Get UP to Drive Harm Down

ND Webinar

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American Hospital Association

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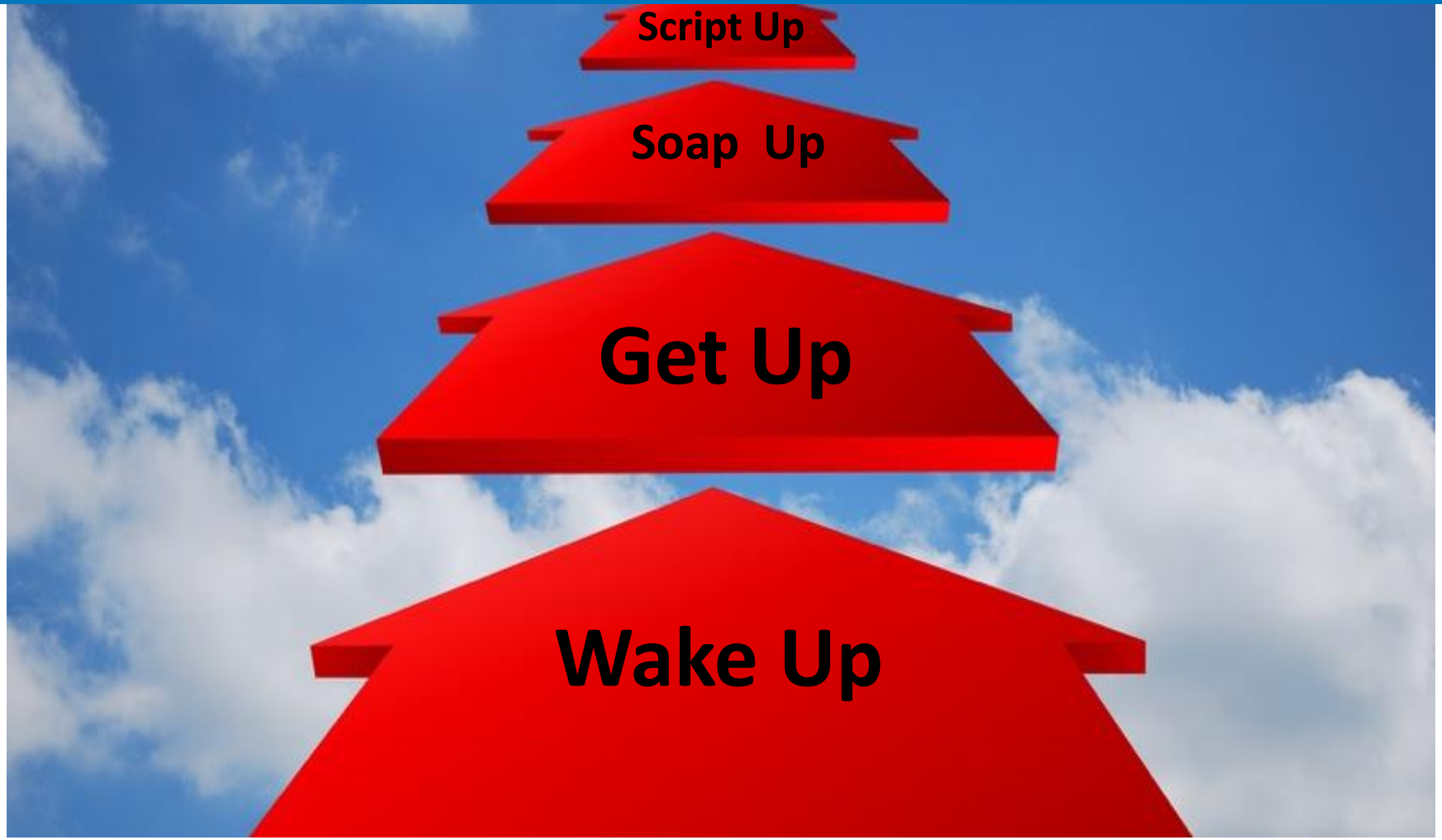
What is your role in your organization?

- Quality Leader
- RN
- MD
- Rehab specialist
- RT
- Other- please chat in your role

