AHA/HRET HEN 2.0 GET UP WEBINAR
“MOVE IT OR LOSE IT”: CROSSCUTTING INTERVENTIONS TO ACCELERATE IMPROVEMENT

May 26, 2016
11:00 a.m. – 12:00 p.m. CT
WELCOME AND INTRODUCTIONS
Emily Koebnick, Program Manager, HRET | 11:00 – 11:05
HRET HEN 2.0 – Get Up: Move It or Lose It
Online Live Webinar – May 26, 2016

The planners and faculty of the HRET HEN 2.0 “Get Up: Move it or Lose it” webinar have indicated no relevant financial relationships to disclose in regard to the content of this presentation.

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ABQAURP is an approved to provide continuing education for nurses. This activity is designated for 1.0 Nursing Contact Hours through the Florida Board of Nursing, Provider # 50-94.
WEBINAR PLATFORM QUICK REFERENCE

Mute your computer audio →

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Today’s Presentation

Download today’s slides and resources
# AGENDA FOR TODAY

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Description</th>
<th>Presenters</th>
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| 11:00-11:05 a.m. | Welcome and Introductions                    | Open and housekeeping information, including review of relevant HRET HEN resources. | Emily Koebnick  
Program Manager, HRET                                                                 |
| 11:05-11:20 a.m. | Patient Mobility — Lost But Not Gone         | Understand the UP Campaign and the role of crosscutting interventions that can reduce multiple hospital-acquired conditions (HACs). Explore how going back to basics with progressive mobility can impact seven HACs. | Maryanne Whitney, RN, CNS, MSN  
Jackie Conrad, RN, MBA, RCC™  
Improvement Advisors, Cynosure Health |
| 11:20-11:35 a.m. | Hospital Stories                             | Learn specific hospitalwide implementation recommendations on how to activate the interdisciplinary team to get your patients back on their feet. | Amie Bulliard RN, CPHQ  
Director of Quality  
St. Martin Hospital, Breaux Bridge, LA |
| 11:35-11:50 a.m. | Teaming to Succeed                           | Learn specific hospital wide implementation recommendations on how to activate the interdisciplinary team to get your patients back on their feet. | Maryanne Whitney, RN, CNS, MSN  
Jackie Conrad, RN, MBA, RCC™  
Improvement Advisors, Cynosure Health |
| 11:50-11:55 a.m. | Discussion                                  | Facilitated conversation with reactor and speakers.                          | Maryanne Whitney, RN, CNS, MSN  
Kim Radant RN, MS  
Patient Safety / Quality Advisor, Indiana  
Patient Safety Center |
| 11:55 a.m.-12:00 p.m. | Bringing it Home                            | Close and reminders about next steps and upcoming UP webinars.              | Emily Koebnick  
Program Manager, HRET                                                                 |
THE UP CAMPAIGN: Get UP

Maryanne Whitney, RN, CNS, MSN and Jackie Conrad, RN, MBA

Improvement Advisors, Cynosure Health
Topic Fatigue?
Rejuvenate with the UP Campaign!
“UP” THE TARGETS
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 the organization
• Simplifies patient safety implementation
# 1 OPIOID & SEDATION MANAGEMENT

ADE  FTR  Delirium  Falls  AS  VTE  VAE

W A K E - U P
<table>
<thead>
<tr>
<th>W</th>
<th>Warn Yourself: This is high risk.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Assess: Use tools (STOP BANG, POSS, RASS, PA-PSA).</td>
</tr>
<tr>
<td>K</td>
<td>Know: Your drugs, your patient.</td>
</tr>
<tr>
<td>E</td>
<td>Engage: Patients and families to set realistic pain expectations, use of non-sedating analgesics, risks of opioids.</td>
</tr>
<tr>
<td>U</td>
<td>Utilize: Dose limits, layering limits, soft and hard stops.</td>
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<tr>
<td>P</td>
<td>Protect: The patient...our ultimate job.</td>
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# 2 EARLY PROGRESSIVE MOBILITY

