Function</th>
<th>Level 0</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>A week ago (using no more than 1 person’s assistance).</td>
<td>Could you sit on the edge of your bed for 2 minutes?</td>
<td>Could you hold each leg in the air while sitting?</td>
<td>Could you stand for 2 minutes?</td>
<td>Could you walk in your home while using a device?</td>
<td></td>
</tr>
</tbody>
</table>

**Assess Stability**

- Includes complex intubated, hemodynamically unstable and stable intubated patients, may include non-intubated

**Goal:** Clinical stability, passive ROM

**ACTIVITY:**

1. HOB ≥ 30°
2. Passive ROM 2x3d performed by RN or Unlicensed Assistant
3. Turn and position for pressure relief every 2 hours
4. Consider continuous lateral rotation therapy

**Goal:** Upright sitting increase strength and activity to tolerance

**ACTIVITY:**

1. Most meals in supported sit 90°, feeding self
2. At least one meal in dangle or chair
3. Assisted dangle 10 mins up to 3x/d OR
4. Full or mechanical assist into chair 2x/day
5. Assisted dangle 5 min up to 3x/d
6. Educate benefits of upright position

**Goal:** Trunk strength, readiness to weight bear and initiate ADLs

**ACTIVITY:**

1. Stand/walk in room 3x/d (if intubated, consider RT)
2. Meals and bathing in chair
3. Toileting at commode or bathroom favor bedpan
4. Transfer to chair/w/2 assist and gait belt
5. Consider safety alarms when upright
6. Educate safety in upright position

**Goal:** Ambulate in halls and resume ADLs’

**ACTIVITY:**

1. Stand/walk in room 3x/d
2. Educate patient to spend 75% of waking hours out of bed.

**Patient is Stable**

- Yes: Start at level I and progress
- No: Patient unstable, start at level 0

**For each level change allow 5-10 minutes for equilibration before determining the patient is intolerant.

The patient’s intolerance to higher mobility level activities necessitates the placement at lower mobility level.

*Mobility is the responsibility of the RN, with the assistance from the RT’s, PTA’s and unlicensed personnel. Always prioritize patient safety using appropriate technology equipment available. Placement is based on critical judgment.*

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Activity Level at Home

Home Function by Self-Report

Number of Patients

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>1</td>
</tr>
<tr>
<td>Level 2</td>
<td>2</td>
</tr>
<tr>
<td>Level 3</td>
<td>3</td>
</tr>
<tr>
<td>Level 4</td>
<td>29</td>
</tr>
</tbody>
</table>

Activity Level by Unit Staff

Current Function by Treatment Team:
Nursing or Therapy

Number of Patients

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>15</td>
</tr>
<tr>
<td>Level 2</td>
<td>1</td>
</tr>
<tr>
<td>Level 3</td>
<td>5</td>
</tr>
<tr>
<td>Level 4</td>
<td>5</td>
</tr>
</tbody>
</table>

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Mobility scale trial data

Activity Level at Home

Activity Level using Mobility Scale

Home Function by Self-Report

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>1</td>
</tr>
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<td>2</td>
</tr>
<tr>
<td>Level 3</td>
<td>3</td>
</tr>
<tr>
<td>Level 4</td>
<td>29</td>
</tr>
</tbody>
</table>

Current Function by Nursing Assessment Using Care Map

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>3</td>
</tr>
<tr>
<td>Level 2</td>
<td>1</td>
</tr>
<tr>
<td>Level 3</td>
<td>6</td>
</tr>
<tr>
<td>Level 4</td>
<td>25</td>
</tr>
</tbody>
</table>
What facilities can we model?

Cleveland Clinic and its 8 regional hospitals

- Instituted an interdisciplinary mobility program across all sites utilizing AMPAC 6 clicks to communicate mobility status and collect outcome data, emphasizes mobility reconciliation, uses 6 clicks data to drive therapy consultation matching provider and needed skill to the functional level.

Johns Hopkins Hospital (994 acute care beds)

- Instituted a facility wide multidisciplinary mobility program, established an administrative policy, utilized consistent mobility language across providers, provides care map based on mobility status changes emphasis on daily reporting of the highest level of mobility, establishing interdisciplinary EPIC mobility goals, required mobility screening as rationale for EPIC therapy order, emphasizes mobility reconciliation, uses functional status to drive therapy consultation, therapists provide initial and ongoing mobility training to nursing staff.

Advocate Lutheran General Hospital (638 licensed beds)

- Instituted a quality improvement program to reduce fall rate and demonstrated that a Mobility Team “is another fall reduction tool resulting in decreased patient falls...increased cost savings, and patient satisfaction.” (Jezierski). Systematized mobility team consultation and provided 3 weeks

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.