A Fresh Approach to Harm Reduction



The Way UP

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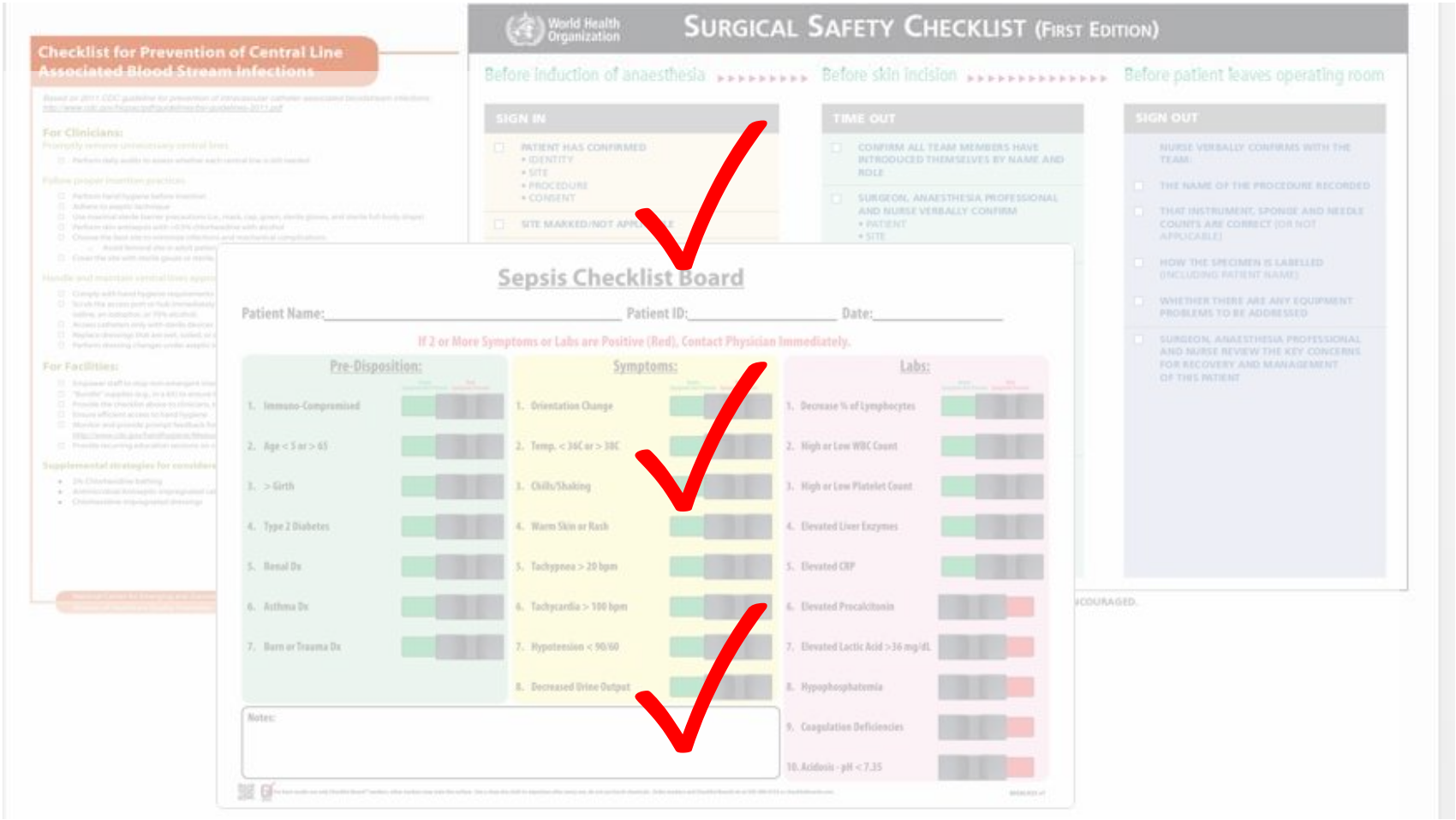
Can we streamline and simplify making it easier for front-line staff and still improve safety?

Why Incorporate UP?

- Patient safety with UP & checklists together!
  - Checklists have been integrated into many processes (necessary).
  - Have staff become too task- focused?
  - UP enhances critical thinking.
  - UP & checklists create synergy for patient safety.

Goal – engage front-line staff and leaders and to increase critical thinking skills.

Are Checklists Enough?



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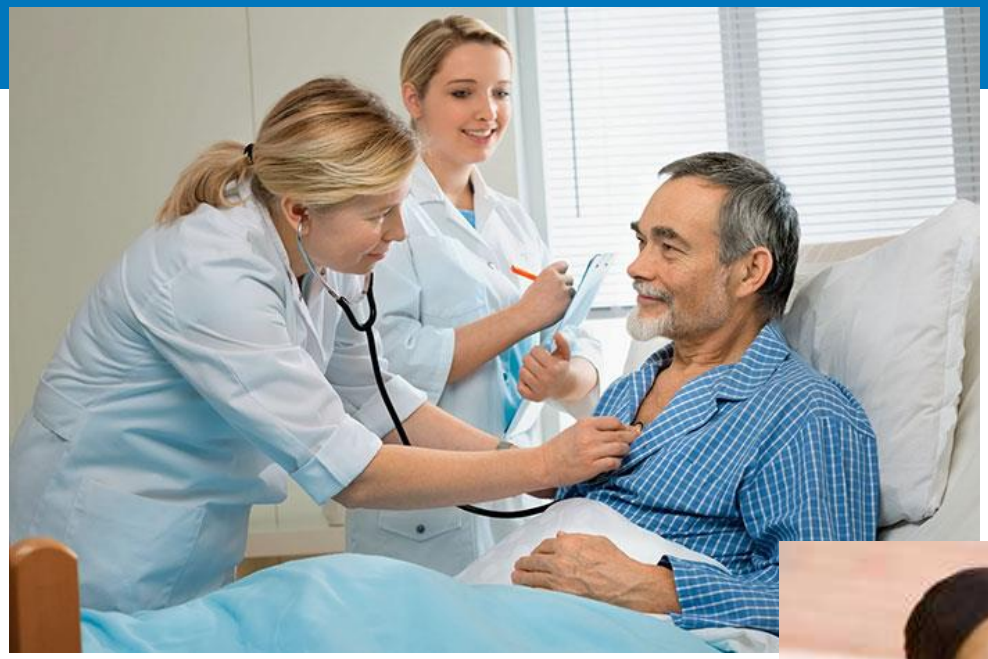

