Mobility Action Group

Change Package and Toolkit

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Background and Rationale

When older adults are hospitalized, there is an inherent tension between preventing falls and promoting mobility, because promoting mobility is often and inaccurately considered a risk factor for falls.[1] It is well known that immobility in the hospital contributes to many undesirable outcomes, including an increased risk of injurious falls, delirium, pressure ulcers, hospital acquired infections (e.g., urinary tract infection and aspiration pneumonia), functional decline, prolonged length of stay, institutionalization, readmission, and increased episode costs. Therefore, evidence suggests that early mobilization actually ***decreases*** the risk of injurious falls. For additional literature on the benefits of early mobility, see **Appendix A**.

Purpose

The CMS Center for Medicare & Medicaid Innovation (CMMI) offered the Mobility Action Group to participants in the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) models to support them in achieving their aim of improving the quality and experience of care while reducing the total cost of care. The Mobility Action Group was based loosely on the Institute for Healthcare Improvement's Breakthrough Series,[2] and many quality improvement concepts were derived from the Model for Improvement.[3]

The goals of the Mobility Action Group were to:

- Test or implement strategies for increasing early mobility in the acute care setting;
- Improve early mobility for BPCI and CJR model beneficiaries, with the ultimate aim of improving quality of care and lowering costs; and
- Identify and leverage BPCI and CJR promising practices in early mobility, to inform other organizations seeking to improve mobility among older, hospitalized patients.

The purpose of this Change Package and Toolkit is to provide a conceptual framework for change and an implementation roadmap that hospitals can use to increase mobility among older, hospitalized adults.

Mobility Roadmap

Hospitals may discover that many components of effective mobility programs are already in place, and may begin their efforts to enhance mobility at various stages of this roadmap (**Figure 1**). This general sequence of activity has been effective for several of the hospitals providing input to this Change Package.

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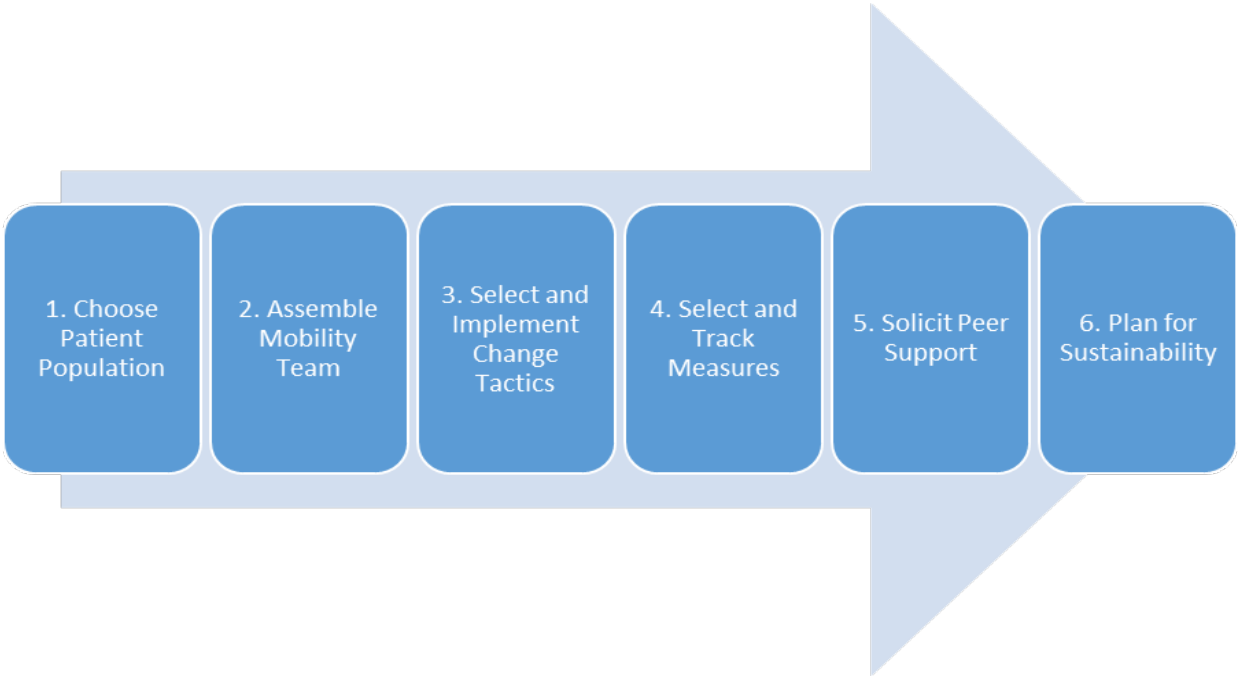
[1] Growdon ME, Shorr RI, Inouye SK. The tension between promoting mobility and preventing falls in the hospital. JAMA Internal Medicine 2017;177:759-60.

[2] The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.

[3] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

Figure 1. Overview of Mobility Roadmap



Step 1: Choose a patient population.

The CMMI Mobility Action Group Change Package (**Table 1**) and accompanying tools and measures are primarily focused on older, hospitalized adults. Mobility Action Group members developed and/or refined their mobility programs on the following units/floors within their hospitals:

- *General Medical*
- *General Surgical*
- *Orthopedics*
- *Geriatrics*
- *Intensive Care*
- *Neurology*
- *Oncology*
- *Cardiology*

When choosing which floor or unit on which to initially focus your mobility program, you may want to consider the clinical appropriateness of frequent ambulation for the patient population on the floor/unit, the interest level and availability of clinical staff on the floor/unit for a mobility program, and leadership interest and support. As mobility programs spread to additional units within the hospital, the roadmap sequence of activity may be repeated.

Step 2: Assemble your Mobility Team.

A multidisciplinary team is best. In addition to including all care team members—such as physicians, nurses, nursing support, physical and occupational rehabilitation specialists and support—consider also including central supply staff (to support availability of assistive devices), information technology staff (to support adaptations to your electronic medical record that will facilitate communication and documentation), and risk management staff (to support use of volunteers in your mobility program if you choose that strategy). It is important that you

have an executive sponsor—a leader with decision-making authority and ability to allocate resources and remove barriers—backing your Mobility Team. As noted in the Change Package, it may be helpful to begin with your Falls Team, expanding their role to include mobility.

Step 3: Select the change tactics your team will be implementing.

Review the Increasing Mobility in Acute Care Bibliography (**Appendix A**), the CMMI Mobility Action Group Change Package (**Table 1**), and the CMMI Mobility Action Group Toolkit (**Appendix B**), and identify 1-2 tactics your team would like to test or implement for your mobility program.

Clinical subject matter experts (SMEs) in early mobility research[4] developed a Mobility Action Group Clinical Framework, now the Mobility Action Group Change Package, to assist Mobility Action Group members with improving early mobility within their organizations (**Table 1**). With input from the Mobility Action Group, this Change Package was refined and further developed, and is intended to assist any hospital in their efforts to increase early mobility for their patients.

The CMMI Mobility Action Group Change Package is organized into strategies, change concepts, tactics, tools/resources/examples, and measure domains. The strategies are presented sequentially, as many successful programs have found it useful to begin with Strategy 1, then move to Strategy 2 and so on. If you are developing a new mobility program, we recommend starting with tactics from Strategy 1, "Create engagement in a mobility culture" or Strategy 2, "Assess and plan for mobility." However, you may decide to begin with later strategies based on the maturity of your mobility program or your hospital's priorities.

Each **strategy** is supported by the change concepts and tactics. **Change concepts** are general approaches that are intended to stimulate creative and critical thinking and are further grounded in specific **tactics** that any organization can begin testing for the purposes of improving quality of care, improving health outcomes, and reducing costs of care. Note that mobility programs are not expected to implement all of the tactics. Lastly, when available, tools, resources, and measures are presented to give concrete examples of how to operationalize the tactics and measure progress towards goals. This Change Package should be seen as providing a starting point for this work. Sites should adapt these strategies and tactics to their local circumstances and use their own materials to optimize the program. Further detail about the tools, resources, and measures can be found in the Appendices.

[4] Sharon Inouye, MD, MPH, Harvard Medical School, Beth Israel Deaconess Medical Center and Hebrew SeniorLife; Cynthia Brown, MD, MSPH, University of Alabama at Birmingham; Susan Heisey, MSW, Inova Fairfax; Fred Rubin, MD, University of Pittsburgh Medical Center; Heidi Wierman, MD, Maine Medical; and Bruce Finke, MD, Centers for Medicare & Medicaid Services and Indian Health Service.

Table 1. CMMI Mobility Action Group Change Package

Strategies	Change Concepts	Change Tactics	Toolkit Resources	Measure Domains
1 – Create engagement in a mobility culture	Engender buy-in and engagement from patients and families	Communicate expectations for mobilization to patients and families (e.g., via patient/family brochures or during rounds)	• Patient and Family Brochure on Mobility • Patient Flyer on Mobility • Adventist Medical Center Spotlight	• Patient Satisfaction
		Collaborate with patients to prioritize mobility within the context of meeting their functional goals (e.g., earlier discharge, maximizing independence)	• Sample Patient Agreement	
		Display visual reminders of mobility goals in room and in hall (e.g., distance markers in hallway)	• Patient Goal Sign • Mobility Action Group Poster	
	Engender buy-in and engagement from executive, clinical and non-clinical staff	Enlist an interdisciplinary team to design the mobility program	• CentraState Medical Center Spotlight	• Organizational Culture • Implementation Progress
		Educate staff about the rationale for increased mobility	• Appendix A: Increasing Mobility in Acute Care Bibliography	
		Share progress towards mobility program goals routinely	• Change Tactic Implementation Progress Survey (for tracking) • Example Report for Daily Walks (Control Charts)	
2 – Assess and plan for mobility	Assess function and mobility throughout hospitalization	Standardize nursing mobility assessment on admission and discharge	• Baseline Mobility Assessment • Nursing Safe Mobilization Assessment • Mobility Assessment with Mobility Levels	• Falls • Staff Injuries
		Assess functional status on admission and discharge	• Checklist of Activities of Daily Living (ADL/IADL) – Functional Assessment for Admission and Discharge	
		Assess for any evidence of acute mental status change	• Mental Status Screen	
		Use a progressive mobility tool or mobilization algorithm to re-assess patient mobility throughout their hospital stay and increase their activity/ambulation accordingly	• Medical Surgical Progressive Mobility Protocol • Progressive Mobility Protocol • Nursing Safe Mobilization Assessment • Shawnee Mission Medical Center Spotlight	

Strategies	Change Concepts	Change Tactics	Toolkit Resources	Measure Domains
		Record mobility daily (e.g., whiteboard, patient flow chart, EHR)	• Baseline Mobility Assessment • Hospital Mobility Documentation • Mobility Tool for Nurses Station • UnityPoint Health – Meriter Hospital Spotlight • Sentara CarePlex Spotlight	
	Include mobilization plan in every patient's Care Plan	Set baseline ambulation goal (distance), with target of 3 times/day	• Patient Goal Sign	
		Limit Physical Therapy referrals for general mobility	• St. Luke's Hospital Spotlight	
		Identify primary and support staff responsible for mobilization	• Sample Mobility Tech Job Description • St. Peter's University Hospital Spotlight • UPMC Shadyside Spotlight	
		Clearly identify which patients have been cleared for ambulation (e.g., in the EHR, on patient white boards)	• Ogden Regional Medical Center Spotlight • St. Peter's University Hospital Spotlight	
	Revise clinical protocols to promote mobility/ambulation (with assistance as needed)	Justify all bedrest orders, and the default should be ambulation	• The Valley Hospital Spotlight	• Mobility • Falls • Functional Status • VTE • Pressure Injury • Discharge Disposition • Length of Stay
		Provide specific activity order (e.g., "ambulate with assistance, 1 lap of unit TID")	• St. Luke's Hospital Spotlight	
3 – Provide early mobilization with safe approaches for patients and staff	Train all staff in safe mobility	Train and demonstrate safe mobility and body mechanics for nurses, aides, sitters, PT techs, volunteers, 'ambulators'	• HELP Mobility Protocol I (HELP Walking I) • Using your Body Safely (HELP) • Care of the Falling Patient (HELP) • HELP Checklist for Walking with Patients • HELP Mobility Competency Checklist • HELP Walking Protocol (Adapted) (HELP Walking II)	• Falls • Staff Injuries
		Reward/recognize front-line staff for new ideas in how to mobilize patients	• Mobility Champion Award	
		Train family members in safe mobility	Training materials at: www.hospitalelderlifeprogram.org	

Strategies	Change Concepts	Change Tactics	Toolkit Resources	Measure Domains
	Ambulate/mobilize patients early and often	Walk patients at least 3 times/day	• HELP Mobility Protocol I (HELP Walking I) • HELP Walking Protocol (Adapted) (HELP Walking II)	
		Progress ambulation/mobilization based on improvements in functional status assessments	• Progressive Mobility Protocol	
	Have appropriate assistive devices for every patient	Provide gait belts in every room	• St. Luke's Hospital Spotlight	
		Make walkers, canes, crutches centrally available—easy and reliable 24-hour access	• Daily Safe Mobility Scan (HELP)	
		Provide glasses, hearing aids, and appropriate footwear as needed	• HELP Mobility Protocol I (HELP Walking I) • HELP Walking Protocol (Adapted) (HELP Walking II)	
	Transition Falls Team to Mobility Team	Pair mobility along with falls as critical outcomes	• Ogden Regional Medical Center Spotlight	• Mobility • Falls
		Always consider maintaining mobility in all corrective actions for fall prevention	• Appendix A: Bibliography (Growdon ME, Shorr RI, Inouye SK. The tension between promoting mobility and preventing falls in the hospital. JAMA Internal Medicine 2017;177:759-60.)	
		Generate unit-specific (and eventually hospital-wide) reports on mobility rates and falls (with and without injury) rates	• Fall Measures Recommended by NQF • Example Report for Daily Walks (Control Charts) • Example Report for Impact of Initiative on Functional Status	
4 – Minimize immobilizing devices	Reduce/minimize bed and chair alarms	Develop system on floor for purposeful hourly rounding (RNs and CNAs) and rapid response to call-bells	• Appendix A: Bibliography (Purposeful Rounding)	• Alerts
		Remove bed/chair alarms from fall protocols and standing order sets	• Bed/Chair Alarms: Evidence and References	
		Measure usage of bed/chair alarms on floor(s)	• Table 2 (Bed/Chair Alarms)	

Strategies	Change Concepts	Change Tactics	Toolkit Resources	Measure Domains
	Daily 'Patient Mobility' Scan to identify mobility barriers	Identify and reduce all tethers (urinary catheters, oxygen with short tubing, compression devices)	• HELP Checklist for Walking with Patients • HELP Mobility Protocol I (HELP Walking I) • HELP Walking Protocol (Adapted) (HELP Walking II)	• Restraints
		Verify availability of footwear and assistive devices	• HELP Checklist for Walking with Patients • HELP Mobility Protocol I (HELP Walking I) • HELP Walking Protocol (Adapted) (HELP Walking II)	
		Confirm unobstructed walking route in patient room and hallway	• Daily Safe Mobility Scan (HELP)	
		Assess for other obstacles to daily mobility	• Daily Safe Mobility Scan (HELP)	

Step 4: Select the measures you will be tracking.