G E T - U P

Falls  PrU  Delirium  CAUTI  VAE  VTE  Readmissions
<table>
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<th>G</th>
<th><strong>Go:</strong> Determine the resources in your institution and how you will implement a mobility program.</th>
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<td><strong>Evaluate (patient capabilities):</strong> Which scale/tool/evaluation method will you standardize?</td>
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<td><strong>Team up for progressive mobility:</strong> Rehab, nursing and respiratory join to implement the mobility plan.</td>
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<td><strong>Unite:</strong> Engage patients, families and friends in mobility progression.</td>
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<td><strong>Promote progress:</strong> Measure and report unit mobility performance.</td>
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# 3 HAND HYGIENE

CDI  CAUTI  SSI  VAE  CLABSI  Sepsis

S O A P - U P
<table>
<thead>
<tr>
<th>S</th>
<th>Scrub: For 20 seconds with the right product. Remember soap for <em>C. diff</em>.</th>
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<tbody>
<tr>
<td>O</td>
<td>Own: Your role in preventing HAIs.</td>
</tr>
<tr>
<td>A</td>
<td>Address: Immediately intervene if breach is observed.</td>
</tr>
<tr>
<td>P</td>
<td>Place: Hand hygiene products in strategic locations.</td>
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<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>Update: Hand hygiene products and policies as needed to promote adherence.</td>
</tr>
<tr>
<td>P</td>
<td>Protect: Patient and families, get them involved.</td>
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</table>
REACTIONS / REFLECTIONS
PATIENT MOBILITY

LOST BUT NOT GONE!
THE HAZARDS OF IMMOBILITY

- Edith V. Olson published this hallmark article in the American Journal of Nursing in April 1967.
PATHOPHYSIOLOGICAL CHANGES WITHIN 24 HOURS OF BED REST

Respiratory System
- Decreased lung volume
- Pooling of mucous
- Cilia less effective
- Decreased oxygen saturation
- Aspiration atelectasis

Psychological
- Anxiety
- Depression
- Sensory deprivation
- Learned helplessness
- Delirium

Gastrointestinal System
- Increased risk of aspiration
- Loss of appetite
- Decreased peristalsis
- Constipation

Circulatory System
- Loss of plasma volume
- Loss of orthostatic compensation
- Increased heart rate
- Development of DVT

Musculoskeletal System
- Weakness
- Muscle atrophy
- Loss of muscle strength by 3-5%
- Calcium loss from bones
- Increased risk of falls due to weakness

Genitourinary System
- Incomplete bladder emptying
- Formation of calculi in kidneys and infection
RESPIRATORY

Effects of immobility and supine function on respiratory functions

• Decreased respiratory motion with abdomen influencing diaphragm motion
• Increased dependent edema with fluid accumulation
• Decreased movement of secretions
The effects of immobility on cardiovascular function

• Fluid shift
  – Loss of plasma volume of 7% in the first 24-48 hours of bed rest

• Cardiac effects
  – Increased workload due to fluid shift
  – Increased resting heart rate and decreased cardiac output

• Cardiac deconditioning and decreased O2 uptake
  – Decreased 23% by week 3 of bed rest

• Orthostatic hypotension
  – Occurs by day 1-2 of bed rest, maximum on week 3
  – Due to decreased autonomic tone and fluid shifts

• Increased risk for thromboembolism
INTEGUMENTARY

• Pressure injury risk factors:
  – Immobility - #1 risk factor for pressure injuries
  – Immobility contributes to pressure, shear, friction and moisture
MUSCULOSKELETAL

- Loss of bone density due to calcium loss
- Risk for hip fracture doubles by week 3 of bed rest due to bone and balance issues (Knight 2009)
- Decreased protein synthesis leads to muscle catabolism resulting in decreased muscle mass
- Muscle groups that lose the most strength are involved in maintaining posture, transferring and ambulation
- One-third of ICU patients with LOS > 2 weeks had at least 2 functionally significant joint contractures (Clavet 2008)

CUMULATIVE IMPACT ON QUALITY OF LIFE

• “New Walking Dependence” occurs in 16%-59% of older hospitalized patients (Hirsh 1990, Lazarus 1991, Mahoney 1998)
• Functional decline in older patients
  – 65% of patients had a significant functional mobility decline by day 2 (Hirsh 1990)
    • 67% showed no improvement by discharge
    • 10% deteriorated further
  – 27% still dependent in walking 3 months post discharge (Mahoney 1998)

THIS IS OLD NEWS

- Despite what we know, hospitals are failing at mobilizing patients.
  - Only 27% of patients who CAN walk DO walk in the hospital (Callen 2004).
  - Average time between manual turns in ICU 4.85 hours (Goldhill 2008).
  - In an eight-hour period only 3% of the ICU patients were turned according to the two-hour standard and close to 50% of the patients had no change in body position (Krishnagopalan 2002).