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Implementation timeline

Culture of Mobility

- Administrative Approval and Position Requests
- Mobility Team:
  1. Policies
  2. Job Descriptions
  3. Create Staff and patient Education Materials
- Whole House Mobility Training and Stake-Holder Buy-In
- 10-1-15 MOBILITY TEAM GO-LIVE
- 7-6-15 Patient Engagement Video Shoot
- 9-1-15 MOBILITY CARE MAP GO-LIVE
- 4-1-16 Assess performance
- June
- July
- August
- September
- October
- November
- December
- FIRST QTR ‘16

Med Exec approval then Announce and Interview for Positions

Staff Surveys:
- Mobility Needs and perceptions.

Analyze 4th Quarter 2015 Results

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1. Presentation to key groups:  
   - Clinical Operations Group  
   - Hospitalists  
   - Orthopedic Surgeons  

2. Corporate sponsor in Safe Patient Handling Initiative  

3. Return on Investment presented to Chief Financial Officer  

4. Approval to hire 4.0 FTE’s into Mobility Program
Value of systematic mobility programs

Value Equation

\[
\text{Value} = \text{OUTCOME} - \text{COST}
\]


**Johns Hopkins Mobility Program estimated reducing hospital costs by $800 for patients who improved highest functional level by 1 point on their scale.

Return on Investment

Quantifiable:
Financial analysis to capture savings over expenses. Initial expenses include time for program development, creation of patient and staff education tools, staff training and engagement. Annual expenses include budgeted time for annual competencies and salaries plus benefits of hiring additional staff dedicated to patient mobility.

Cultural:
Collaboration and silo breakdown, team success, morale, employee engagement and satisfaction

# 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% ↓ Total LOS by 20%</td>
<td>↓ Total LOS by .4 days</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>Friedman M &amp; Stilphen M. Creating value by establishing a culture of mobility in the hospital setting. <em>APTA Learning Center Webinar</em>. Available at: <a href="http://www.apta.org/learningCenter">http://www.apta.org/learningCenter</a>, Accessed 5/14/14.</td>
</tr>
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Sources:
## Evidence-based goals for mobility program ROI

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<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>
## 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>Replaceme n of position cost</td>
<td></td>
</tr>
</tbody>
</table>

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Is this topic feeling a little heavy yet?
Foundational Strategies to calculate a realistic ROI

- Know your baseline state and collect real data

- Solicit information from others
  - Finance
  - Quality
  - Satisfaction
  - Human Resources
  - Worker’s compensation
  - “Sister facilities”

- Research evidence-based goals
  - From literature review
  - Contact the experts

- Establish goals that consider evidence, culture, and current outcomes

- Correlate goals to dollars
  - Cost savings through reduced adverse events
  - Cost savings through employee safety and engagement
  - Cost savings associated with higher value care
  - Income generated through changes in therapy (PT/OT) utilization

- Realistically estimate program expenses
## Expenses associated with a Mobility Program

<table>
<thead>
<tr>
<th>Expense</th>
<th>Initial Year Only</th>
<th>Annual Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional salaries and benefits</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Program Planning and Stakeholder engagement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Employee education and training</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Patient engagement materials/resources</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Patient education materials</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Office supplies and duplicating needs</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Compliance and outcome tracking</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Equipment: Minor or Capital</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Putting it all together...

- Net revenue = Income + Cost Savings
- Subtract Expenses
- Calculate Return on Investment
- Identify Break-Even Point
- Track outcomes
- Plan on evaluating performance at 6 months and make nimble adjustments
Hang on for a bumpy ride ahead... Can we really engage our front-line staff??
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
   Strongly Disagree  1  2  4  5  Strongly Agree

2. I have had enough training in safe mobilization techniques
   Strongly Disagree  1  2  4  5  Strongly Agree

3. I have enough equipment to move patients safely
   Strongly Disagree  1  2  4  5  Strongly Agree

4. I believe that if I help patients get up more they are more likely to fall
   Strongly Disagree  1  2  4  5  Strongly Agree

5. I believe patients are resistant to activity so a formal mobility program will decrease patient satisfaction.
   Strongly Disagree  1  2  4  5  Strongly Agree

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.
   Strongly Disagree  1  2  4  5  Strongly Agree

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 task
   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:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>20</td>
<td>12</td>
<td>1</td>
<td>cover</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>

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Best practices of progressive mobility competence

- Use the same Progressive Mobility Scale throughout the System of Care
- Adopt the assumption that patient mobility is a fundamental nursing skill
- Formalize the role of all hands-on care providers in progressive mobility (RN, PCA, PT, OT)
- Approach mobility from the patient’s perspective through the system of care
- Design formats for different disciplines to teach each other and learn from each other
“Move Me”: engaging our peers and our patients...
https://www.youtube.com/embed/e6BOqd0JPwc?rel=0
Key Messages within Mobility Competence

**Nursing**

1. Promote patient activity level: make it part of our nursing care.
2. Only rate the patient’s experience of movement.
3. Inform the patient of the activity goal and current level.
4. Remember: A mobile patient makes our work easier.
5. Apply what we know about one patient group to another.
6. Trust our clinical decisions; Use *Progressive Mobility Continuum* to assess the patient’s Readiness to Move.