Tracking the status of key implementation, clinical process, and outcome measures is critical to quality improvement strategies such as enhancing early mobility. It will allow you to celebrate successes as they occur and identify and prioritize opportunities for improvement. It is recommended that you track and share with your Mobility Team and your leadership progress towards your implementation, clinical process, and outcome goals. Which measures you choose to track will depend on your hospital's priorities and capacity. **Table 2** presents measures recommended by experts experienced in improving mobility in older hospitalized adults, as well as measures that the Mobility Action Group members found helpful to their hospitals.

There may be additional measures that your hospital is currently collecting which will be relevant to your mobility program.

Table 2. Measures to assess progress and outcomes associated with your organization's mobility program

Domain		Measure and Definition	Rationale
Clinical Process Measures	Mobility	Patient walks per day: Number of walks per patient day. Walks are defined as the patient leaving his/her room on foot (walks to the bathroom or in their own room do not count).	Number of patient walks has been shown to be associated with positive health outcomes. This will also help determine the effectiveness of the initiative.
		Proportion of patients meeting optimal ambulation goal: Proportion of patients with at least 3 walks per day	Number of patient walks has been shown to be associated with positive health outcomes, and the optimal goal is at least 3 walks per day.
	Bed/Chair Alarms	Bed/chair alarms: Average number of bed/chair alarms used per patient day for the calendar month	Bed/chair alarms are a deterrent and do not encourage mobility. This measure will alert the team to potential barriers of early mobility that need to be addressed.
	Physical Restraints	Average number of physical restraints used per patient day for the calendar month	Physical restraints are a deterrent and do not encourage mobility. This measure will alert the team to potential barriers of early mobility that need to be addressed.

Domain		Measure and Definition	Rationale
Outcome Measures	Falls	Overall Falls with Injury: NQF Measure Number 0202 (Falls With Injury): Number of all injury falls with an injury level of minor or greater per 1000 patient days (Total number of injury falls in the calendar month / Patient days) X 1000)	Decrease in falls with injury is one of the expected positive outcomes of early mobilization. Monitoring its frequency will be an indicator of the impact of the initiative. Alternatively, an increase in falls with injury may point to populations or circumstances where early mobilization may cause unintended consequences.
		Participant Fall Rate: NQF Measure Number 0141 (Patient Fall Rate): Number of falls experienced by participants in the mobility program per 1000 patient days (Total number of falls experienced by patients in the mobility program in the calendar month / Patient days X 1000)	Decrease in falls is one of the expected positive outcomes of early mobilization. Monitoring its frequency will be an indicator of the impact of the initiative. Alternatively, an increase in falls may point to populations or circumstances where early mobilization may cause unintended consequences.
		Participant Falls With Injury Rate: NQF Measure Number 0202 (Falls With Injury): Number of injury falls with an injury level of minor or greater experienced by participants in the mobility program per 1000 patient days (Total number of injury falls experienced by patients in the mobility program in the calendar month / Patient days X 1000)	Decrease in injuries with falls is one of the expected positive outcome of early mobilization. Monitoring its frequency will be an indicator of the effectiveness of the initiative. Alternatively, an increase in injury may identify populations or circumstances where early mobilization may cause unintended consequences.
	Functional Status	▪ Nursing ADL/IADL tools ▪ Average PROMIS® Item Bank v2.0 – Mobility score for mobility participants during the calendar month ▪ Average HOOS/KOOS – Function, Daily Living score for mobility participants during the calendar month ▪ Veterans RAND 12	Improved functional status (multi-domain) is an intended benefit from the intervention and proxy measure of effectiveness of the initiative. Assess at admission and discharge and evaluate the change.

Domain		Measure and Definition	Rationale
Outcome Measures (cont'd)	Delirium	▪ Delirium measures at: http://www.hospitalelderlifeprogram.org	Mental status changes and delirium are complications of immobility. In addition, patient mobility can be difficult or unsafe in patients who are actively delirious. Assess at admission, discharge, and with any suspected mental status change. These measures can help to track decreases related to a successful mobility program.
	VTE (Venous Thrombo-embolism)	▪ Number of Doppler screenings for patients on restrictions or bed rest ▪ Hospital uses a VTE order set ▪ Number of times VTE order set used for appropriate patients ▪ VTE measures at: https://www.jointcommission.org/venous_thromboembolism/ ○ **VTE 1:** This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. ○ **VTE 2:** This measure is used to assess the percent of surgery patients who receive appropriate venous thromboembolism (VTE) prophylaxis within 24 hours prior to anesthesia start time to 24 hours after anesthesia end time. ○ **VTE 6:** This measure is used to determine the number of VTE patients with VTE diagnosed after arrival that failed to receive appropriate VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	Deep venous thrombosis and pulmonary embolism are complications of immobility. These measures can help to track decreases related to a successful mobility program.

Domain		Measure and Definition	Rationale
Outcome Measures (cont'd)	Pressure Injury	▪ Braden Scale ▪ Number of pressure ulcers in each stage (I-IV, unstageable) ▪ Movement from a lower stage to a higher stage	Pressure ulcers are complications of immobility. These measures can help to track decreases related to a successful mobility program.
	Discharge Disposition	▪ Percent of mobility patients discharged to sub-acute rehab facility ▪ Percent of mobility program patients discharged to skilled nursing facility	This measure will allow you to assess whether increased mobility has resulted in improving patients' health such that they are able to enter lower acuity first discharge settings, which has the potential to reduce costs within bundled payment models.
	Length of Stay	▪ Average number of days in hospital, specific to a diagnostic related group	This measure will allow you to assess whether increased mobility has resulted in improving patients' health such that they are safely discharged sooner.
	Patient Satisfaction	▪ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ▪ Hospital-specific customer service or patient satisfaction survey results	At most hospitals, patient satisfaction improves with mobility programs. Thus, patient satisfaction should not be compromised to achieve mobility goals. This measure will allow you to assess whether patient satisfaction is declining because of your mobility program, and adjust accordingly if needed.
Measures Associated with Potential Unintended Consequences of Increased Mobility	Staff Injuries	▪ Number of staff injuries per participant in the mobility program during the calendar month ▪ Total Case Incidence Rate of OSHA Recordable Injuries ▪ Days away restricted or transferred (OSHA) ▪ Number of back or patient handling injuries among SPUH staff per hours worked for the month	This measure will identify any increase in staff injuries as unintended consequences of the initiative.
Implementation Assessment Tools	Implementation Progress	▪ Assess plans and progress related to the tactics in the Mobility Action Group Change Package as listed in the Change Tactic Implementation Progress Survey	This survey will assist in monitoring your progress in implementing the initiative and alert the team if barriers exist.
	Organizational Culture	▪ Organization's readiness and commitment to change using the Organizational Readiness for Implementing Change (ORIC) Survey	This measure will identify organizational strengths that will enable implementation and barriers that could impact implementation of the initiative.

Step 5: Solicit the support of your peers.

Sharing with and learning from other hospitals who are also pursuing increased mobility may help you reach your goals more quickly and efficiently. Two resources that can facilitate this sharing include:

- The Hospital Elder Life Program (HELP). HELP is a comprehensive patient-care program that ensures optimal care for older adults in the hospital, including prevention of delirium and falls. Increasing mobility is one strategy recommended by HELP. Among other support, the HELP program provides an opportunity for peer-to-peer sharing via a Google Group. For more information about HELP, go to http://www.hospitalelderlifeprogram.org/.
- The Mobility Action Group on the Integrated Learning System's Connect site. The Mobility Action Group Connect group is an online community where BPCI Awardees and CJR participant hospitals can share tips and advice for successfully developing and refining a mobility program. The group houses all of the materials developed as part of the Mobility Action Group, including webinar slides, the Change Package, and resources shared by Mobility Action Group members, and provides a discussion board for communicating with group members. If you are interested in joining the Mobility Action Group Connect group, email mobility@lewin.com.

Step 6: Plan for sustainability.

As you move forward with your mobility program, we recommend planning for long-term sustainability. This is important at every stage of the program. Continued measurement and comprehensive, routine communications will help you to continue to develop, refine, and sustain your mobility programs.

Continued Measurement. You may find it helpful to continue to measure key clinical process and care outcome measures as you continue to develop, refine, and sustain your programs. These data may help your Mobility Team make the case for continued efforts to increase mobility. We recommend prioritizing the following measures for ongoing tracking: walks per day; proportion of patients with at least 3 walks per day; use of bed/chair alarms; use of physical restraints, falls, functional status, length of stay, and discharge disposition.

Comprehensive, Routine Communications. Consider sharing your mobility program's progress with hospital leaders, clinical and non-clinical staff within the unit(s) on which your mobility program is focused, local and national media, and professional associations via conference presentations. These communications can take many formats. Reach out to your target audience to find out what is preferred. For example, some hospital leaders prefer a PowerPoint presentation. Others prefer a written document. Some will ask for both.

Appendix A: Increasing Mobility in Acute Care Bibliography

This listing provides background references that may be useful to you as you implement a Mobility Program at your hospital. These may be important to provide to your hospital leaders to justify the initiative, or provide you important background information as you develop your case. The links provided below are either to PubMed abstracts or PubMed Central (PMC) full text when available.

General Background for the CMMI Mobility Action Group:

- Inouye SK, Brown CJ, Tinetti ME. Medicare nonpayment, hospital falls, and unintended consequences. The New England Journal of Medicine 2009;360:2390-3.
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    - PubMed (full text): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5500203/

Background on Immobility – Its Frequency and Complications:

- Brown CJ, Redden DT, Flood KL, Allman RM. The under recognized epidemic of low mobility during hospitalization of older adults. Journal of the American Geriatrics Society 2009;57:1660-5.
    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/19682121

- Hirsch CH, Sommers L, Olsen A, Mullen L, Winograd CH. The natural history of functional morbidity in hospitalized older patients. Journal of the American Geriatrics Society 1990;38:1296-303
    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/2123911

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    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/18314571

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    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/1747003

- Covinsky KE, Pierluissi E, Johnston CB. Hospitalization-associated disability: "She was probably able to ambulate, but I'm not sure". JAMA 2011;306:1782-93.
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- Fisher SR, Kuo YF, Sharma G, et al. Mobility after hospital discharge as a marker for 30-day readmission. The Journals of Gerontology Series A, Biological Sciences and Medical Sciences 2013;68:805-10.
    - PubMed (full text): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3674716/

Costs Associated with Complications of Immobility:

- Rizzo JA, Bogardus ST, Jr., Leo-Summers L, Williams CS, Acampora D, Inouye SK. Multicomponent targeted intervention to prevent delirium in hospitalized older patients: what is the economic value? Medical Care 2001;39:740-52.
    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/11458138

- Rubin FH, Neal K, Fenlon K, Hassan S, Inouye SK. Sustainability and scalability of the hospital elder life program at a community hospital. Journal of the American Geriatrics Society 2011;59:359-65.
    - PubMed (full text): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3588581/

- Leslie DL, Zhang Y, Bogardus ST, Holford TR, Leo-Summers LS, Inouye SK. Consequences of preventing delirium in hospitalized older adults on nursing home costs. Journal of the American Geriatrics Society 2005;53:405-9.
    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/15743281

- Schiffman J, Golinko MS, Yan A, Flattau A, Tomic-Canic M, Brem H. Operative debridement of pressure ulcers. World Journal of Surgery 2009;33:1396-402.
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- Wong CA, Recktenwald AJ, Jones ML, Waterman BM, Bollini ML, Dunagan WC. The cost of serious fall-related injuries at three Midwestern hospitals. Joint Commission Journal on Quality and Patient Safety 2011;37:81-7.
    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/21939135

- Scott RD. The direct medical costs of healthcare-associated infections in U.S. hospitals and the benefits of prevention: Centers for Disease Control and Prevention; 2009 March.
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    - Full text: http://www.beckershospitalreview.com/finance/average-cost-per-inpatient-day-across-50-states.html

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Examples of Successful Hospital Mobility Programs:

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    - PubMed (full text): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4388802/

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    - PubMed: https://www.ncbi.nlm.nih.gov/pubmed/10053175

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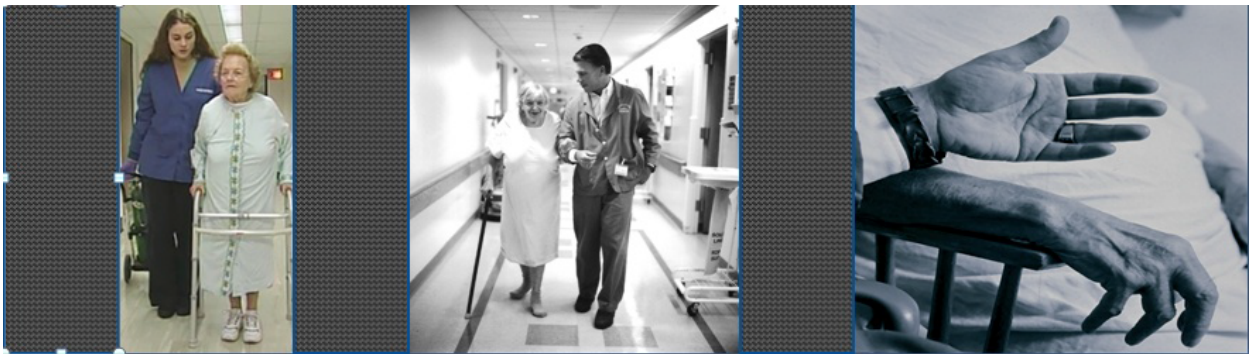


HELP Mobility Protocol I (HELP Walking I)

(Adapted from Hospital Elder Life Program, HELP www.hospitalelderlifeprogram.org)

Bedrest interferes with the function of major body organs and leads to generalized deconditioning including loss of muscle strength, balance, and endurance. Keeping older people upright, moving and walking regularly can prevent serious complications.

Purpose: The goal of the early mobilization initiative is to keep older patients physically moving while they are in the hospital. For patients who were walking at home, walking with assistance three times/day is recommended. For those who are unable to walk, simple exercise movements called active range of motion exercises should be performed three times/day. Walking at least 2-3 times/day is essential for physical and mental well-being. Walking helps to prevent loss of muscle mass and flexibility, which happens very quickly when older adults are confined to bed.

Procedure:

1. Check with nurse to ensure patient is able to get out of bed and walk. The nurse may need to fix I.V. lines (if any) for walking.
2. Lower bed to lowest possible position, raise head of bed, lower side rails.
3. Assist patient to sitting position:
    a. Ask patient to roll onto side, slide legs to edge of bed, and then lower legs over edge of bed.
    b. Ask patient to push up to the sitting position by pushing the elbow of one arm and palm of the other into the bed.
    c. Allow patient to sit at edge of bed for a few minutes to prevent dizziness. Encourage them to pump ankles up and down to stimulate circulation.
    d. Help patient put on non-skid slippers/shoes.
4. Assist patient to standing position:
    a. Ask patient to slide or scoot to edge of bed.
    b. Have patient position feet flat on floor directly under knees.
    c. Have cane/walker readily available, if needed.
    d. Allow patient to stand a few minutes to gain balance. Encourage patient to stand erect with head up, shoulders back and back straight.
5. Assist the patient to walk:
    a. If needed, support with your arm behind patient's waist.
    b. Follow, walking behind and to one side.
    c. Encourage patient to walk normally; do not rush. Stay with patient at all times.
    d. Walk only as far as patient feels comfortable. Remember to start the return trip before patient is too fatigued. The long-term goal is one lap around the nursing station 3x/day.
    e. Return patient immediately for dizziness or weakness.
6. Return patient to bed:

a. Have patient stand at side of bed, near top of bed so their head can easily reach the pillow.
b. Ask the patient to back up to the bed until they feel the backs of their legs reach the side of the bed.
c. Ask the patient to reach back one hand at a time to edge of the bed.
d. Bend waist, hips and knees and lower slowly to a sitting position.
e. Have patient scoot buttocks back so patient is firmly seated away from the edge of mattress.
f. Once safely seated, remove slippers and have patient swing legs back up onto bed.