We may be inadvertently reducing the joy in work by adding successive, well evidenced tools that becomes a growing burden in the work flow of our front-line caregivers.

Why the "UP" Campaign?

- Increases impact on harm reduction
- Generates momentum in your organization
- Focuses support from leadership
- Engages front line staff
  - connects the dots
  - creates a vision
- Applies throughout organization
- Simplifies patient safety implementation
- Help patients recover **faster** and with **fewer** complications

Objectives

- Identify essential next steps for Get-UP
- Understand the risk of forced immobility for inpatients
- Optimize team coordination to enhance mobility for patients

Survey Says!

- ✓ Do you have a mobility team? **12.5%**
- ✓ Do you have a mobility protocol? **12.5%**
- ✓ Have you clearly identified staff that have the capacity to ambulate patients daily? **50%**
- ✓ Do your nurses or rehabilitation/physical therapists evaluate each patient's mobility status upon admission? **50%**
- ✓ Do you have safe patient handling and movement training for nursing and assistive staff? **42.8%**
- ✓ Is mobility equipment readily available for nurses and patients to access? (canes, walkers, lifting and safe patient handling devices, gait belts) **75%**
- ✓ Do you have a way to document and monitor daily mobility? **75%**

2 Early Progressive Mobility

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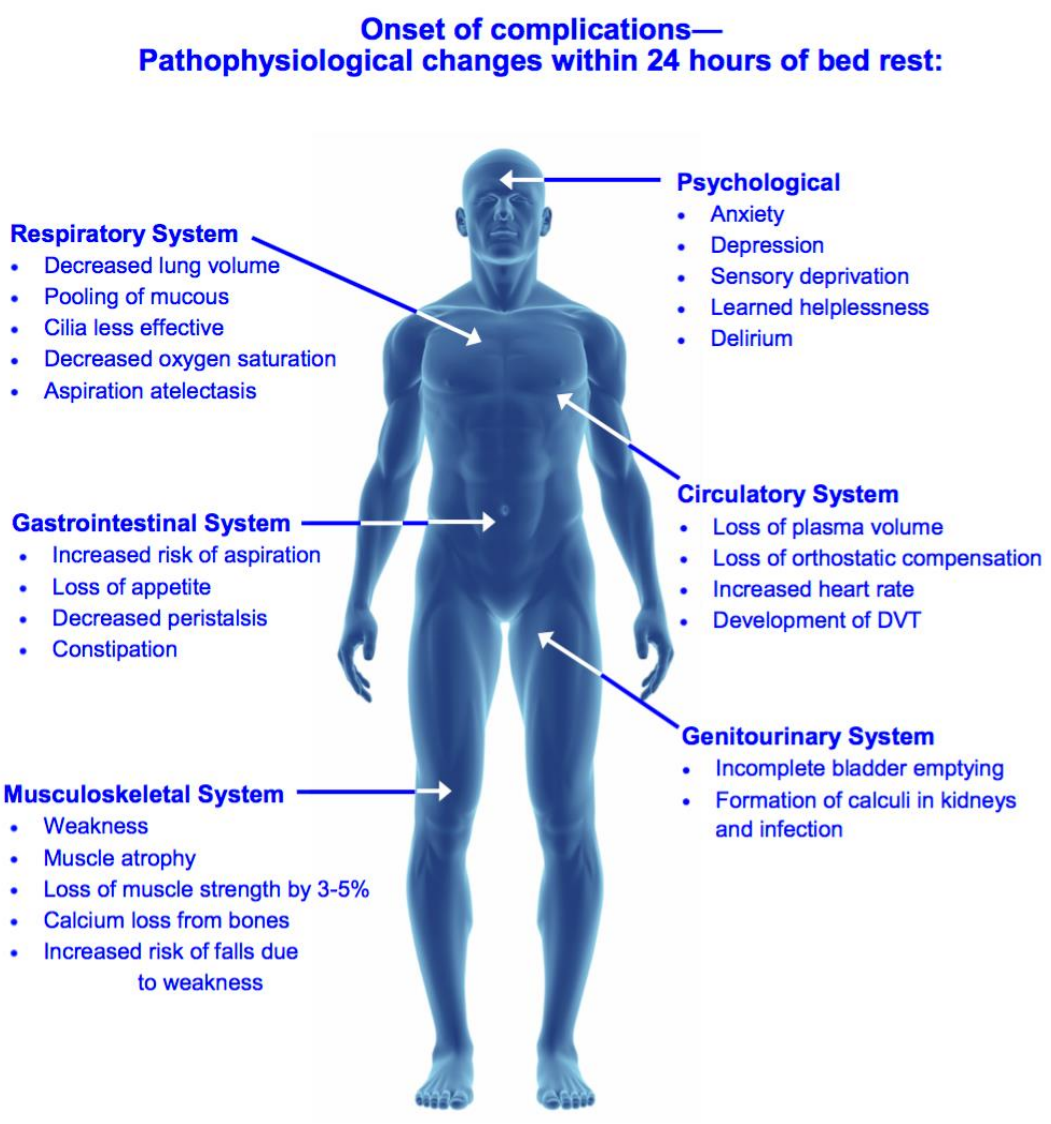
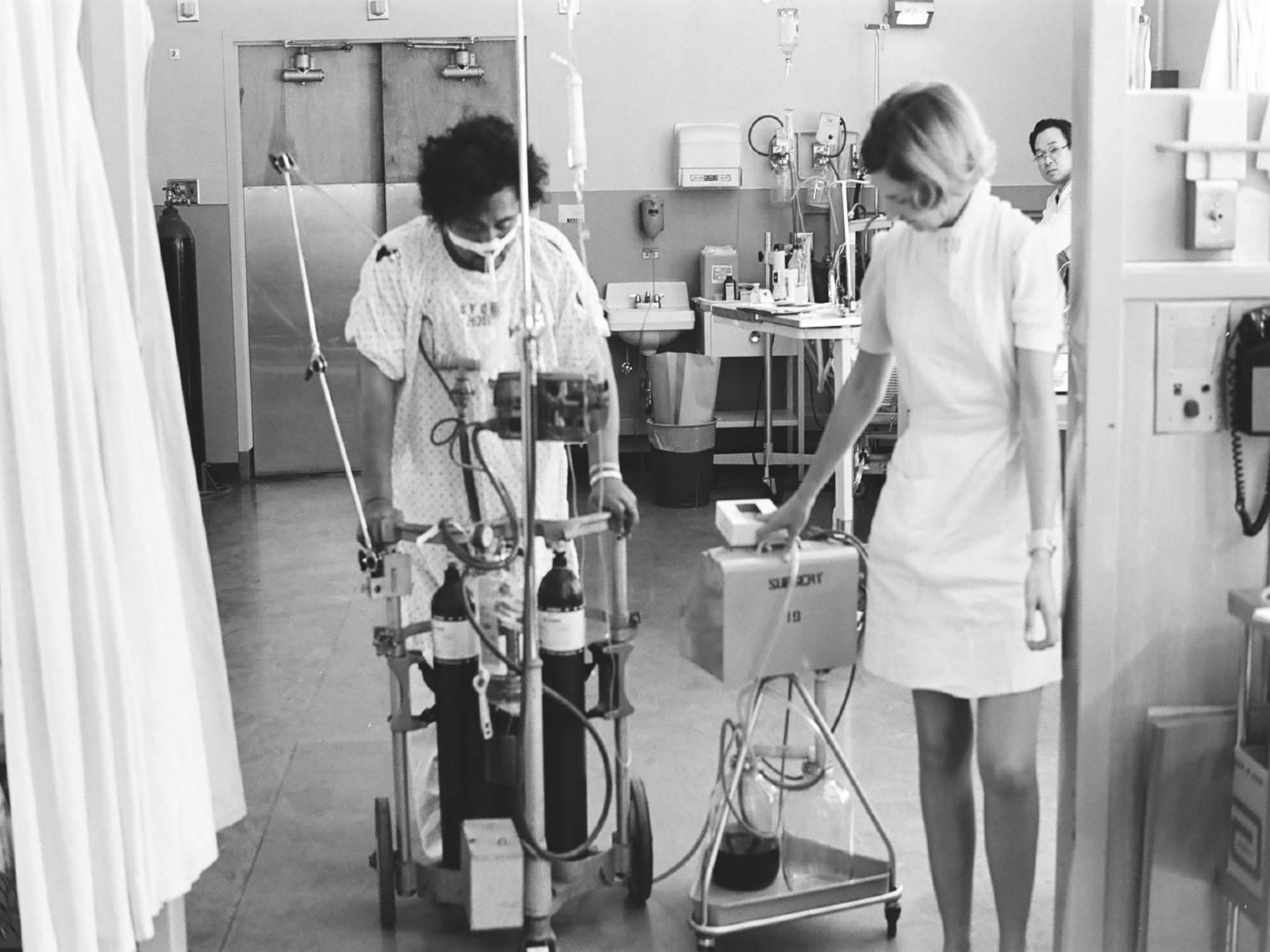
Pathophysiological changes within 24H of bed rest