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)

STEP 1 – SAFETY SCREENING

Early Progressive Mobility Protocol

Evaluate Daily

(Patient must meet all criteria)

M – Myocardial stability
- No evidence of active myocardial ischemia x 24 hrs.
- No dysrhythmia requiring new antidyssrhythmic agent x 24 hrs.

O – Oxygenation adequate on:
- FiO2 < 0.6
- PEEP < 10 cm H2O

V – Vasopressor(s) minimal
- No increase of any vasopressor x 2 hrs.

E – Engages to voice
- Patient responds to verbal stimulation

Fails

Re-evaluate in 24 hours

Passes

STEP 2 – PROGRESS MOBILITY

DUKE RALEIGH HOSPITAL CASE STUDY

EARLY ICU MOBILITY OUTCOMES

• Morris 2008
  – Patients out of bed earlier – day 5 vs day 11
  – Reduced ICU LOS from 6.9 to 5.5 days
  – Reduced hospital LOS from 14.5 to 11.2 days
  – No adverse outcomes
RESOURCES

Position paper: Advancing the Science and Technology of Progressive Mobility


Article: Vollman K. (2010) Introduction to Progressive Mobility
http://ccn.aacnjournals.org/content/30/2/S3.full.pdf

Article: Doherty-King B (2011) How nurses decide to ambulate hospitalized older adults
http://gerontologist.oxfordjournals.org/content/51/6/786.long

John Hopkins Early Mobility Toolkit
https://cdn.community360.net/app/jh/VAP/resources_e/Early_Mobility_Toolkit%206.10.14_nr.docx

Case study: Duke Raleigh Hospital: Early Progressive Mobility in the Medical-Surgical ICU
MOVING OUR QUALITY METRICS USING CROSSCUTTING STRATEGIES

Amie Bulliard, RN, CPHQ
Director of Quality
Breaux Bridge, Louisiana
St. Martin Hospital
A part of Lafayette General Health System
2010: SMH began our Journey to Excellence
2012: EMR implementation
  - Allowed us to identify opportunities to improve outcomes
  - Electronic reports were more accurate and more efficient than many of the manual processes that were being used
  - Allowed us to use automation and constraints to achieve results.
    • Hard stop: skin assessment, fall assessment, DVT risk and present on admit conditions

<table>
<thead>
<tr>
<th></th>
<th>Prior to HEN</th>
<th>Current Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall assessment within 24 hours</td>
<td>33%</td>
<td>100%</td>
</tr>
<tr>
<td>Skin assessment within 24 hours</td>
<td>98%</td>
<td>100%</td>
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</tbody>
</table>
HOW WERE QUALITY GOALS ACHIEVED?

- People: Invest in your staff, listen to what they are telling you. To achieve success, you must have the right people.
- Education: Staff, patient, family and caregivers. Education is only a tip of the iceberg. Education alone will NEVER hardwire expectations and behaviors.
READY, SET, GO!

- Explain expectations of the staff to both the patient and family AND follow up.
  - What should occur in the day: hourly rounding, therapy twice daily, etc.
  - Determine if we met the expectations.
  - Patients will be honest and give feedback! Use this feedback to improve process and/or to reward staff giving great care.
MOBILITY 365 DAYS A YEAR

Weekdays: Therapy twice a day to mobilize.

Weekend restorative care: Provided to all patients twice daily. This plan is developed by our therapist and provided by our nursing staff.