7. Put call bell within reach.

HELP Walking Protocol (Adapted)
(HELP Walking II)

(Adapted from Hospital Elder Life Program, HELP www.hospitalelderlifeprogram.org)

Providing interventions to increase an elder patient's mobility and activity is one of the most beneficial services the HELP team can work with to support patients. Increasing physical activity can assist patients in maintaining muscle strength, provide relief from pain, prevent pneumonia and pressure sores. Activity and mobility can be increased through working with staff to encourage patients to sit up in a chair, working with a patient on exercises while they are in bed or sitting up in a chair. Volunteers may also walk with patients independently or with the support of the HELP Unit Coordinator (HUC) or Nursing staff.

Volunteers should only walk with patients if they have instructions from the HELP worksheet or staff that the patient needs only stand by assist or guidance while walking. Volunteers who have higher levels of skill through education or practice may also support patients in walking who are listed as one (1) assist. If a patient has any equipment that you are not comfortable in supporting, ask for assistance from the HELP Coordinator or Nursing staff.

Volunteers should only walk with a patient after receiving permission from an RN prior to the walk. Volunteers should ask for assistance or defer to ROM activity for any patients who have a higher need than your level of skill.

Prior to Walking with a Patient

- Verify that the HELP worksheet or RN has suggested volunteers walking with the patient. An RN must be asked prior to each walk with a patient to check for any needs that may arise and so staff knows the location of the patient.
- Check to see if the patient has any medical equipment. Do they have a catheter, IV pole, oxygen? IVs may be taken along on a walk and sometimes they can be disconnected. If a patient is on oxygen then they need to be switched to a portable tank by hospital staff for the walk.
- What equipment does the patient need while walking (i.e., walker, cane).
- Ask the patient where they will go when they return from walking. You might want to have the chair or bed ready and the path clear for when you return.
- If the patient is not able to be independent in their room, then HELP volunteers should use a gait belt for safety when walking with patients unless instructed that the patient does not need a gait belt.
- Prior to walking, volunteers should obtain a robe to put on the patient for walks into the hallway. Patients may have a robe in their room or you can find one in the Clean Utility Room.
- Prior to the patient standing, pause the bed alarm if the patient is on fall precautions.
- Prior to the patient standing, check footwear to make sure that grip socks are on correctly or that the patient is wearing shoes.

Walking

Start off by moving slowing to give blood pressure time to adjust and to also monitor the patient for tolerance of activity.

- When someone is lying in bed prior to walking, have them sit for a couple minutes prior to standing. Once they stand, ask them to stand in place for a minute. Then ask, "Are you feeling alright?" "Are you dizzy?" If there are any symptoms, the patient can sit back down.
- Ask the patient to walk slowly from their room.
- Observe the patient for unsteadiness, weakness, shortness of breath or improper use of the walker and take a break or correct as needed. You may need to instruct patients to stay close to the walker, look straight ahead or stand tall.
- Make sure to check in with the patient to see if they are ready to turn around. If a patient has a cognitive impairment, we should recommend that the patient turn around at a distance that will allow them to safely return to their room. If you return to the room and the patient is tolerating the walk well you can always proceed further.
    - If a patient becomes fatigued or short of breath during a walk, ask the patient to stop and take some breaths before proceeding. If needed, look for a place to sit that you can offer to the patient. If there is no place for the patient to sit, you could look for a passing staff person to help by getting a chair or wheelchair. If needed, call for HELP.

Returning to Room and Reporting Results of Walk

- Please give the patient notice when they are approaching their room. If you do not do this there is a good chance they will pass by.
- Give the patient directions as they approach a chair or bed to:
    - Keep the walker with them until they sit. Please remind them of this before going into their room as some people have the habit of parking their walker when they approach a destination.
    - Make sure they feel the bed or chair behind them prior to sitting. They should reach back with one hand to feel a handle and to sit slowly. If they are getting into the bed, ask the patient to sit as close to the bed rail as possible.
    - If the patient was on a bed alarm ensure that the alarm is again activated.
    - As needed, call staff if the patient needs any of the following: to have oxygen switched over, needs to be boosted in bed, adjustment of bed check pads, or any other concern or assist that Nursing should provide.
    - Report to staff how far a patient walked, how they tolerated activity and the patient's current status. The message can be given to the HUC, CNA or RN.

Using Your Body Safely (HELP)

(Adapted from Hospital Elder Life Program, HELP www.hospitalelderlifeprogram.org)

Purpose: In order to assist others in walking, the first step is to learn how to use your own body safely to prevent injury to yourself and the patients.

Procedure:

1. Body Mechanics
    a. Definition - using the right muscles and positioning to do the job. You use your body most effectively when you use your muscles properly.
2. Posture
    a. Good body mechanics start with proper posture. With proper posture there is a balance between the muscle groups, and body parts are in good alignment (position), i.e., ears over shoulders over hips over knees over heels. This allows the body to function at its best in all activities
    b. Good standing posture:
        i. Feet flat on the floor, separated about 12 inches
        ii. Arms at the sides
        iii. Back straight
        iv. Abdominal muscles tightened
3. Basic Rules to Remember to Help Your Muscles Work for You
    a. Take time to assume the proper posture before assisting others. Avoid rushing.
    b. Keep your back straight.
    c. Move your feet apart to provide a wide base of support.
    d. Bend from the hips and knees to get close to the patient/object. Do not bend from the waist. The back is held straight to protect small muscles along the spine.
    e. Hold heavy objects close to your body.
    f. Use the weight of your body to help to push or to pull the object. Pushing or pulling an object is easier and safer than lifting.
    g. Use the strongest muscles to do the job.
    h. Avoid twisting your trunk or at the knees as you work and bend for long periods of time. Pivot the whole torso as a unit.
    i. Always ask for help if you feel someone or something is too heavy to move by yourself. Do not start a movement you will not be able to stop.

Care of the Falling Patient (HELP)

(Adapted from Hospital Elder Life Program, HELP www.hospitalelderlifeprogram.org)

Purpose:

Occasionally, patients begin to fall when standing or walking. They may become weak, lightheaded, or dizzy. Falling may also be due to slipping because of spills, waxed floors, etc. When a patient is falling, there is a natural tendency to want to stop the fall. However, trying to prevent the fall could cause greater harm. Twisting and straining to stop the fall could result in injuries to you and the patient.

If you feel a patient begin to fall, the best thing to do is to help the patient to the floor. By easing the patient to the floor, you can control the direction of the fall. You will also be able to protect the patient's head.

Procedure:

1. Keep your back straight and feet apart as you assist the falling patient.
2. Hold the patient under the arms or around the waist and get close to the patient as quickly as possible.
3. Ease patient to the floor, protecting the head. Bend at your hips and knees as you lower the patient. Keep your lower back straight.
4. Stay with patient. Call for a nurse or physician to check the patient. Do not move the patient until they have been checked.

HELP Checklist for Walking with Patients

(Adapted from Hospital Elder Life Program, HELP www.hospitalelderlifeprogram.org)

- ☐ Identify from HELP worksheet, Nursing staff recommendation or mobility clipboard that a patient is recommended for walks.
- ☐ Check in at the Nurses Station and report that you would like to walk with patient in Room _____. Receive permission from the patient's RN that the patient is currently appropriate to walk. If uncertain, ask if the patient needs any equipment during the walk. If the patient is on oxygen, ask staff to assist with switching to a portable tank.
- ☐ Meet with the patient and explain that you have checked with their RN and that you would like to walk with them into the hallway.
- ☐ Ask the patient if they need to use the restroom before walking, and call for staff if they need to use the restroom.
- ☐ Check for tubes and wires attached to the patient such as IV, catheter, pulse ox, and call for assistance as needed.
- ☐ Prepare the patient for the walk and modify the room as needed. Ask if they will sit in a chair after the walk.
- ☐ Ask the patient to sit on the edge of the bed. Sit for one (1) minute before standing. You could work on ROM exercises at this time to warm up.
- ☐ Put on robe, gait belt and ensure proper footwear.
- ☐ Prior to standing inform the patient of the plan to stand at the bedside before walking and to communicate any difficulties while walking.
- ☐ Pause bed alarm if needed and instruct patient to stand. Ask the patient if they are dizzy or light headed and observe patient's appearance. Stand at the bedside for one (1) minute and adjust robe and gait belt as needed.
- ☐ Instruct the patient to walk slowly out of the room.
- ☐ Monitor the patient during the walk for signs of difficulty. Ask the patient how they are feeling.
- ☐ If the patient is showing signs of fatigue, instruct the patient to return to their room.
- ☐ Once the patient has returned to their bed or chair, call Nursing if you need assistance to reposition the patient or reapply any medical equipment.

- Verify the bed or chair alarm has been reactivated. If the patient had an alarm while in bed they will also need one when in a chair.
- Notify RN, CNA or HUC of the patient's status and the results of the walk. Report or document the distance.

HELP Mobility Competency Checklist

(Adapted from Hospital Elder Life Program, HELP www.hospitalelderlifeprogram.org)

The Hospital Elder Life Program

COMPETENCY BASED CHECKLIST
HELPING THE PATIENT TO WALK

- ☐ Wash hands
- ☐ Knock; Call patient by formal name; Introduce self
- ☐ Explain what you are going to do
- ☐ Get walking aid (cane, walker) if needed
- ☐ Get robe (or extra hospital gown), non-skid footwear
- ☐ Clear obstacles

Assisting Patient in Getting Out of Bed:

- ☐ Lower bed to lowest horizontal position, raise head of bed, lower side rails
- ☐ Assist patient to sitting position:
  - ☐ Have patient roll onto one side, slide legs to edge of bed, lower legs over edge of bed
  - ☐ Ask patient to push up to a sitting position by pushing the elbow of one arm and palm of the other onto the bed
  - ☐ Have patient sit at edge of bed for a few minutes to prevent dizziness
  - ☐ Have patient pump ankles to stimulate circulation
  - ☐ Help patient put on robe and slippers
- ☐ Assist patient to standing position:
  - ☐ Have patient slide to edge of bed
  - ☐ Position feet flat on floor directly under knees
  - ☐ Have cane/walker available
  - ☐ Give verbal coaching: Lean forward, push hands down onto bed, push feet onto floor, stand at edge of bed, and grasp cane/walker for balance
- ☐ Have patient stand for a few minutes to prevent dizziness

Assist Patient to Walk:

- ☐ Support patient with arm behind waist (if needed)
- ☐ Follow, walking behind and to one side
- ☐ Encourage patient to walk normally, heel-toe; not shuffling or toe walking
- ☐ Stay with patient at all times
- ☐ Walk as far as directed, stop if patient fatigues
- ☐ Return patient to bed/chair if dizzy or weak

Returning Patient to Bed:

- ☐ Have patient stand near top of bed, remove robe
- ☐ Have patient back up to bed until backs of legs reach bed
- ☐ Have patient reach back one hand at a time to edge of bed
- ☐ Have patient bend waist, hips and knees and lower slowly to sitting position
- ☐ Have patient scoot buttocks back toward center of bed
- ☐ Remove slippers, have patient swing legs onto bed
- ☐ Assist patient in centering in bed
    - ☐ Lower head of bed
    - ☐ Have patient bend both knees, push with feet and elbows to lift buttocks and position themselves in bed
- ☐ Make sure patient is comfortable, replace covers
- ☐ Put side rails up, call bell within reach
- ☐ Replace clothing, furniture, walking aids
- ☐ Wash hands

Name _____

Validated by _____

Date _____

COMPETENCY BASED CHECKLIST
THE FALLING PATIENT

- ☐ Keep back straight and feet apart
- ☐ Hold patient under arms or around waist and get close to patient as quickly as possible
- ☐ Ease patient to floor, protecting the head
- ☐ Bend at hips and knees as you lower the patient. Keep your back straight.
- ☐ Call for nurse
- ☐ Stay with patient until nurse arrives. Do not move the patient

Name_____

Validated By_____

Date _____

Daily Safe Mobility Scan (HELP)

(Adapted from Hospital Elder Life Program, HELP www.hospitalelderlifeprogram.org)

- Verify all needed equipment available for walking (See HELP Mobility Protocol), e.g., walker or cane. Verify footwear or nonskid slippers.
- Check for any barriers or obstacles to mobility along entire walking path

Potential Barrier	Notes	Checklist
Oxygen	• Obtain portable oxygen tank	
Intravenous (IV) lines	• Check with nurse and obtain portable IV pole	
Urine catheter	• Check with nurse, attach to bedclothes or walker	
Other wires or tubing	• Check with nurse for assistance	
Clear path in room	• Clear at least 3 foot diameter • Move all rolling furniture and equipment (e.g., bedside table, wheelchair) • Check for trash cans since they pose a fall risk. • Note: Patients may try to support themselves on rolling tables, which is unsafe.	
Clear path in hallway	• Clear a path at least 3 foot diameter. • Remove all obstructions in hallway up to intended walking goal. • Be sure moveable/rolling items are moved • Check for trash cans since they pose a fall risk.	

Sharon K. Inouye, MD, Hospital Elder Life Program, 10/7/2017

Progressive Mobility Protocol

(Shawnee Mission Medical Center)

Expected Outcome: Maintain baseline or progress patient functional status during hospital stay.

Level: Patient functional status assessment is performed by the RN. CA may assist with the progression of activity at the direction of the RN.

Relevant Information: Immobility leads to decreased muscle strength, decreased aerobic capacity, increased bone loss, and the development of vasomotor instability. Immobility is a risk factor for deconditioning, delirium, aspiration events, pneumonia, pressure ulcers, falls, and venous thromboembolism. Decreased functional status is a potentially modifiable factor that may contribute to acute care hospital readmissions.