**Therapy**

1. We must stop owning mobility.
2. A team approach supports therapy; this is not a competition.
3. Speak language that nurses can understand.
4. Use our skills to equip others.
5. Teach how to use Lift devices like the (SARA Stedy).
6. Provide specific examples of skilled vs nonskilled mobility services.

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Skills—Development for Progressive Mobility…
Have a Little Fun
## Nursing Mobility Skills Check

**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

**Employee Self-Assessment**

<table>
<thead>
<tr>
<th></th>
<th>Never Done</th>
<th>Needs Review/Practice</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Validation of Competency**

- **Able to Perform Without Cuing or Prompts**
- **Evaluation Method** (Use Evaluation Key on Left)
- **Referred to CNS or Educator for Remediation**

### Mobility Program:
- Provides verbal education about benefits of mobility
- Explain procedure to the patient/family
- Applies gait belt and uses it safely
- Selects medical equipment appropriate for Mobility Level
- Recognizes and complies with mobility precautions
- Utilizes safe lifting techniques for patient
- Utilizes appropriate body mechanics for staff safety
- Progresses mobility to highest level on Care Map
- Accurately rates mobility on the 1-4 Mobility Scale
- Recommends appropriate activity for Mobility Level
- Documents mobility appropriately on white board in room
- Documents mobility appropriately in medical record (EPIC)
- Sets up the patient safely upon completion of mobility
- Establishes the patient's expectation for next mobility episode
- Provides a verbal report including Mobility Level and time

**Signature**

<table>
<thead>
<tr>
<th></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>-70%</td>
</tr>
<tr>
<td>Fall Rate</td>
<td>-10%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Worker Back Injuries</td>
<td>-10%</td>
<td>-40%</td>
</tr>
<tr>
<td>Nursing Turnover Rate</td>
<td>-5%</td>
<td>-45%</td>
</tr>
<tr>
<td>CNA Turnover Rate</td>
<td>-5%</td>
<td>-9%</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>-39%</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>Agree/Strongly Agree (n = 14–19)</td>
</tr>
<tr>
<td></td>
<td>Disagree/Strongly Disagree (n = 1–3)</td>
<td>Disagree/Strongly Disagree</td>
</tr>
<tr>
<td>Patients receive more opportunities to move since Mobility Team</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>My patients are satisfied with the Mobility Team</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>The Mobility Team safely mobilizes patients</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Parts of my job are easier because we have a Mobility Team</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>The Mobility Team has contributed to my job satisfaction</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>The Mobility Team contributes positively to DC planning</td>
<td>93%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>
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)
Spreading mobility throughout Franciscan Health
Spreading mobility throughout Franciscan Health
Spreading mobility throughout Franciscan Health

Moving Towards Better Documentation
Great Work on keeping your patients at their highest level of mobility.
Thank you, from your Mobility Team!

BEDREST
What’s my take home?

- Optimizing patient quality of life upon discharge is an important interdisciplinary goal.

- The effects of bedrest can be minimized by the attitude and the culture of our caregiving team.

- Mobility *early in the hospital stay* is most predictive of a good functional outcome.

- Patient mobility is everyone’s priority.

- A strong interdisciplinary team is absolutely necessary to achieve Early and Progressive Mobility of all patients.
The sky is the limit!


For further information on Franciscan’s Mobility Program, contact

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Bobbi.herron@franciscanalliance.org

Brooke Nack, Inpatient Therapy Manager, Mobility Program Manager
Brooke.nack@franciscanalliance.org
219–877–1133
Get Up Resources
How Can IHA Help?

- What resources do you need to help with your improvement efforts?
Another Great Falls Resource
Organizational Assessment Tool for Fall Prevention

SAFE from FALLS 3.0

http://www.hret-hin.org/Resources/falls/16/safe_from_falls_3.0_roadmap.pdf

IHACoconnect.org/Quality-Patient-Safety
Video Tools for Fall Prevention

http://www.hret-hiin.org/resources/display/ucla-critical-thinking-fall-prevention-case-studies
HRET Change Package/Fact Sheet - Falls and Immobility

http://www.hret-hiin.org/topics/injuries-from-falls-immobility.shtml
Teach-Back Tool

http://www.hret-hiin.org/resources/display/hret-hiin-teachback-tool-for-falls-prevention
Pressure Ulcer/Injury Prevention Tools


http://www.hret-hinin.org/resources/display/hospital-acquired-pressure-ulcersinjuries-change-package
AHRQ Toolkits for Falls & Ventilator Acquired Events


https://wwwprofessionals/systems/h.ahrq.gov/ospital/fallpxtoolkit/index.html

https://wwwprofessionals/systems/h.ahrq.gov/ospital/fallpxtoolkit/index.html

IHAconnect.org/Quality-Patient-Safety
IHA Resource Sheet

GET UP

GET UP focuses on mobilizing patients to return to function more quickly.