Activities: Different activities are scheduled on weekdays and weekends, requiring patients to leave their room to participate. Examples include, bingo, praying of the rosary, etc.
INTEGRATING MOBILITY INTO CARE

• Mobilizing during purposeful hourly rounding
  – Pain, potty and position
    • Avoid phrases like, “Do you need the bathroom?”
    • Instead say, “Let’s get up and walk to the bathroom.”
  – Decrease call bell usage, increases patient satisfaction, increases the efficiency of staff
• Whiteboards: excellent communication tool used between the interdisciplinary team and patient regarding mobility
  – Scheduled therapy times
  – Pain controlled to achieve maximum benefits from therapy
  – Any planned hospital activities
• Nurse driven protocol: related to patients with indwelling catheter
  – If patient does not meet criteria, automatic order for catheter removal
  – Removal of catheters increases patients mobility
**VALIDATION**
- Concurrent chart audits
- Consistent communication with physicians
- Leadership support: we are all one team
- Nurse leader rounding with patients:
  - Always asking open-ended questions
  - Validating hourly rounding
  - Bringing feedback from patients back to the nursing staff; Closing the loop is essential

**ACCOUNTABILITY**
- Reward and recognize: thank you notes to staff members whose patients complimented during nurse leader rounding
HARDWIRING ACCOUNTABILITY

• OUTCOMES TIED TO EVALUATIONS
  – Based on organizational and departmental goals
  – LEM: leadership evaluation manager
  – SEM: staff evaluation manager
  • People 15% - Decrease first year turnover
  • Service 15% - Increase patient satisfaction
  • Quality 30% - HCAHPS and quality metrics
  • Funding our future 20% - operating margin
  • Growth 20% - adjusted discharges
## RESULTS

<table>
<thead>
<tr>
<th></th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 16-October to Current</th>
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<tbody>
<tr>
<td><strong>FALLS</strong></td>
<td>21 Patients</td>
<td>11 Patients</td>
<td>5 Patients</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>Data Not Collected</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>CLABSI</strong></td>
<td>Data Not Collected</td>
<td>0</td>
<td>1 Patient</td>
</tr>
<tr>
<td><strong>READMISSION- ALL Cause</strong></td>
<td>Data Not Collected</td>
<td>16</td>
<td>5</td>
</tr>
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MEASURES – CAUTI, CLABSI, FALLS

• Reported at:
  – Medical Executive Committee (MEC) meeting
  – Reported bimonthly at Board of Trustees meeting
  – Reported quarterly at Performance Improvement Meeting and Infection Prevention Meeting

• Updated results are posted on our departmental pillar boards and discussed at monthly department meetings

• Quarterly hospital forums led by our CEO
ADVICE FOR OTHERS

• Always involve your front-line staff in decision making.
• Consistency and clear communication across the organization is imperative to success.
• Always make processes patient focused and not provider focused; we are here to serve our patients.
• Reward and recognition reinforces positive behaviors and inspires others.
• Questions?

• Amie Bulliard

• acbulliard@lgh.org

• 337-507-1217
Teaming to Succeed

Maryanne Whitney, RN, CNS, MSN and Jackie Conrad, RN MBA
Improvement Advisors, Cynosure Health
NURSING IS BEST POSITIONED TO POSITIVELY IMPACT MOBILITY
NURSING IS BEST POSITIONED TO POSITIVELY IMPACT MOBILITY

• Facts:
  – Mobility interventions are regularly missed
    • Nursing perceptions
      – Lack of time
      – Ease of omission
      – Belief it is PT’s responsibility
  • Survey results
    – Concern for patients level of weakness, pain and fatigue
    – Presence of devices – IVs and urinary catheters
    – Lack of staff to assist

FACTORS INFLUENCING NURSES MOBILIZING PATIENTS

• Nursing focus in the phases of hospitalization:
  – Acute illness – focus is on VAP, HAPU prevention through turning
  – Recovery period – concern for DVT
  – Getting ready for D/C – functional ambulation

FACTORS INFLUENCING NURSES MOBILIZING PATIENTS

- Unit or organizational factors
  - Availability of resources
    - CNAs
    - Equipment
  - Unit activity
    - High activity / acuity shifts interfere with getting patients up
  - Unit or organizational expectations
    - Is expectation explicitly communicated to staff and patients?
      - White boards
      - Handoffs

FACTORS INFLUENCING NURSES MOBILIZING PATIENTS

• RN skill / experience
  – Size matters
  – Rehab and LTC experienced RNs more likely to ambulate

• Patient “label”
  – Nursing Home residents ambulated less or not at all
  – Anticipated d/c to community – more likely to ambulate