(Continued on next page)

Assessment:	1. Assess on admission the patient's baseline functional ability. 2. ICU Patient: Perform Safety Screening from ICU Algorithm to determine initial level of activity 3. Assess daily the appropriateness of the activity order. Collaborate with MD for clarification if the patient has a bed rest order. a. Indications for Bedrest include but are not limited to: • Unstable fractures • Hemodynamic Instability • Cerebrospinal (CSF) fluid leak • Post-Procedure restrictions limited by time or device 4. Assess on admission, first time out of bed, and with any change in status, the patient's current functional ability utilizing the Egress test to determine: b. Activity Assistance level: • Independent – patient performs 100% of the task (for example patient performs all ADL's and ambulates in halls without any assistance). • Minimal Assistance – patient performs at least 75% of task (for example patient is able to ambulate in hall with standby assist and minimal prompts/cues (consider gait belt). • Moderate Assistance – patient performs at least 50% of task (for example patient needs one person assist to help transfer and or walk with assistive devices, such as cane/walker/gait belt/specialty braces). • Maximum Assistance – patient performs at least 25% of task (for example patient needs 2 person assist to help stand, pivot, and/or walk a few steps with assistive devices/gait belt). • Total Assistance – patient performs less than 25% of task. Mechanical lift is required to move patient out of bed to chair. c. Assistive device needs
Plan:	1. Collaborate with the patient to set mobility goals to return to baseline activity level each shift. 2. Define a stepwise mobility progression to achieve goals. 3. Collaborate with physician to consider a physical therapy consult for unsuccessful attempts to mobilize patient.
Interventions:	1. Identify patient's current level of mobility and implement interventions to progress through the Mobility Milestones. 2. Mobility Milestones

	Acute/Intermediate Care Patients	ICU Patients
Milestone 1	1. Head of bed elevated at mealtimes 2. Reposition every 2 hours 3. Range of motion (ROM) **AND** 4. Up to chair daily *Progress to milestone 2 as appropriate*	1. HOB ≥ 30° 2. Passive ROM 2X/day 3. CLRT initiated if patient meets criteria **OR** Q 2 hour turning if CLRT criteria not met
Milestone 2	1. Sit in chair at mealtimes **AND** 2. Walk up to 25 feet *Progress to milestone 3 as appropriate*	1. Q 2 hour turning 2. Passive / Active ROM 3X/day 3. HOB 45° X 15 min. 4. HOB 45°; legs in dependent position X 15 min. 5. HOB 65°; legs in dependent position (full chair mode) 6. X 20 min., 3X/day **OR** Full assist into chair 2X/day
Milestone 3	1. Sit up in chair at mealtimes **AND** 2. Walk 25 feet or more (to door and back) *Progress to milestone 4 as appropriate*	1. Self or assisted Q 2 hour turning 2. Sitting on edge of bed (max inflated), feet touching floor or stool X 15 min. 3. Progressive bed sitting position X 20 min. minimum, 3X/day **OR** Stand-Pivot to chair position 2X/day
Milestone 4	1. Sit up in chair at mealtimes **AND** 2. Walk in hall, increasing distance as tolerated *Progress to milestone 5 as appropriate*	1. Self or assisted Q 2 hour turning **AND** 2. Bed sitting Position Min 20 min. 3X/day 3. Sitting on edge of bed (max inflated) feet touching floor or stool; stand w/assist 4. Active Transfer to Chair (OOB) w/ assist Min 3X/day
Milestone 5	Walk in hall independently, increasing distance as tolerated Encourage patient to continue mobility activity post discharge	1. Self or assisted Q 2 hour turning **AND** 2. Chair (OOB) w/assist min. 3X/day 3. Meals consumed while dangling on edge of bed or in chair if eating 4. Ambulate progressively longer distances with less assistance 2-3X/day

Interventions: (continued)	3. Document in iView: Activity Status Activity Assistance Assistive Device Time Up in Chair Gain distance
Evaluation:	1. Track Mobility Milestone Goal on Communication Board 2. Document education using teach back. 3. Communicate Mobility Milestone Goal and activity assistance level during hand-off.

Medical Surgical Progressive Mobility Protocol

(Inova Fairfax Hospital)

ADDENDUM

Medical Surgical Progressive Mobility

STEPS	Step 1* Bed Rest	Step 2 Supine Exercises	Step 3 Bed Mobility	Step 4 Edge of Bed (EOB)	Step 5 OOB to Chair	Step 6 Walks in Room	Step 7 Walks out of Room
Patient Participation	Not required	Required					
Range of Motion	Passive ROM	Active ROM while in bed					
Positioning	Turn Q2 Hr **		Assist with turns every 2 hours	Remind patient to turn every 2 hours			
New Activity	1. HOB 30 degrees or reverse trendelenburg	1. Assist with rolling in bed 2. Assist with scooting to HOB 3. Assist with hygiene 4. Sitting in position using chair mode in bed where available	1. Able to lift arms and legs against gravity. 2. Assist with scooting to HOB 3. Assist with Hygiene 4. MD order obtained as needed for PT and OT	1. Dangle on side of bed	1. Stand at side of bed 2. Seated ADL 3. Transfer to chair	1. Ambulate in room with hand-held assistance	1. Ambulate in hallway with RN/CT assistance.
Progress When	1. Participation in care 2. Clinical stability	1. Able to perform active movement 2. Sitting upright 3. Assists with bed mobility	1. Assist with bed mobility 2. Can lift arms and legs off bed	1. Able to sit at EOB without dizziness	1. Stand with minimal assistance 2. Tolerate chair BID and participates in upper body ADLs 3. Stand with minimal assistance. 4. Able to march in place for 10 steps	1. Walk in room with hand-held assistance on one person 2. Complete bathroom ADL with minimal assistance	1. Ambulate independently. 2. Complete ADLs independently.

Progress to next level once goal has been achieved; allow patient to skip Steps as tolerated or return to previous level if level is not tolerated.
* Consider PM&R consult if unable to assess the step number at beginning of mobility or if patient is not progressing to the next level.
** Patients should be encouraged to assist with turning as they are able on all steps starting at Step 2.

Baseline Mobility Assessment

(Tracking Health Recovery in Veterans: THRIVe)

Mobility Assessment: The level of mobility recommended to the patient by nursing staff will be dependent on the individual patient and will incorporate the activities patients were deemed able to do independent of cueing or assistance during each walking session.

For example, if a participant could stand at the bedside independently, but required standby assistance for walking, the participant would be encouraged to sit on the side of the bed for meals and stand up beside the bed for 3-5 minutes every two hours as able.

Assessment of Readiness for Mobility: Check with nursing to assure patient is hemodynamically stable (pO2 > 90%, blood pressure and pulse stable) prior to visiting patient.

Ask the patient to roll over in bed and sit up.
Assess the patient's ability to this without assistance. Once sitting are they able to maintain their upright posture without help? If yes, then progress.

Ask the patient to stand from the side of the bed.
Ask the patient to plant their feet firmly on the ground, after assuring they have on proper footwear and ask them to stand from the side of the bed. Assess if they are able to get themselves to standing and the level of assistance they need to stand. If able to stand and hold this position without difficulty, then progress.

Ask the patient to shift their weight from the left foot to the right and back again. Repeat this several times while encouraging the patient to hold onto the bed rail. Are they able to shift their weight while remaining upright? If yes, then progress.

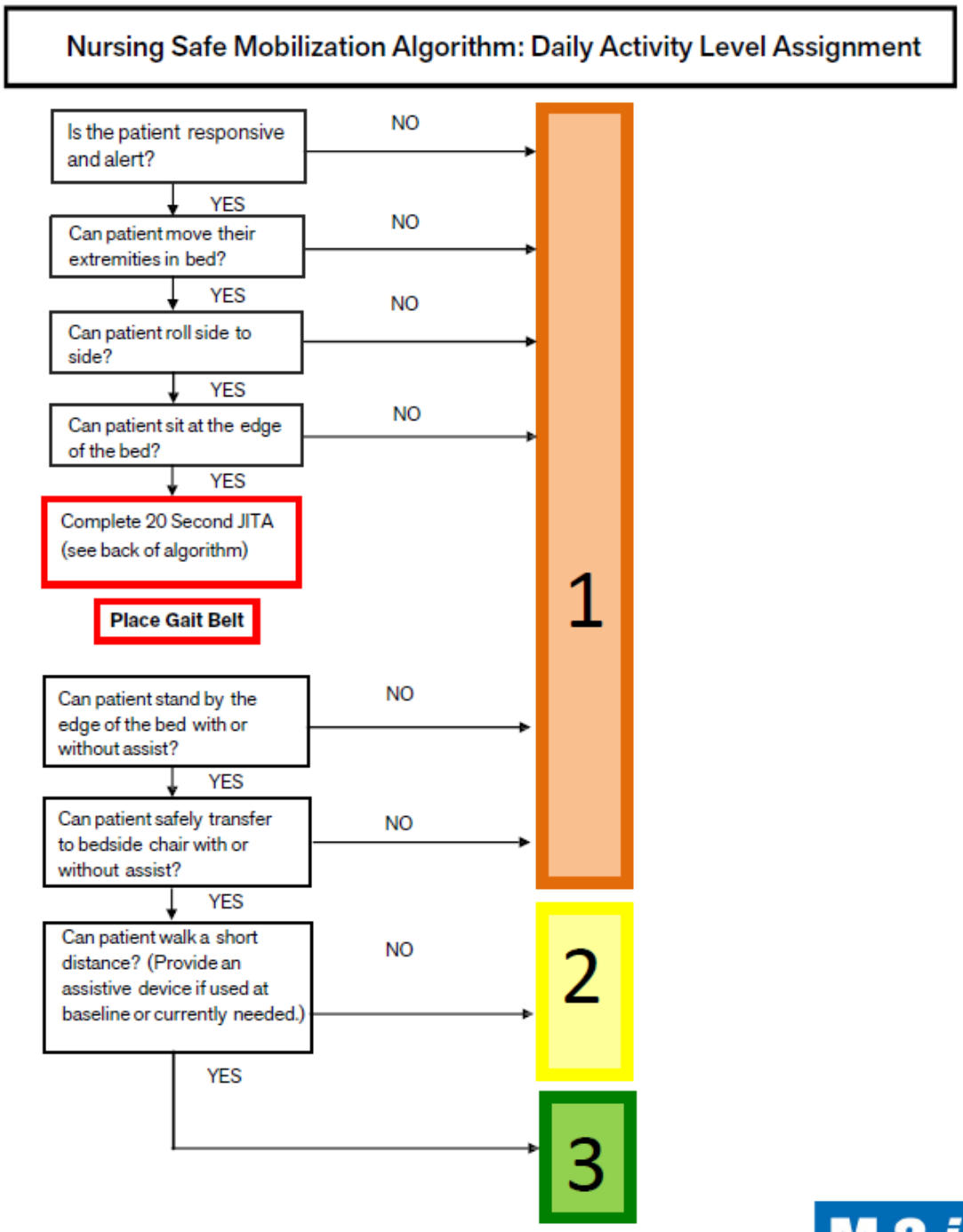
Ask the patient to march in place at the bedside, still holding the bed rail.
March for approximately 20-30 seconds. Are they able to pick up both feet?
Are they able to maintain their balance while marching? If yes, then progress.

Ask the patient to walk using the rolling walker as needed and the gait belt. Ask the patient to walk as far as they can, before becoming fatigued. If needed, set up a chair in the hallway to give the patient a target. Can also pull a wheelchair behind you so the patient can sit when they feel fatigued. A rolling walker or rollator will be provided for walking as needed. This ambulatory device may be left in the room if participants wish, and if they demonstrate that they are able to use the device safely and independently.

PI: Cynthia J. Brown, MD, MSPH

Nursing Safe Mobilization Assessment

(Adapted from: MultiCare Health System)



20 Second
Just In Time Assessment
(JITA) of patient's mobility:

- Prior to moving, repositioning, transferring, or standing a patient, have the patient do all of the following:
  a. Ask the patient to lift their right leg and hold for 5 seconds, then lower it
  b. Ask the patient to lift their left leg and hold for 5 seconds, then lower it
  c. Ask the patient to hold both arms up for 5 seconds, and then lower them

- When the patient is ready, have them sit edge of bed, dangle with protection from falling forward.
  Coach, assist, and or raise head of bed/gurney to allow them to sit up.

Repeat the above assessment prior to standing.

- If the patient can perform all 3 tasks completely, then:
  - The patient understands you and can follow directions
  - The patient is cooperative

Prior to standing with the patient, put a GAIT BELT snuggly around them.

- Have the patient stand, assisting as needed, pause, and step in place for 5 seconds.
- If safe to stand with patient, proceed with transfer and Ambulation.
- If unsafe with these activities and/or the patient cannot come to stand, use lift for out of bed mobility.

The final decision on safe mobility plan is based on the caregiver's judgment, taking into consideration the patient's overall medical status, strength, and level of alertness.

M 2 i
Move 2 improve
MultiCare

Mobility Assessment with Mobility Levels

(Adapted from: Sentara Healthcare)

Patient Mobility Protocol

- Within 12 hours of admission, all patients are assessed for mobility by the RN and each shift thereafter
- Mobility status prior to admit and baseline status upon admit are considered when determining mobility activities and goals
- Mobility is initiated at the highest level possible based on present condition and pre-admit status
- Activity is offered at least 3 x/day
- Document all mobility on Doc Flowsheet

Mobility Scores	
Mob Score 1:	Turn/position, ROM, Bed MOB, Bed in chair mode, Sitting Edge of Bed, Mechanical lift to chair, Consider PT Order
Mob Score 2:	Transfers to chair tid, Transfers to BSC, Consider PT Order
Mob Score 3:	Patient in chair tid, Ambulate in room & hall with assist, Consider PT Order
Mob Score 4:	Ambulate in room and halls without assist

Exclusion Criteria:

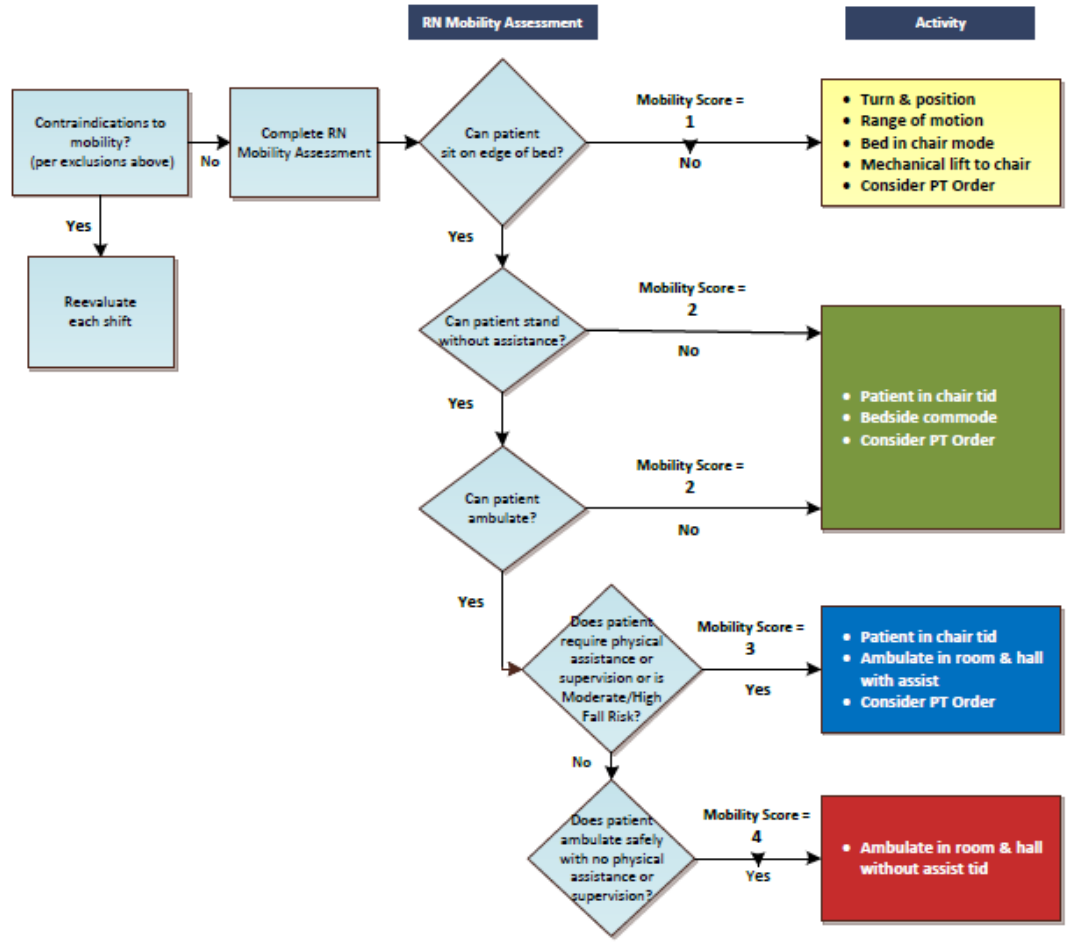
Contraindications are present:

- Uncleared spine or fracture
- Increased ICP
- Femoral sheath
- Traction

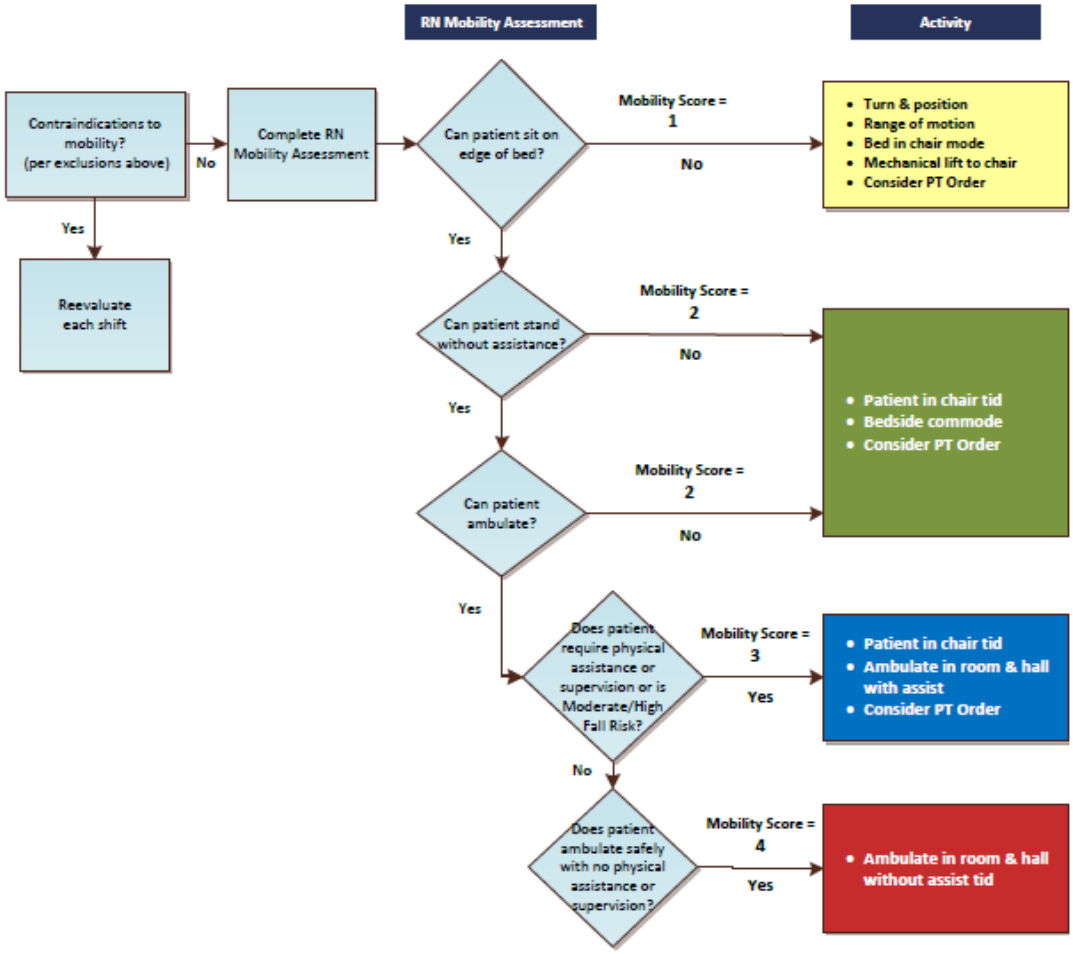
Take extra precaution when mobilizing patients with the following conditions:

- orthostatic hypotension, hypertension, cognitive impairment PTT/PT/INR outside of normal range, hemodynamic instability, comfort measures, DVT

**This protocol is superseded by any Activity order



Patient Mobility Assessment and Activity – October 2013 Pilot (with Fall Risk Statement)



Checklist of Activities of Daily Living (ADL/IADL) – Admission

pbs.org/caringforyourparents PBS

Caring FOR YOUR Parents

Checklist of Activities of Daily Living (ADL)

Check the level of function of each activity of daily living listed below. This will help you determine how much assistance an elder needs.
(Obtain on Admission)

Function	independent	needs Help	dependent	does not do
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking				
Climbing Stairs				
Eating				
Shopping				
Cooking				
Managing Medications				
Using the Phone				
Housework				
Doing Laundry				
Driving				
Managing Finances				

Caring for Your Parents is A klRk dOCuMentARy gROup, ltd. pROduCtlOn FOR wgbh bOstOn.

MAJOR Funding FOR *Caring for Your Parents* is pROvided by the hARRAh's FOundAtlOn. AdditlOnAl Funding pROvided by the CORpORAtlOn FOR publlC bROAdCAsting And publlC televlsiOn vieweRs.

speCIAl thAnks tO the stAFF OF AARp publlCAtlOns FOR theIR geneROus AssistAnCe with this pROgRAM.

Checklist of Activities of Daily Living (ADL/IADL) – Discharge

Checklist of ADL

Obtain at Discharge

Activities ofDaily Living (ADL)

ADL Function	Independent	Needs Help	Dependent	Cannot Do
Bathing				
Dressing				
Grooming				
Mouth care				
Toileting				
Transferring bed/chair				
Walking				
Climbing stairs				
Eating				

Senior Planning Services
ElderCare Solutions
1811 State Street · Santa Barbara, CA 93101
805-966-3312 • 805-963-7146 Fax
SeniorPlanningServices.com
info@seniorplanningservices.com

Mental Status Screen

(Adapted from the FAM-CAM in Hospital Elder Life Program, HELP
www.hospitalelderlifeprogram.org)

1. Ask the family/caregiver to think about the past week: During this week, have you noticed any changes in the patient's thinking or concentration, such as:
    a. being less attentive,
    __YES __ NO
    b. appearing confused or disoriented (not knowing where he/she was),
    __YES __ NO
    c. behaving inappropriately, or
    __YES __ NO
    d. being extremely sleepy all day?
    __YES __ NO

2. Were any of the changes present all the time, or did they come and go from day to day?
__ Come and go __ All the time

If 1 = Yes OR 2 = Come and Go, then the patient may have delirium and you should proceed to a cognitive assessment and/or refer to the physician.

Consider patient a fall risk until further evaluation completed.

Reference: Steis MR, Evans L, Hirschman KB, Hanlon A, Fick DM, Flanagan N, Inouye SK. Screening for Delirium via Family Caregivers: Convergent Validity of the Family Confusion Assessment Method (FAM-CAM) and Interviewer-Rated CAM. J Am Geriatr Soc. 2012; 60:2121-26. www.hospitalelderlifeprogram.org

Change Tactic Implementation Progress Survey

Please characterize your plans and progress related to the change tactics listed below and repeat these measures each month. Remember that the change tactics below are a list of all possible tactics; it is not expected that an organization will work on all of these tactics as part of their mobility program. It is acceptable to report "1 – Not considering this change tactic" for several of these tactics and for this rating to not change over time. Some tactics may already have been implemented by your organization prior to this initiative. Therefore, it is also acceptable to start with a rating higher than 1 during the first reporting month.

Note: 1 = Not considering this change tactic; 2 = Considering this change tactic, but have not pursued it yet; 3 = Change tactic is in the planning stages; 4 = Implemented this change tactic, but experiencing challenges; 5 = Implemented this change tactic and it is working well.

Strategy	**Change Concept**	**Change Tactics**	**Implementation Progress**
1 – Create engagement in a mobility culture	Engender buy-in and engagement from patients and families	Communicate expectations for mobilization to patients and families (e.g., via patient/family brochures or during rounds)	
		Collaborate with patients to prioritize mobility within the context of meeting their functional goals (e.g., earlier discharge, maximizing independence)	
		Display visual reminders of mobility goals in room and in hall (e.g., distance markers in hallway)	
	Engender buy-in and engagement from executive, clinical and non-clinical staff	Enlist an interdisciplinary team to design the mobility program	
		Educate staff about the rationale for increased mobility	
		Share progress towards mobility program goals routinely	

Strategy	Change Concept	Change Tactics	Implementation Progress
2 – Assess and plan for mobility	Assess function and mobility throughout hospitalization	Standardize nursing mobility assessment on admission and discharge	
		Assess functional status on admission and discharge	
		Assess for any evidence of acute mental status change	
		Use a progressive mobility tool or mobilization algorithm to re-assess patient mobility throughout their hospital stay and increase their activity/ambulation accordingly	
		Record mobility daily (e.g., whiteboard, patient flow chart, EHR)	
	Include mobilization plan in every patient's Care Plan	Set baseline ambulation goal (distance), with target of 3 times/day	
		Limit Physical Therapy referrals for general mobility	
		Identify primary and support staff responsible for mobilization	
		Clearly identify which patients have been cleared for ambulation (e.g., in the EHR, on patient white boards)	
	Revise clinical protocols to promote mobility/ambulation (with assistance as needed)	Justify all bedrest orders, and the default should be ambulation	
		Provide specific activity order (e.g., "ambulate with assistance, 1 lap of unit TID")	

Strategy	Change Concept	Change Tactics	Implementation Progress
3 – Provide early mobilization with safe approaches for patients and staff	Train all staff in safe mobility	Train and demonstrate safe mobility and body mechanics for nurses, aides, sitters, PT techs, volunteers, 'ambulators'	
		Reward/recognize front-line staff for new ideas in how to mobilize patients	
		Train family members in safe mobility	
	Ambulate/mobilize patients early and often	Walk patients at least 3 times/day	
		Progress ambulation/mobilization based on improvements in functional status assessments	
	Have appropriate assistive devices for every patient	Provide gait belts in every room	
		Make walkers, canes, crutches centrally available—easy and reliable 24-hour access	
		Provide glasses, hearing aids, and appropriate footwear as needed	
	Transition Falls Team to Mobility Team	Pair mobility along with falls as critical outcomes	
		Always consider maintaining mobility in all corrective actions for fall prevention	
		Generate unit-specific (and eventually hospital-wide) reports on mobility rates and falls (with and without injury) rates	

Strategy	Change Concept	Change Tactics	Implementation Progress
4 – Minimize immobilizing devices	Reduce/minimize bed and chair alarms	Develop system on floor for purposeful hourly rounding (RNs and CNAs) and rapid response to call-bells	
		Remove bed/chair alarms from fall protocols and standing order sets	
		Measure usage of bed/chair alarms on floor(s)	
	Daily 'Patient Mobility' Scan to identify mobility barriers	Identify and reduce all tethers (urinary catheters, oxygen with short tubing, compression devices)	
		Verify availability of footwear and assistive devices	
		Confirm unobstructed walking route in patient room and hallway	
		Assess for other obstacles to daily mobility	
		Total	

Total scores can range from 25-125. Higher scores indicate greater implementation progress.

Organizational Readiness for Implementing Change (ORIC) Survey

Please indicate the extent you agree or disagree with the following statements and repeat these measures each month.

Note: 1 = Disagree; 2 = Somewhat Disagree; 3 = Neither Agree nor Disagree; 4 = Somewhat Agree; 5 = Agree.

Statement	**Agreement Level**
1. People who work here feel confident that the organization can get people invested in implementing this change.	
2. People who work here are committed to implementing this change.	
3. People who work here feel confident that they can keep track of progress in implementing this change.	
4. People who work here will do whatever it takes to implement this change.	
5. People who work here feel confident that the organization can support people as they adjust to this change.	
6. People who work here want to implement this change.	
7. People who work here feel confident that they can keep the momentum going in implementing this change.	
8. People who work here feel confident that they can handle the challenges that might arise in implementing this change.	
9. People who work here are determined to implement this change.	
10. People who work here feel confident that they can coordinate tasks so that implementation goes smoothly.	
11. People who work here are motivated to implement this change.	
12. People who work here feel confident that they can manage the politics of implementing this change.	
Total	

Total scores can range from 12-60. Higher scores indicate greater organizational readiness to implement a mobility program.

Hospital Mobility Documentation

HOSPITAL MOBILITY DOCUMENTATION
(Record daily)

Patient ID

_____ _____ _____

DURING THE PAST 24 HOURS HAVE YOU…

		FREQUENCY	HOW DID YOU GET THERE? *Did you have help from Another person?*	*Did you use aids or Special equipment?*
Gotten out of bed to the chair (Level 1)	Yes No 1 0	Once twice 3x ≥4x 1 2 3 4	Yes No 0 1	Yes No 0 1
Score	_____ +	_____ +	_____	= Level 1 Score _____
Walked in the room (Level 2)	Yes No 1 0	Once twice 3x ≥ 4x 1 2 3 4	Yes No 0 1	Yes No 0 1
Score	_____ +	_____ +	_____	= Level 2 Score _____
Walked in the hall on the unit (Level 3)	Yes No 1 0	Once twice 3x ≥4x 1 2 3 4	Yes No 0 1	Yes No 0 1
Score	_____ +	_____ +	_____	= Level 3 Score _____
Walked off the unit (Level 4)	Yes No 1 0	Once twice 3x ≥4x 1 2 3 4	Yes No 0 1	Yes No 0 1
Score	_____ +	_____ +	_____	= Level 4 Score _____

Type of equipment used:

_____ Trapeze _____ Bed rails _____ Transfer board _____ Cane _____ Walker _____ Rolling walker _____ Crutches _____
Other (specify): _____

Have you fallen in the last 24 hours? _____ Yes _____ No **Did you sustain an injury when you fell?** _____ Yes _____ No

What were the injuries? (Explain)_____

PI: Cynthia J. Brown, MD, MSPH

Mobility Tool for Nurses Station

(UnityPoint Health – Meriter Hospital)

Date: **Goal: 3 Walks each day!**

Room #	Pt Initials	Walk By:	Refusal: (time)	Walk 1 (feet/time)	Walk 2 (feet/time)	Walk 3 (feet/time)	Room #
801		Vol HELP Staff					801
		Vol HELP Staff					
802		Vol HELP Staff					802
		Vol HELP Staff					
803		Vol HELP Staff					803
		Vol HELP Staff					
804		Vol HELP Staff					804
		Vol HELP Staff					
805		Vol HELP Staff					805
		Vol HELP Staff					
806		Vol HELP Staff					806
		Vol HELP Staff					
807		Vol HELP Staff					807
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808		Vol HELP Staff					808
		Vol HELP Staff					
817		Vol HELP Staff					817
		Vol HELP Staff					
818		Vol HELP Staff					818
		Vol HELP Staff					
819		Vol HELP Staff					819
		Vol HELP Staff					
820		Vol HELP Staff					820
		Vol HELP Staff					
821		Vol HELP Staff					821
		Vol HELP Staff					
822		Vol HELP Staff					822
		Vol HELP Staff					
823		Vol HELP Staff					823
		Vol HELP Staff					

Check with RN prior to walking!