Keeping a patient mobilized is key to helping them avoid various types of harm. Maintaining a continued emphasis on mobility can assist in the prevention of several harm events. Including CAUTI, delirium, falls, HAPU/L, readmissions, VAE and VTE.

There are many resources available at IHAConnect.org, including those below, to help your organization address these harm events and engage with the UP Campaign.

GET UP Resources

Including IHA Connect Change Exchange, available post webinars and additional resources.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to the UP Campaign</td>
<td><a href="https://www.ihaconnect.org">https://www.ihaconnect.org/</a></td>
</tr>
<tr>
<td>GET UP Virtual Event - May 2023</td>
<td><a href="https://www.ihaconnect.org">https://www.ihaconnect.org</a></td>
</tr>
<tr>
<td>Delirium</td>
<td><a href="http://www.ihttn.org/topics/delirium.html">http://www.ihttn.org/topics/delirium.html</a></td>
</tr>
<tr>
<td>Falls</td>
<td><a href="http://www.ihttn.org/topics/falls.html">http://www.ihttn.org/topics/falls.html</a></td>
</tr>
<tr>
<td>Pressure Ulcers/Injuries</td>
<td><a href="http://www.ihttn.org/topics/pressure-ulcers.html">http://www.ihttn.org/topics/pressure-ulcers.html</a></td>
</tr>
<tr>
<td>Readmissions</td>
<td><a href="http://www.ihttn.org/topics/readmissions.html">http://www.ihttn.org/topics/readmissions.html</a></td>
</tr>
<tr>
<td>VAE</td>
<td><a href="http://www.ihttn.org/topics/vaso-vascular-embolism.html">http://www.ihttn.org/topics/vaso-vascular-embolism.html</a></td>
</tr>
<tr>
<td>VTE</td>
<td><a href="http://www.ihttn.org/topics/venous-thromboembolism.html">http://www.ihttn.org/topics/venous-thromboembolism.html</a></td>
</tr>
</tbody>
</table>

GET UP Resources

View the below resources for information on various harms topics and how increasing mobility can prevent these harms.

Pressure Ulcers/injuries:

Falls:
- Falls Test Performance Worksheet [http://www.ihttn.org/Resources/Falls/17-76-BL-Fall_Performance_Worksheet.pdf](http://www.ihttn.org/Resources/Falls/17-76-BL-Fall_Performance_Worksheet.pdf)
- The Importance of Promotion and Preventing Falls in the Hospital [http://www.ihaconnect.org/journals/innovate/nursing/innovate-nursing/article-abstract/5332265](http://www.ihaconnect.org/journals/innovate/nursing/innovate-nursing/article-abstract/5332265)

CAUTI:

VAE:
- Our Lady of Lourdes Regional Medical Center [http://www.ihttn.org/Resources/vaso/3-16/VAE-Our-Lady-of-Lourdes-Regional-Medical-Center-Care-Study.PDF](http://www.ihttn.org/Resources/vaso/3-16/VAE-Our-Lady-of-Lourdes-Regional-Medical-Center-Care-Study.PDF)
- St. Jude Medical Center VAE Case Study [http://www.ihttn.org/Resources/vaso/15/VAE-St-Jude-Medical-Center-Care-Study.PDF](http://www.ihttn.org/Resources/vaso/15/VAE-St-Jude-Medical-Center-Care-Study.PDF)

Early Progressive Mobility:
- Introduction to Progressive Mobility [http://ccnjournal.com/content/40/2/53](http://ccnjournal.com/content/40/2/53)
- Implementation of Early Exercise and Progressive Mobility: Steps to Success [http://ccnjournal.com/content/30/5/52](http://ccnjournal.com/content/30/5/52)
Social Media Messaging

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

• Messaging provided for formats:
  
  - Twitter
  - Facebook
  - LinkedIn
GET UP Webinar Series

Webinar Dates:

• January 23 at 3 p.m. ET: State of the State: Opioids & ED’s
• February 20 at 3 p.m. ET: Sleep Apnea & Sedation Prevention
• March 6 @ 3pm. ET: To be Determined
• March 20 at 3 p.m. ET: Delirium Assessment, Prevention & Management
How are you incorporating GET UP within your organization?

http://www.hret-hiin.org/engage/up-campaign.shtml
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