Forced immobility is causing harm

- "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)

Facing the Facts about Mobility

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

Tips to Promote mobility

- Delegation of patient mobility
  - Replace sitters with a mobility aide
  - Train sitters to ambulate patients
  - Create mobility tech role
- Rehab and Nursing face-to-face bedside handoffs
  - Document plans and progress on white boards

Doherty-King, B Bowers, B. How nurses decide to ambulate hospitalized older adults: development of a conceptual model. Gerontologist. 2011 Dec:51(6): 786-97

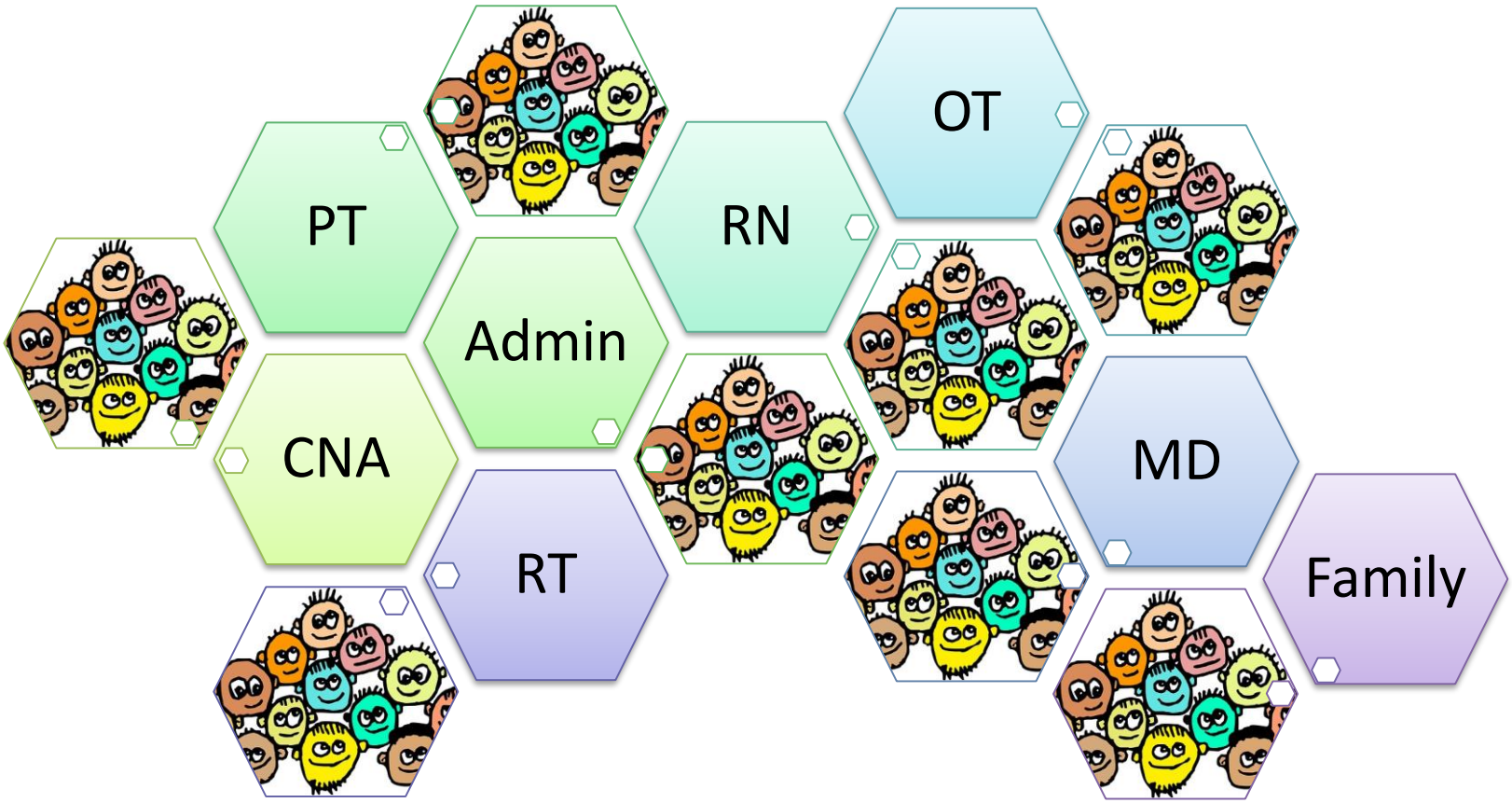
It’s Simple

If they came in walking, keep them walking

Use mobility to accelerate progress

"When am I going to walk? I walked yesterday. It's better than just being in the chair. I feel better when I am walking."

TEAMING UP TO MOBILIZE



Who ambulates patients in your facility?

- PT
- RN
- Whoever has time
- Mobility tech
- Volunteer
- Other- chat in the response

MUST DO's

GET-UP MUST DO'S!