Take Credit--Document This!

Key:	
Vol= Team Up	*Independent level patients*
HELP	*Assist of 1 person for ambulation; could be 2nd person for 2 Assist*

Fall Measures Recommended by NQF

(To verify no increase in risk of falls with the mobility initiative)

Measure Name	Measure Description	Numerator Statement (on a reporting hospital unit)	Denominator Statement
Overall Falls with injury	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000	Total number of patient falls of injury level minor or greater (whether or not assisted by a staff member) by eligible hospital unit during the calendar month X 1000. This may include patients on the unit not participating in the mobility program. Included Populations: • Falls with Fall Injury Level of "minor" or greater, including assisted and repeat falls with an Injury level of minor or greater • Patient injury falls occurring while on an eligible reporting unit	Patient days by type of unit during the calendar month. Included Populations: •Inpatients on eligible inpatient units for all or part of a day on adult medical, surgical, and medical-surgical combined units •Medicare beneficiaries age 65 and older on an eligible reporting unit are included in the patient day count.
Participant Fall Rate	The quarterly incidence rate of falls amongst mobility participants per 1,000 participant days.	Falls experienced by participants in the mobility program during the month.	•Number of inpatient days on the unit, multiplied by 1,000. •The denominator represents exposure of mobility participants to the risk of falling.
Participant Falls With Injury Rate	The quarterly incidence rate of falls with injury amongst mobility participants per 1,000 participant days.	Falls with injury (minor or greater) experienced by participants in the mobility program during the month.	•Number of inpatient days on the unit, multiplied by 1,000. •The denominator represents exposure of mobility participants to the risk of falling.

For more information on these measures please visit the National Quality Forum: http://www.qualityforum.org/QPS/

Example Report for Daily Walks (Control Charts)

The Mobility Action Group team used control charts to analyze the progress each hospital made over the course of their mobility program. Control charts were created for hospitals that submitted at least 17 consecutive weeks of data. Data were analyzed by:

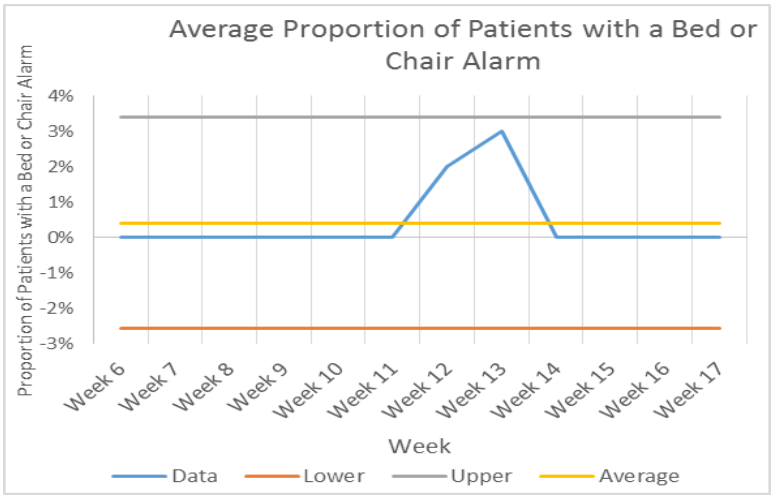
- average proportion of patients with a bed or chair alarm,
- average walks per patient, and
- average proportion of patients with at least three walks per day

To develop the control charts, the team identified the mean, standard deviation, and upper and lower bounds, which are three points plus or minus the standard deviation, for each hospital within each of the three data elements. These control charts were designed for hospitals to use their own data in a meaningful way. Some hospitals experienced an overall upward or downward trend, while others witnessed fluctuations throughout the duration of their mobility programs. During the October 5th Mobility Action Group Feedback Session, three hospitals were asked to speak to their control charts, including providing details about what changes occurred from one week to another that may have resulted in the trends witnessed.

UPMC Presbyterian Shadyside

UPMC Presbyterian Shadyside indicated that they were working with a small, 13-bed unit with a centrally located nurse's station that enables the nurses to have a direct line of sight to the patients. They do not normally use bed chair alarms, or any forms of restraint generally, but there was one week where they used the bed/chair alarm for a patient who would frequently try to get up on his own rather than wait for assistance.

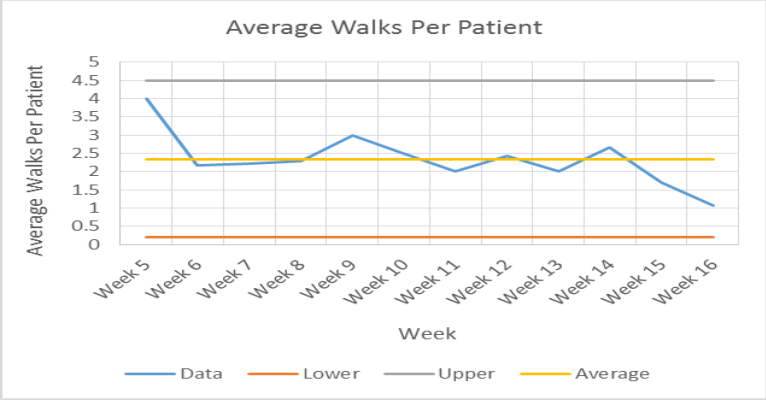
Figure 1. UPMC Presbyterian Shadyside: Average Proportion of Patients with a Bed/Chair Alarm



St. Peter's Hospital

St. Peter's Hospital witnessed a significant dip in the number of walks per patient during week nine. A closer look revealed that they had two patients who had low blood pressure and needed to be transfused and two patients who refused to be walked, which presented a challenge in terms of ambulating patients. Another issue identified is sometimes patients are discharged earlier in the day and are unable to get their three walks in prior to discharge. But for the most part, they have volunteers trained to ambulate patients and fill in gaps in nursing staff on the unit.

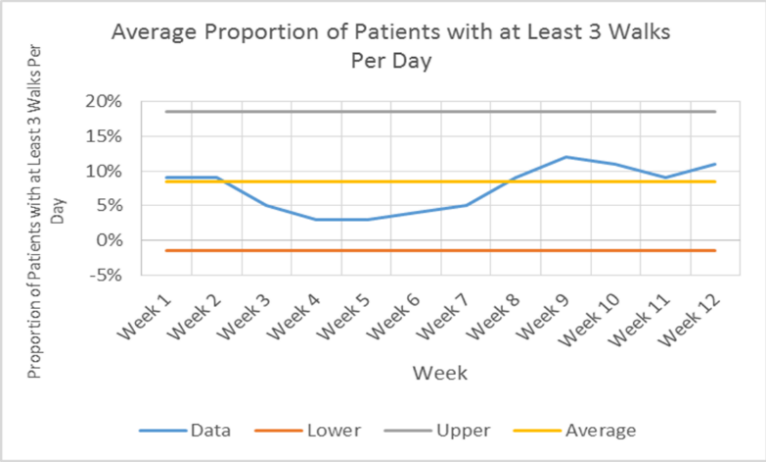
Figure 2. St. Peter's Hospital: Average Walks per Patient



Scott and White Hospital

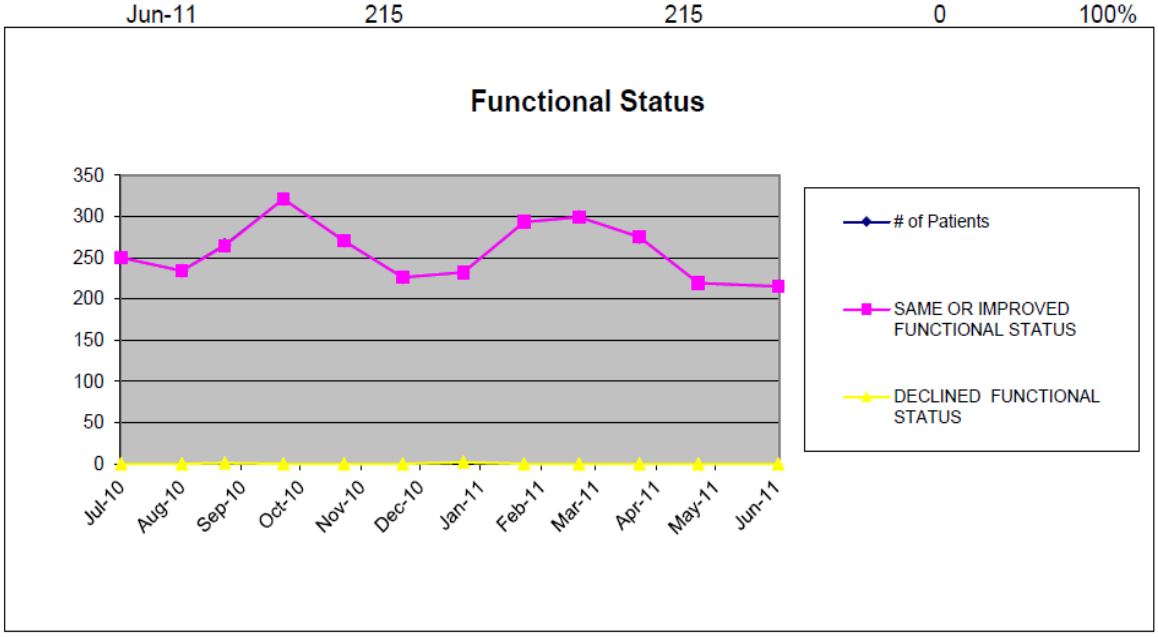
Scott and White Hospital's average proportion of patients with at least three walks per day fluctuated across weeks. The hospital indicated they found it difficult to count the walks on days of admission and discharge, particularly for patients requiring stabilization prior to ambulation. In addition, they are located in a rural county, and patients often deal with quite a bit of walking over uneven surfaces, long driveways, etc. Therefore, mobilizing on the same day of discharge is not a huge priority for the hospital.

Figure 3. Scott and White Hospital: Average Proportion of Patients with at Least 3 Walks per Day



Example Report for Impact of Initiative on Functional Status

MONTH/YEAR	# of Patients	SAME OR IMPROVED FUNCTIONAL STATUS	DECLINED FUNCTIONAL STATUS	Functional Status Percentage
July-10	250	250	0	100%
August-10	234	234	0	100%
September-10	265	264	1	99%
October-10	321	321	0	100%
November-10	270	270	0	100%
December-10	226	226	0	100%
January-11	232	232	2	99%
February-11	293	293	0	100%
Mar-11	299	299	0	100%
Apr-11	275	275	0	100%
May-11	219	219	0	100%
Jun-11	215	215	0	100%



Bed/Chair Alarms: Evidence and References

Demonstrated lack of efficacy for fall prevention:

Most hospital fall prevention programs make frequent usage of bed and chair alarms, which alarm whenever patients attempt to move out of the bed or the chair. Published evaluations of the efficacy of specific programs using these types of alarms have not demonstrated any effectiveness for fall prevention. In a randomized controlled trial published in 2012, bed and chair alarms were found to be ineffective at reducing falls, and the authors suggested that they may contribute to nursing stress in the form of alarm fatigue and to higher healthcare costs (Shorr 2012). A more recent study published in 2014 showed that bed and chair alarms do not reduce hospital falls and are not cost-effective (Sahota 2014). A cluster-randomized trial, published in 2016 and employing a multi-component intervention strategy which included bed and chair alarms, found no significant reduction in falls or falls with injuries (Barker 2016).

References (See also Appendix A: Bibliography):

Barker AL, Morello RT, Wolfe R, et al. 6-PACK program to decrease fall injuries in acute hospitals: a cluster randomized controlled trial. BMJ. 2016; 352:h6781.

Sahota O, Drummond A, Kendrick D, et al. REFINE (Reducing Falls in In-patient Elderly) using bed and bedside chair pressure sensors linked to radio-pagers in acute hospital care: a randomized controlled trial. Age Aging. 2014; 43:247-253.

Shorr RI, Chandler AM, Mion LC, et al. Effects of an Intervention to Increase Bed Alarm Use to Prevent Falls in Hospitalized Patients: A Cluster Randomized Trial. Ann Intern Med. 2012; 157(10):692-699.

PI: Sharon K. Inouye, MD, MPH

Sample Patient Agreement

(Adapted from: Adventist Health System)

Aspire Orthopedic Institute
Adventist Health

Thank you for choosing Aspire Orthopedic Institute for your joint replacement. Your successful surgery and recovery are very important to us! We work hard to make your time with us extraordinary. Please let us know if there is anything we can do to improve your care. We look forward to serving you.

The more you know now about your surgery and new joint, the better prepared you will be for life after surgery. The Aspire Orthopedic Institute Joint Replacement Program is made up of a team of health care professionals who will help you before, during, and after your surgery. We will teach you about your surgery and hospital stay ahead of time. Your doctors, nurses, and physical/occupational therapy team will work together with you to coordinate the best care for your specific needs.

We've found ways to make sure your time in our Joint Replacement Program is a success. We want you to be as healthy and prepared as possible before your surgery. We aim to have you up and out of bed the day of surgery. Moving around as soon as possible will help you avoid problems as you heal.

New pain management techniques help decrease levels of pain after surgery and lessen the need for sedating pain medications. Our patients are more alert and comfortable after surgery. This improved pain control and reduced sedation allows patients to mobilize and be ready to go home sooner than in the past. At home you will continue to do your recommended physical therapy exercises, rest, and gradually return to your activities of everyday life.

The Aspire Orthopedic Institute Joint Replacement Program Enrollment Agreement is to make sure you understand our program. We also want to ensure you have friends and family ready to help you as you continue to recover at home. We are honored you have chosen us to care for you before, during, and after your surgery. We are happy to have you in our program!

Please bring this signed form with you to the Preoperative Education Class you will attend before your joint replacement surgery.

Sincerely,

The Aspire Orthopedic Team

Welcome to the **Aspire Orthopedic Institute Joint Replacement Program**! By following the instructions below you will help yourself to have the best possible experience with your joint replacement surgery, at the hospital, and as you return home. Your surgeon wants to send you home (with help from family and friends) as soon as it is safe. Your surgeon does not plan to send you to a skilled nursing facility unless you need more assistance than can be provided at home.

We have a list of things that need to happen to help you return home quickly:

- You are required to attend a Joint Replacement Preoperative Education Class. During this class, we will tell you how to prepare for your surgery including: what will happen during your surgery and in the hospital, about your physical/occupational therapy, daily exercise and mobility, equipment you might need at home, and plans for after you leave the hospital. *This class is required.*
- Your coach—the main person who will help you at home—must come to the Preoperative Class with you. Your coach must be ready to help you for the first 5-7 days after you leave the hospital.

  Coach Name:_____ Relationship:_____
- You will have to meet certain health guidelines to make sure you are safe to have surgery. 2-4 weeks prior to your surgery, you will be seen in your surgeon's office for a history and physical examination. If further medical clearance is necessary, your surgeon's office will schedule appointments with the appropriate specialists for you.
- In order to improve healing following your surgery, if you are a smoker, you must avoid smoking for at least 4 weeks prior to surgery.
- You will have a pre-surgery orientation appointment at the hospital 2 weeks before your surgery. At this visit, we will go over your surgery and hospital stay. We will also check your health to make sure you are medically ready for surgery.
- You will be given phone numbers so you can contact us with any questions or concerns you have after you leave the hospital. We don't want you to have to visit the Emergency Room for problems with pain, swelling, redness, or signs of infection without talking with your surgeon first.
- You may receive prescriptions for pain medicine you can take at home. The prescriptions may be for up to the first 90 days after your surgery. After 90 days, you should no longer need this prescription medication for surgery pain.