• Accountability
  – Documentation of mobilization activities
  – Visibility of ambulation

TEAMING UP TO MOBILIZE

PT  CNA  Admin  RN  OT  MD  Family  RT
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GO – DETERMINE THE RESOURCES NEEDED

• Assess current state of nursing skill and confidence in mobilization
• Mobility Aid – PTA or CNA
  – Instead of “low census days” pilot mobility aid
  – Ambulate patients twice a day
• Unit-based PT/OT staff
  – Bedside treatment
  – Involve nursing in transfers and ambulation to build skill and confidence.
• ICU Mobility Team – Critical Care RN, CNA, PT
• Equipment
  – Gait belts in rooms
  – Sit-to-stand transfer device
EVALUATE

• Select or develop a tool to assess patient readiness for early mobilization
  – Exercise / Mobility Safety Screen Parameters—examples

**AACN Protocol**
M – Myocardial stability
  • No myocardial ischemia x 24H
  • No dysrhythmia requiring new antidysrhythmic x 24H
O - Oxygenation is adequate
  • FiO2 > 6
  • PEEP < 10cm H2O
V – Vasopressors minimal
  • No increase of any vasopressors x 2H
E – Engage to voice
  • Patient responds to verbal stimulation

**Other Screening Parameters**
- PaO2/FiO2 > 250
- Peep < 10
- RR 10-30
- HR 60-120
- MAP 55-140
- SBP 90-180
- RASS 3 or greater
- No new or increasing vasopressors
TEAM UP

• Develop the mobility protocol as a team
  – MD
  – NP, Clinical Spec
  – Nursing – RN, CNAs
  – Physical Therapy
  – Occupational Therapy
  – Respiratory

• Consider ICU and Med Surg
  – Decide where to start
UNITE PATIENTS, FAMILIES, AND FRIENDS

- Use whiteboards
- Teach mobilization skills using teach back
- Proper footwear

Hospital Hazards
Four practices that can harm older people

A hospital stay can be risky, especially for older people. For example, many seniors who could walk on their own and care for themselves before entering the hospital lose these abilities during their stay. They may also develop delirium (sudden, intense confusion). As part of the Choosing Wisely series, the American Academy of Nursing has identified four over-used hospital practices. These practices are usually unnecessary, and they may harm you.

Question these hospital practices.
If you notice doctors or nurses using any of these practices, ask why. Explain your concerns to the nurse. Nurses can often stop these practices.

BED REST

The problem: Usually, older people spend most of their time in bed during a hospital stay. This is because we used to think that bed rest helped the body recover. But research now shows that walking helps older patients recover faster. They get out of the hospital sooner, and they can walk farther when they get home.

Bed rest can be harmful: When you're not active, your leg muscles get weaker. You're also more likely to become dehydrated. This can make you dizzy and lead to falls. These are serious issues because older people already have problems with dizziness and balance.

Some older patients grow so weak that they:
- Need help dressing and bathing.
- Need to go to a nursing home before they go home.
PROMOTE PROGRESS

• For individual patients
  – Document progression towards baseline in medical record
    • Current mobility level
    • Activities performed
    • Patient tolerance
    • Required support and assistance
    • Education given
      – Use whiteboard to document current level and activity goals
• Celebrate the team’s progress
REFLECTIONS AND REACTIONS
BRING IT HOME
Emily Koebnick, Program Manager, HRET | 12:00
NEX T STEPS

Are you a quality lead in your organization?
• Conduct a gap analysis on Early Progressive Mobility

Are you a unit-based clinical lead in your organization?
• Assemble a team to assess current practices and to identify barriers and a plan to mitigate

Are you a physician champion in your organization?
• Share the evidence regarding benefits of early progressive mobility for patients and the organization

Are you a patient and family advocate in your organization?
• Create patient and family education materials on early progressive mobility

Are you a senior leader or a board member for your organization?
• Allocate necessary staff and equipment resources to safely mobilize patients in ICU and in medical surgical units
CONTINUING EDUCATION CREDITS

- Launch the evaluation link in the bottom left-hand corner of your screen.

- If viewing as a group, each viewer will need to submit separately through the CE link.
THANK YOU!

• Find more information on our website: www.hret-hen.org

• Questions/Comments: hen@aha.org