1. Walk in, walk during, walk out!
2. Belt and bolt!
3. Three laps a day keeps the nursing home away!

MUST DO #1
Walk In, Walk During, Walk Out!

- Determine pre admission ambulation status
- Don’t assume a frail appearance means weakness
- Use Get Up and Go or BMAT test to assess ambulation skills

Get Up and Go Test

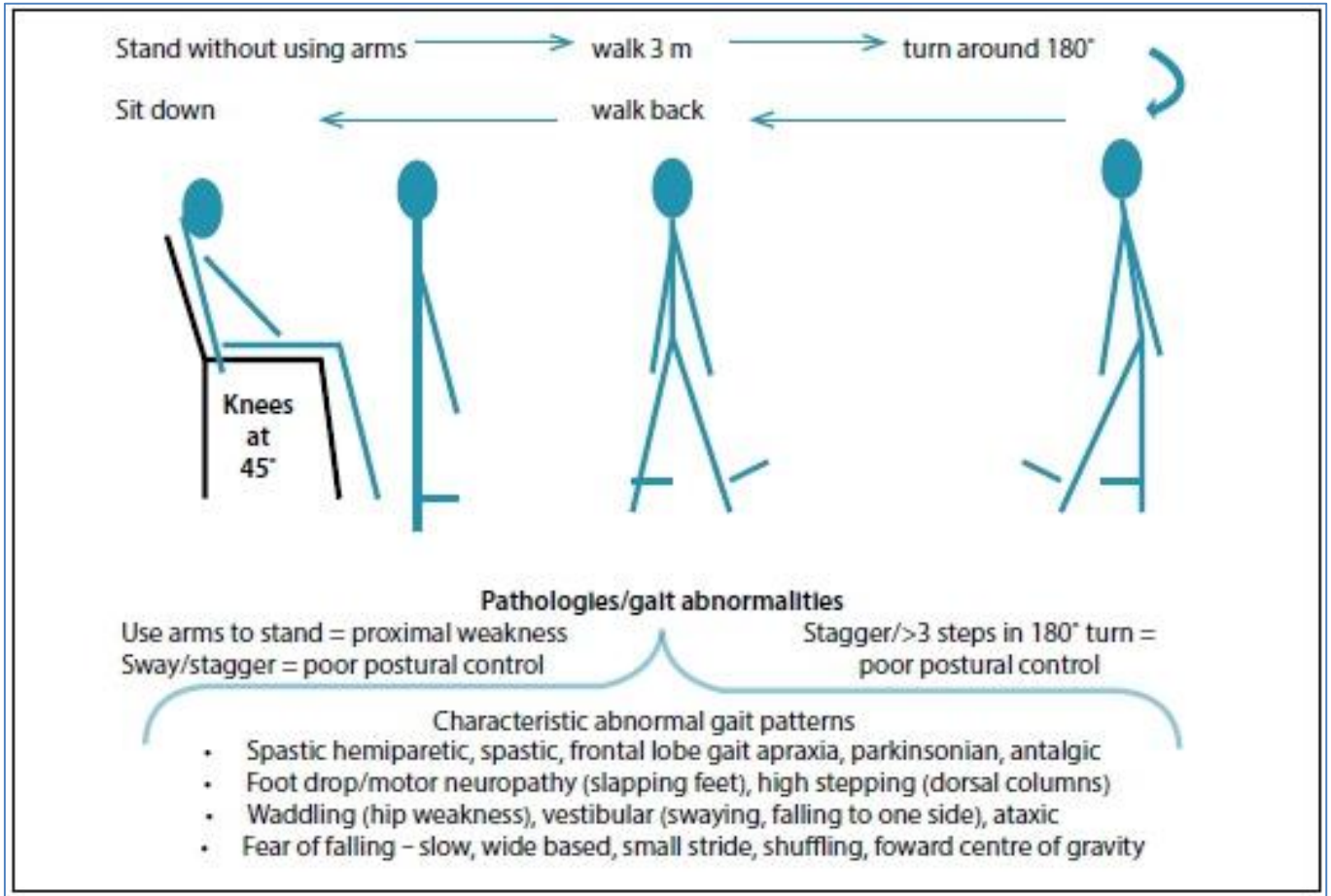


Fig. 4. The Get Up and Go test.