Sign below to indicate you have read this list and know what you must do in our program. You also agree to make a plan for when you leave the hospital that will follow what your surgeon says you need to do. If you don't make a plan that takes care of everything on the list above, your surgery will be canceled or delayed until you have your plan in place.

_____	_____	_____
Patient Signature	Print Name	Date

Aspire Orthopedic Institute, Adventist Medical Center, Portland Oregon
JOINT REPLACEMENT PROGRAM ENROLLMENT AGREEMENT
Page 1 of 1

163
Patient Agreement 248902 rev. 4/16

Patient and Family Brochure on Mobility

(MultiCare Health System)

BENEFITS OF GETTING OUT OF BED WHILE IN THE HOSPITAL

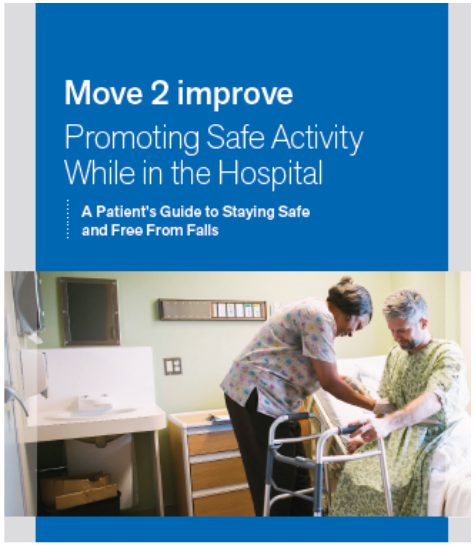
- Improved breathing
- Improved appetite
- Assists in preventing loss of strength
- Helps keep skin healthy
- Improved sleep
- Improved mood

THINGS YOU CAN DO TO KEEP MOVING

- Sit up in a chair for all your meals
- Sit up in a chair when you have visitors
- Walk around the room or unit, with assist if needed
- Ask staff about your safe activity plan when you start getting up out of bed.

VISITORS

- Do not assist your loved one to get out of the bed or chair unless you have discussed this with nursing staff.
- Remind your loved one to use the call light and wait for staff to come unless they are independent. The Pink Activity Level Assist sign in the room will indicate if the patient is independent.
- Keep the room free from clutter.
- Keep items that the loved one needs within reach.



Mary Bridge Children's Hospital & Clinics
MultiCare Allenmore Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Hospital
MultiCare Tacoma General Hospital
MultiCare Clinics

MultiCare
BetterConnected

multicare.org

multicare.org

M 2 i
Move 2 improve
MultiCare

Promoting Your Safety in the Hospital

MultiCare Health System wants to ensure that we are assisting you in maintaining your strength, balance and level of independence while you are staying with us. In the hospital, the risk for falls is higher because your body may not be functioning as it normally does (due to illness, medications, surgery, pain, noise, multiple people in and out of room, tubes, equipment, etc). At the beginning of your stay and throughout your time with us, we will work with you on developing a safe activity plan. This plan will explain how you will get out of bed/chair and move as you are able, with the goal of regaining and maintaining your previous level of function. We are dedicated to making your stay with us safe. Together with you and your family and friends, there are many things we can all do to promote safety and still have you up and moving during your hospital stay.

PATIENT

While you are with us, please:

- Let us know how you get around at home, and if you need help.
- Let us know if you need a cane, walker, brace or other equipment to walk.
- Use your eyeglasses and hearing aids as you would at home.
- Alert staff if you become dizzy, lightheaded or experience increased pain with activity.
- Always wear non-skid footwear. Request your shoes if you need them to walk.
- Ask staff about your activity plan and when you can start getting up out of bed.
- Always call and wait for assistance unless cleared by staff to be up and moving by yourself.
- Be aware of tubes and wires that may be attached to you.
- If there is a yellow isolation cart outside your room, please check with nursing before entering the hallway.

NOTES:

_____

_____

_____

_____

_____

_____

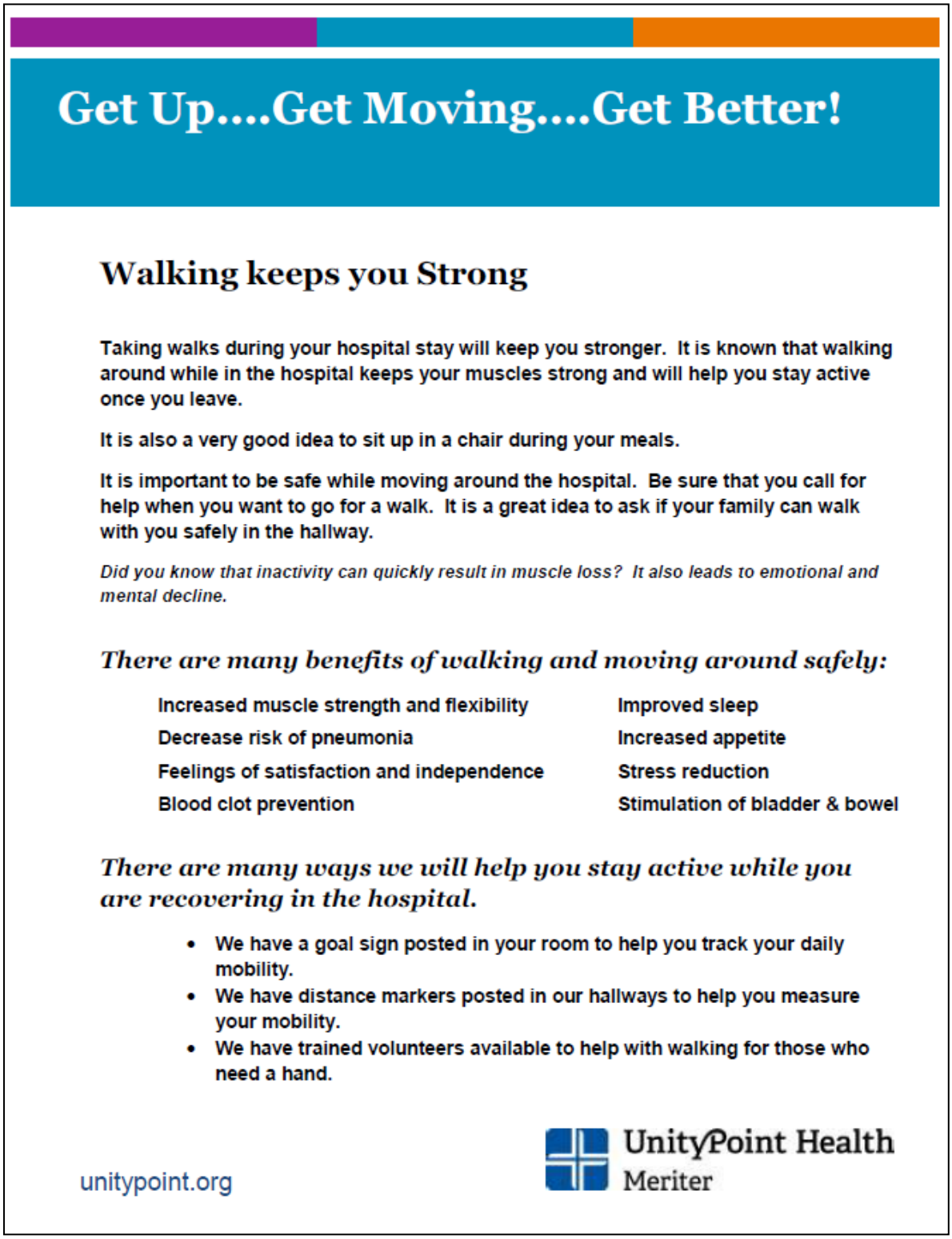
EXPECTATIONS OF STAFF

- Within 24 hours of your admission, we will work with you to create a safe activity plan.
  - A pink Activity Level Assist sign will be posted in the room. This sign lets us know what help you may need when moving.
    - For example, we will assist you in getting up to the chair and if safe, to walk.
    - We will assign an activity level of 1,2 or 3 based on your ability to move safely.
- We will check in with you at least hourly throughout the day and every two hours at night asking about pain, repositioning you, making sure everything is within your reach, offering toileting and anything else you may need.
- We may use a chair or a bed alarm while you are with us. They let us know when you are getting up if you forget to call for help. This creates a safe environment for you. All patients have bed alarms at night per hospital policy.

M 2 *i*
Move 2 improve
MultiCare

Patient Flyer on Mobility

(UnityPoint Health – Meriter Hospital)



Get Up....Get Moving....Get Better!

Walking keeps you Strong

Taking walks during your hospital stay will keep you stronger. It is known that walking around while in the hospital keeps your muscles strong and will help you stay active once you leave.

It is also a very good idea to sit up in a chair during your meals.

It is important to be safe while moving around the hospital. Be sure that you call for help when you want to go for a walk. It is a great idea to ask if your family can walk with you safely in the hallway.

Did you know that inactivity can quickly result in muscle loss? It also leads to emotional and mental decline.

There are many benefits of walking and moving around safely:

Increased muscle strength and flexibility	Improved sleep
Decrease risk of pneumonia	Increased appetite
Feelings of satisfaction and independence	Stress reduction
Blood clot prevention	Stimulation of bladder & bowel

There are many ways we will help you stay active while you are recovering in the hospital.

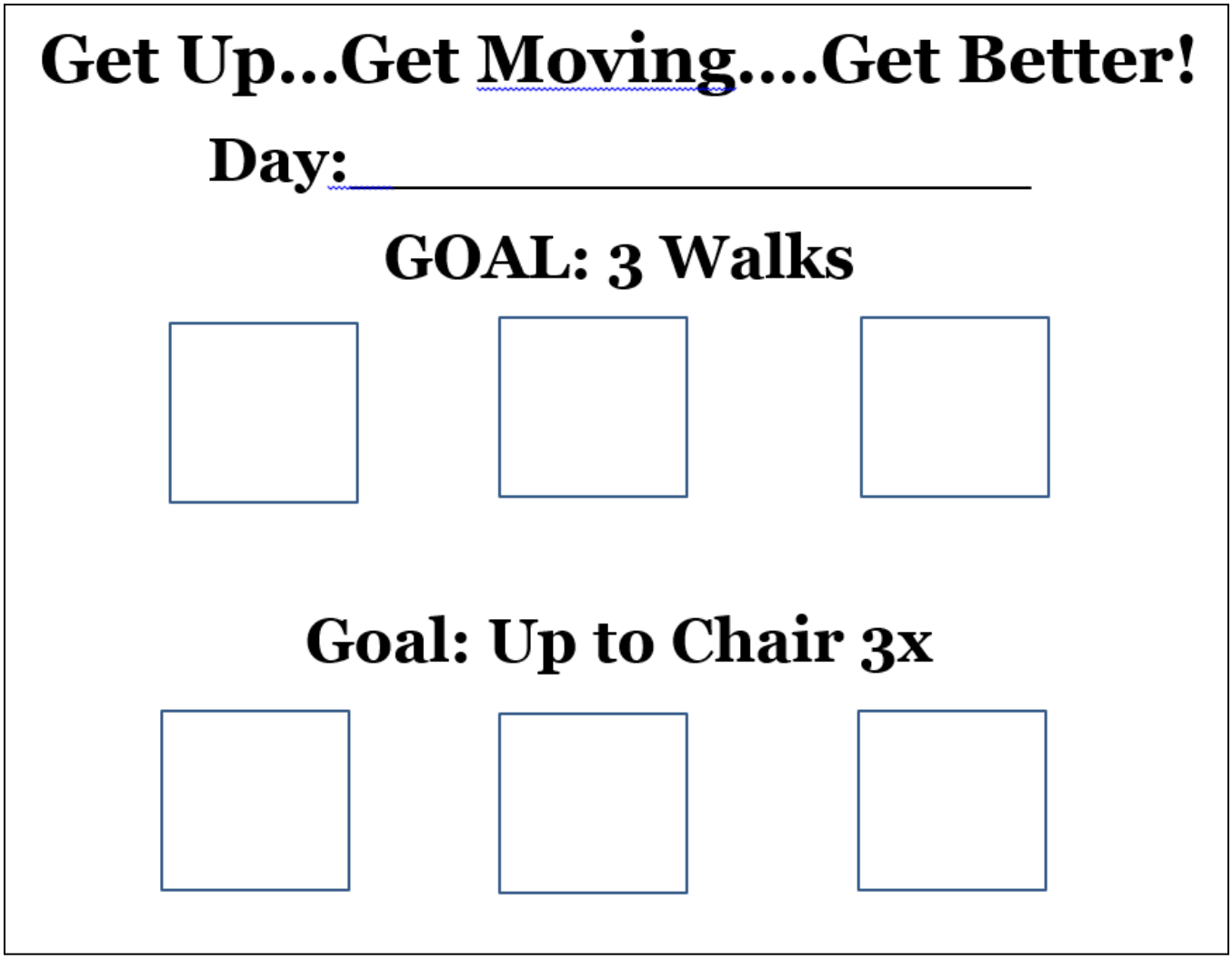
- We have a goal sign posted in your room to help you track your daily mobility.
- We have distance markers posted in our hallways to help you measure your mobility.
- We have trained volunteers available to help with walking for those who need a hand.

unitypoint.org

UnityPoint Health
Meriter

Patient Goal Sign

(UnityPoint Health – Meriter Hospital)



Sample Mobility Tech Job Description

DEPARTMENT: Info Desk and Escort

JOB TITLE/JOB CODE: Patient Mobility Team Member

ACCOUNTABLE TO: Manager of Info Desk / Escort

1. JOB SUMMARY:

The Patient Mobility Team Member is a Nurse Assistant (certification preferred) or PT Aide with additional patient mobility training who provides safe patient transfer assistance and mobility using approved assistive devices and procedures in the acute hospital setting.

II. JOB DUTIES:

Essential Functions:

1. Able to select the appropriate equipment and method of patient transfer after consideration of the patient's ability to provide assistance, bear weight, cooperate and follow directions, height/weight, special circumstances, and MD orders – based on training and/or algorithm.
2. Demonstrates use of patient transfer equipment/device use, patient mobility techniques, and body mechanics in a safe manner. Examples of transfers to be performed include: bed to chair, toilet/commode, or W/C and return, bed to gurney and return, and repositioning up in bed or chair.
3. Provides safe mobility, with a goal of progressing to mobility three times/day, following the mobility team procedures
4. Able to manage multiple priorities when necessary and communicates well with other members of the mobility team and healthcare team in carrying out daily responsibilities.
5. Documents and communicates completion of mobility in electronic health record for each patient at end of shift, following mobility team procedures
6. Teaches/coaches staff on mobility and enlists their assistance as needed.
7. Performs warm-up exercises each shift prior to beginning work duties.
8. Responds to calls for assistance in a timely, customer friendly manner.
9. Offers assistance to escort team or nurses as needed.
10. May provide direct patient care within the C.N.A licensure as needed and time allows, during performance of mobility duties i.e. incontinence care, setting patient or tray up for meals, etc.