B.M.A.T. - Banner Mobility Assessment Tool for Nurses

Test	Task	Response	Fail = Choose Most Appropriate Equipment/Device(s)	Pass
Assessment Level 1 Assessment of: -Cognition -Trunk strength -Seated balance	**Sit and Shake**: From a semi-reclined position, ask patient to sit upright and rotate* to a seated position at the side of the bed; *may use the bedrail.* Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across his/her midline. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	**Sit:** Patient is able to follow commands, has some trunk strength; caregivers may be able to try weight-bearing if patient is able to maintain seated balance greater than two minutes (without caregiver assistance). **Shake:** Patient has significant upper body strength, awareness of body in space, and grasp strength.	**MOBILITY LEVEL 1** - Use total lift with sling and/or repositioning sheet and/or straps. - Use lateral transfer devices such as roll board, friction reducing (slide sheets/tube), or air assisted device. **NOTE:** *If patient has 'strict bed rest' or bilateral 'non-weight bearing' restrictions, do not proceed with the assessment; patient is MOBILITY LEVEL 1.*	Passed Assessment Level 1 = Proceed with Assessment Level 2.
Assessment Level 2 Assessment of : -Lower extremity strength -Stability	**Stretch and Point**: With patient in seated position at the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten the knee, then bend the ankle/flex and point the toes. If appropriate, repeat with the other leg.	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).**	**MOBILITY LEVEL 2** - Use total lift for patient unable to weight-bear on at least one leg. - Use sit-to-stand lift for patient who can weight-bear on at least one leg.	Passed Assessment Level 2 = Proceed with Assessment Level 3.
Assessment Level 3 Assessment of: -Lower extremity strength for standing	**Stand**: Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	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).** **If any assistive device (cane, walker, crutches) is needed, patient is Mobility Level 3.**	**MOBILITY LEVEL 3** - Use non-powered raising/stand aid; *default to powered sit-to-stand lift if no stand aid available.* - Use total lift with ambulation accessories. - Use assistive device (cane, walker, crutches). NOTE: Patient passes Assessment Level 3 **but requires assistive device** to ambulate or **cognitive assessment** indicates poor safety awareness; ***patient is MOBILITY LEVEL 3.***	Passed Assessment Level 3 **AND no assistive device needed** = Proceed with Assessment Level 4. ***Consult with Physical Therapist when needed and appropriate.***
Assessment Level 4 Assessment of: -Standing balance -Gait	**Walk:** Ask patient to march in place at bedside. Then ask patient to advance step and return each foot. Patient should display stability while performing tasks. Assess for stability and safety awareness.	Patient exhibits steady gait and good balance while marching, and when stepping forwards and backwards. Patient can maneuver necessary turns for in-room mobility. Patient exhibits safety awareness.	**MOBILITY LEVEL 3** If patient shows signs of unsteady gait or ***fails* Assessment Level 4,** refer back to **MOBILITY LEVEL 3;** ***patient is MOBILITY LEVEL 3.***	**MOBILITY LEVEL 4** MODIFIED INDEPENDENCE **Passed = No assistance needed to ambulate**; use your best clinical judgment to determine need for supervision during ambulation.

Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt in the patient's ability to perform the task.

Originated: 2011; revised: 2/27/12, 3/02/12, 3/07/12, 3/19/12, 4/19/12, 5/01/12, 5/03/12, 05/20/2013

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[Banner Mobility Assessment Tool for Nurses (BMAT) viceo and Tool]

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MUST DO #2
Grab and Go Mobility Devices!

- Gait Belts in every room*
- Patients and staff have access to mobility devices
- Safe mobilization and patient handling training for staff

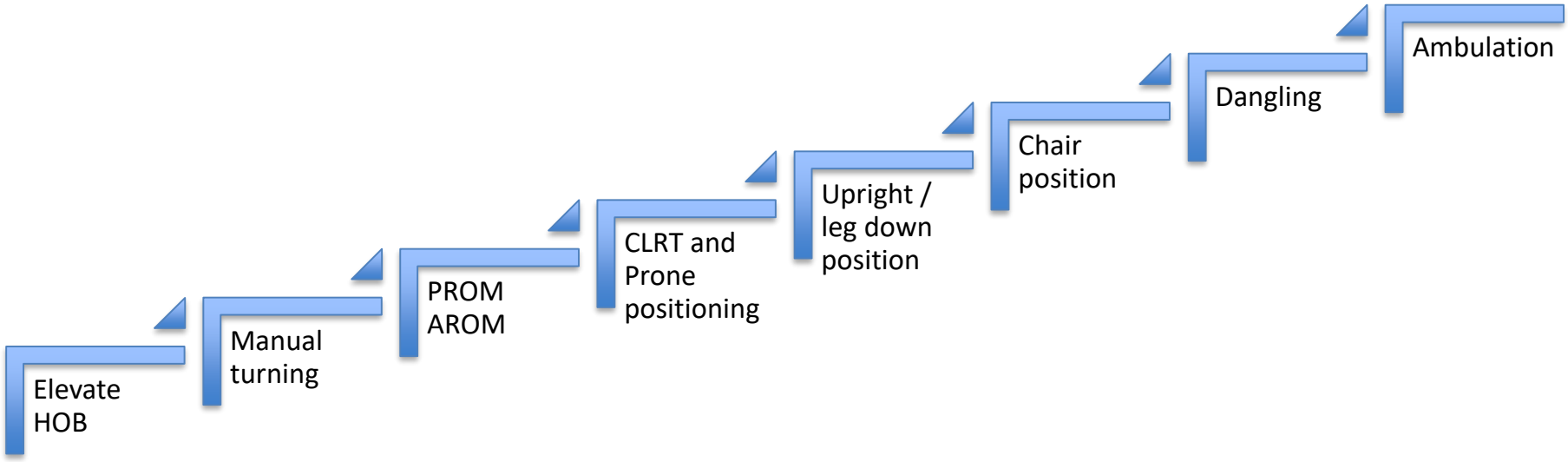
Gait belts are used to help control the patient's center of balance.

*with the exception of rooms for behavioral health patients

What is progressive mobility?

- 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)



Vollman, KM. Introduction to Progressive Mobility. Crit Care Nurs. 2010;30(2):53-55.

MUST DO #3
3 Laps a Day, Keeps the Nursing Home Away!

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Make it visible

- Get the Docs involved!
- Engage patients and families

[5A Walk of Fame Board]

How do you track mobility progress?

- White boards
- Electronic medical record
- Floor markers
- Published in the department
- We don’t have a mechanism
- Other- chat in

Tips for Promoting Mobility

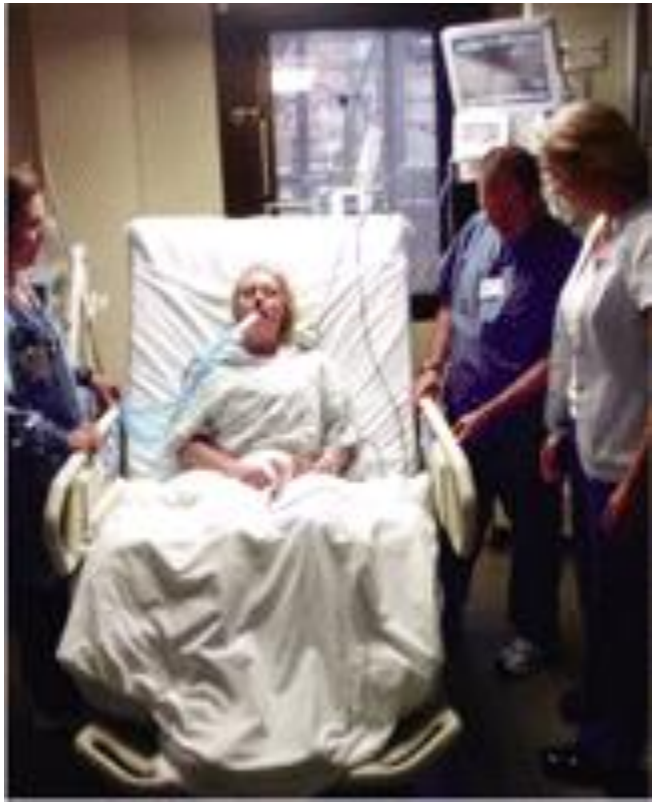
- Order Modifications
  - Delete orders for
    - Bedrest
    - Ad lib
  - Replace with specific orders
    - Times, activities, distance
- Promote Team Mobility Management
  - Delegation of patient mobility
    - Replace sitters with a mobility aide
  - Rehab and Nursing face-to-face bedside handoffs
    - Document plans and progress on white boards

Tips for General Wards

- What works in Surgery?
- Everyone up for meals
- Promote ambulation in hallways – *earn a four and you're out the door*
- Provide activities, mental stimulation – cross word puzzles, card games
- Work with families as partners in mobility. Bring adequate shoes to the hospital.

Tips for the ICU

- Start with micro-turns to prevent gravitational disequilibrium
- Use a safe mobility screening tool or protocol
- Use beach chair positioning
- Engage rehab, respiratory, physicians



Beach Chair Position

STOP Thinking you cannot afford a mobility program

Case Study: St Francis, Michigan City, IN

- 3 mobility trained nursing assistants
  - 70% reduction in HAPI
  - 40% reduction in worker back injuries
  - -45% reduction in RN turnover
  - 43% reduction in readmission
  - 39% reduction in d/c to SNF

Case Study: John Hopkins MICU

- ICU rehab program
  - 10% reduction in mortality
  - 30% (2.1 day) reduction in MICU LOS
  - 18% (3.1 day) reduction in hospital LOS

Progressive mobility can reduce patient harm, employee injuries and length of stay.

GET UP
Checkpoint

Must Do's

1. Walk in, walk during, walk out!
2. Grab and go mobility devices.
3. Three laps a day keeps the nursing home away!

Next Steps

- ✓ Do you have a mobility team?
- ✓ Do you have a mobility protocol?
- ✓ Have you clearly identified staff that have the capacity to ambulate patients daily?
- ✓ Do your nurses or rehabilitation/physical therapists evaluate each patient's mobility status upon admission?
- ✓ Is mobility equipment readily available for nurses and patients to access? (canes, walkers, lifting and safe patient handling devices, gait belts)
- ✓ Do you have a way to document and monitor daily mobility?

Get UP Discussion

- Successes
  1. Have you had success in the area of mobility in your organization?
- Barriers
  1. What do you see as barriers to Get UP?

Questions

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