Additional Responsibilities:

1. Performs other duties as assigned.

III. JOB SPECIFICATIONS:

1. Education – High School diploma or GED, current Certified Nurse Assistant certification preferred, and current BLS certification required.
2. Demonstrates ability to speak, read, write, perform simple arithmetic calculations and follow oral or written instructions in English.
3. Experience – 2 years' experience as a C.N.A. or P.T. Aide preferred. Excellent customer service skills required.

Authority and Responsibility:

1. The Patient Mobility Team Member has no supervisory responsibilities.

Interpersonal Relationships in the Hospital Environment:

1. This position has contact with all patient care staff and patients on all inpatient care units.
2. May come in contact with staff from ancillary departments during the course of duty.

Working Conditions and Physical Hazards:

Work will be performed in patient rooms and nursing units, possibly in ancillary departments. Position is physical work with many patient lifts, moving patients in bed, and transfers of immobile patients. Position requires moving of furniture, gurneys, wheelchairs, scales, lifting and other devices frequently.

Physical Demands:

10 % Standing
20 % Walking
__ % Sitting
__ % Stooping
__ % Reaching
__ % Kneeling
__ % Climbing
70 % Lifting

___	10 lbs. max.
___	20 lbs. max.
___	50 lbs. max.
X	75 lbs. max.
X	100 lbs. Or more with device and assistance

IV. STATISTICS:

1. Hours:	0700 - 1930
2. Weekends:	Every other weekend required.
3. Special Clothing:	White uniform pants and navy blue scrub top, clean, white shoes.
4. Equipment/Software:	Patient transfer equipment and devices, computer, phone, pager

Mobility Action Group Poster

(Inova Fairfax Hospital)

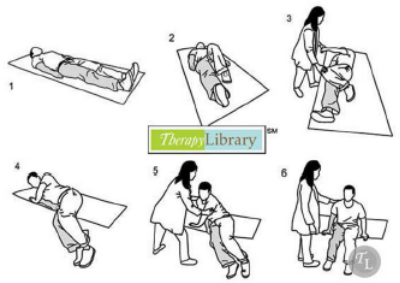
INOVA
Join the future of health.

The Mobility Action Group Pilot Program

The Main Idea

- **The Mobility Action Group** is trying to change mobility culture at Inova Fairfax.
- Your unit is one of two units chosen to pilot the program.
- The main idea is for nurses and clinical technicians to be able to safely get patients up and walking.
- The ideal number of walks per day is 3 per patient
- We know that every patient won't be able to walk, so we are also measuring their progression through something called the **Progressive Mobility Protocol (PMP)**
- The PMP is a section of the **"Daily Care/Safety"** Flowsheet in EPIC.
- If you are having trouble finding it, you can call Mark Kassab in the HELP Program
- 67959

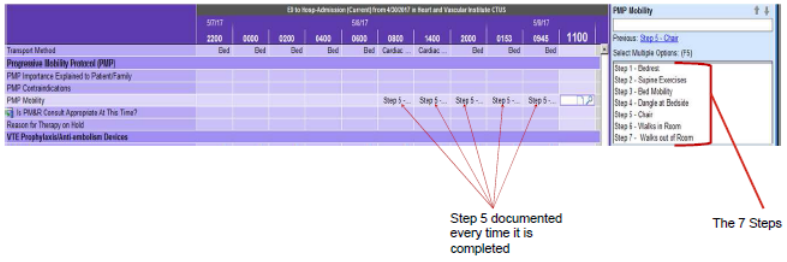
Supine to Sit



Sit to Stand

Documentation

- This is what the PMP looks like
- Notice that there are 7 steps, step 7 being the most mobile
- Every time a patient walks or does whatever mobility step they are on, it should be charted
- This way we can measure (for example) walks/day



The Benefits

- Mobility has a strong correlation with decreased length of stay
- Laying in bed for long periods of time puts weight on vital organs, increases skin degradation, and blood clots
- Mobility can also be mentally stimulating and prevent delirium.

Mobility Champion Award

Mobility Action Group Participant Spotlight: Adventist Medical Center

Organization name and location	Adventist Medical Center, *Portland, OR*
Name and contact information for core mobility program personnel	• Paul Krull, KrullPL@ah.org
Mobility Action Group highlights	• Patient engagement and buy-in with Patient Agreement • Training of nursing staff, nursing assistants, and family members in walking
What departments/roles are involved in your mobility program?	• The discussion as to how to initiate a mobility program included Rehabilitation, Nursing, and clinic staff, as well as physicians. • Physical therapists, physical therapy assistants, certified nursing assistants, and occupational therapists have all been trained and are responsible for walking the patients.
What key change tactics has your hospital put into practice to increase mobility?	• All patients partake in two exercise classes while they are on the inpatient unit at 10:30 AM and 2:30 PM. • Patients are pre-operatively optimized in terms of smoking status, BMI, A1c levels, albumin levels, and lung/kidney disease status in order to get them in the best shape possible ahead of surgery. • They utilize a Patient Agreement that describes what the hospital is going to do for the patient and what the patient is going to do for themselves.
How has your hospital implemented these change tactics?	• Communication has been key to set expectations and educate patients. The team tells patients that "This is going to be work; there will be pain involved; we will get you up and walking within two hours of surgery." Getting patient buy-in is necessary, and the hospital guides them into owning their health. • In addition to staff, patients' family members can also assist with walking when the patient has demonstrated that they are ambulating well. Family members receive a brief one-on-one training from staff in order to do this.

What tools or resources do you use to support the implementation of these change tactics?	• The team uses the "Fitness for Surgery" standards developed by the Bree Collaborative (http://www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf`) to ensure patients are appropriately optimized before surgery.

Mobility Action Group Participant Spotlight: CentraState Medical Center

Organization name and location	CentraState Medical Center, *Freehold, NJ*
Name and contact information for core mobility program personnel	• Barbara Yuhas, byuhas@centrastate.com • Hazen Yu, hyu@centrastate.com
Mobility Action Group highlights	• CEO, physician, and nursing engagement • Nursing and Physical Therapy take ownership of mobility • Hospital policy: Every patient gets out of bed as default, not bedrest
What departments/roles are involved in your mobility program?	• 3N Ace Unit (42 beds, 65-75% of patients are 65 and older and LOS has been increasing) • Have an interdisciplinary team with physician and administrator champions. Roles involved include: the DON Medical Surgical Division, the Nurse Manager for the 3N ACE Unit, a Physician Champion, and the Director of Rehabilitation Services. • CEO has been very invested in mobility for approximately 10 years.
What key change tactics has your hospital put into practice to increase mobility?	• Mobility training for all staff with SPH; want nursing staff as well a therapy staff to take ownership. • Implementing a baseline mobility assessment tool. • Increasing awareness for the need and appropriate utilization of bed and chair alarms.

How has your hospital implemented these change tactics?	• Transitioning to an Acute Care for Elders unit • Developing a brochure for the ACE unit that will include information about mobility for patients. • Promoting early mobilization to prevent functional decline (by using data collected). • Re-educating staff on hospital policies regarding mobility and the use of bed rest orders (have had a mobility policy that everyone gets out of bed unless there are on bed rest orders, but staff were not following it). • Staff are taking the time to ask patients if they have walked outside of their rooms, in additional to visually monitoring the patients. • Using white boards located next to nurses' station to track how many times a patient has walked (called "mobility boards"). • Promoting early mobilization to help identify needs for assistive devices prior to discharge.
What tools or resources do you use to support the implementation of these change tactics?	• EMR • Mobility Boards • Educational Materials/Activities for Staff (i.e. a dementia tour, in which staff went through what it is like to be a patient with dementia)

Mobility Action Group Participant Spotlight: UnityPoint Health – Meriter Hospital

Organization name and location	UnityPoint Health – Meriter Hospital, *Madison, WI*
Name and contact information for core mobility program personnel	• Haley Nehring, haley.nehring@unitypoint.org • Rick Dahl, richard.dahl@unitypoint.org
Mobility Action Group highlights	• Program goals were chosen based on Change Package and change tactics • Signs in hospital room emphasize the importance of walking three times per day • Attendance at nursing meetings to engage staff in mobility
What departments/roles are involved in your mobility program?	• As part of HELP, they always worked on mobility with their elder patients who were enrolled in the program. • Prior to the Mobility Action Group they did not have a specific mobility program for their units, so there was no formal way that therapy was directly involved in helping with any type of mobility program in their hospital. • Piloting HELP in their general neuro unit (16 bed) for the Mobility Action Group.
What key change tactics has your hospital put into practice to increase mobility?	• Have been participating in the Hospital Elder Life Program (HELP) for 7 years. • The Action Group reinforced the need for better communication between HELP and therapy. • More patient walking in neuro unit.
How has your hospital implemented these change tactics?	• Developing a communication tool/protocol based on what others shared during Mobility Action Group calls and input from nursing staff. • Added signs in hospital rooms emphasizing walks 3 times per day. • Attended several staff meetings in the neuro unit and there was a lot of energy behind getting more patients walking. Plan to attend nursing staff meetings and unit council meetings in order to remind and re-engage staff about mobility. • Plan to use their therapy aides to support this program once fully staffed. • Currently developing a way to show nurses data on how they're doing.

What tools or resources do you use to support the implementation of these change tactics?	• The Mobility Action Group Charter and Change Package
	  ○ Used some components to aid with developing the communication tool/protocol and to justify staff engagement and education on the importance of mobility.
	  ○ Used articles when speaking with senior leaders about why they need time to speak with nurses from different units.
	  ○ Reviewed the action steps, which helped them choose goals for their program.

Mobility Action Group Participant Spotlight: Ogden Regional Medical Center

Organization name and location	Ogden Regional Medical Center, *Ogden, UT*
Name and contact information for core mobility program personnel	• Dena Stephenson, *Therapy Director*, dena.stephenson@mountainstarhealth.com
Mobility Action Group highlights	• Refocused the Falls Team to target mobility
What departments/roles are involved in your mobility program?	• Ogden does a lot of therapy and ambulation within their Total Joint Center and Spine Institute. • They are Joint Commission certified for both of those programs and want most of those patients walking four times/day and have other measures they try to get those patients to meet, but their mobility program is focused on their medical floor.
What key change tactics has your hospital put into practice to increase mobility?	• Staff meetings were used to introduce and promote the mobility program within the hospital. • Have a Therapy Tech with a long tenure in the unit and great familiarity with staff who walks patients rather than recruiting volunteers or doing any additional training. • White boards are used to identify which patients are cleared to walk.
How has your hospital implemented these change tactics?	• Therapy Tech wasn't consistent with walk frequency for patients, as it was dependent on her other activities within the hospital. So, Ogden is now integrating one volunteer, trained by the Therapy Tech, who works twice a week. • Nurses put a dot on the white board to indicate to the Therapy Tech which patients need to be walked. This saves time. They are planning to take the mobility program to the CNAs and the RNs on the floor, give them the evidence and research, and have them be the "drivers" of the program.

What tools or resources do you use to support the implementation of these change tactics?	• White boards for indicating patients that need walking • Phone Meetings - Falls Team changed their name to the "Mobility Dream Team," which helped gain buy-in among staff. The Medical Director and their Assistance CNO are involved with this team. • Volunteers - They currently have one volunteer who is great and very willing but has transportation issues, so she only comes in 1-2 days a week. They are planning to train more volunteers (1-2 at least) and have their only responsibility be walking patients. Ideally, these volunteers will help from 4-8 pm. • Working to develop a formal training program after increasing nurse involvement. • Used clinical framework in Mobility Action Group Charter and Change Package to help distinguish what they are and are not already doing. • Working on adding a Mobility Assessment from the Mobility Action Group Charter and Change Package into Ogden's EMR.

Mobility Action Group Participant Spotlight: Sentara CarePlex

Organization name and location	Sentara CarePlex, *Hampton, VA*
Name and contact information for core mobility program personnel	• Melissa Waugh, mnwaugh@sentara.com • Tara Henderson, thenderson@sentara.com
Mobility Action Group highlights	• Full time, daily mobility aide • Weekly meetings of interdisciplinary mobility team • EHR documentation and tracking of mobility
What departments/roles are involved in your mobility program?	• Have a mobility aide (current nurse care partner staff member) on day shift M-F with occasional weekend coverage that was trained by therapists. Also involve the nurse manager (Tara) and the therapy manager (Melissa). • 3 month pilot in the Hematology/oncology unit. [Had a 2-3 weeks start-up period.] • Engaged Nursing leadership, therapy leadership, system BPCI leadership, and hospital administrators.
What key change tactics has your hospital put into practice to increase mobility?	• Track falls, pressure areas, restraints and call bells used, as well as mobility attempts • Aide is designated for functional mobility/activity with patients on the unit

How has your hospital implemented these change tactics?	• The hematology/oncology nursing assistant staff was informed that a mobility pilot would be done on their unit. Staff who were interested reached out and were interviewed. An individual was chosen and the therapy department performed training. • Prepared EPIC documentation for tracking purposes and provided information to MDs and Admin for support and referrals. • Weekly meetings were scheduled with management, the mobility aide, and a therapy point of contact to address barriers and concerns as well as improve communication and role responsibility. • Use an order called restorative program, which enables therapy and nursing to specify what interventions the aide is to perform with the patients each day. Referrals are made from therapy, nursing, and physicians and this helps to create the daily case load.
What tools or resources do you use to support the implementation of these change tactics?	• Mobility Action Group Charter and Change Package provided a framework and helped with goal setting. Also made tweaks to staff training, communication, scheduling, and the referral process. • EPIC EMR System – helped with tracking and with referrals.

Mobility Action Group Participant Spotlight: Shawnee Mission Medical Center

Organization name and location	Shawnee Mission Medical Center, *Shawnee, KS*
Name and contact information for core mobility program personnel	• Beth Armstrong, beth.armstrong@shawneemission.org
Mobility Action Group highlights	• Patients are educated preoperatively about mobility goals • Nursing staff is accountable for mobility; performed by CNAs and nurses
What departments/roles are involved in your mobility program?	• The mobility program initially started with a multidisciplinary team (physicians, Nursing, and Physical Therapy) in the ICU that then spread to other floors. • Certified nursing assistants are doing most of the patient walking. • They worked with Anesthesia to lower the incidence of hypertension and nausea post-operatively, which has improved mobility.

What key change tactics has your hospital put into practice to increase mobility?	• Surgeons were educated that patients would be walked on post-operative day one.
	• The following three strategies were in place as part of an earlier initiative, "Mobility Matters":
	  ○ The mobility team developed a written policy that puts patients through a progression of activity levels and sets mobility goals with individual patients, which are tracked on whiteboards.
	  ○ The number of bed rest orders were reduced.
	  ○ Egress tests were implemented, which evaluate a patient's mobility to go from a sitting position to a standing one; march in place; and step forward and back. Patients must successfully complete all three steps to ambulate independently.

How has your hospital implemented these change tactics?	• Patients are educated during pre-operative education that they will be up and moving after their surgery. • If patients are on the floor before noon, they receive two PT visits that day. If they are on the floor by six in the evening, they receive one PT visit that day. • An expectation was set with nursing staff that it was their job to get patients moving and if patients were not ambulating, they needed to document the reason why. • Physicians agreed to order physical therapy if a patient was not meeting their activity goals. • Documentation was challenging, but staff are now tracking how often a patient is getting up, how far the patient is walking, and how much effort it takes the patient to walk.
What tools or resources do you use to support the implementation of these change tactics?	• They have researched benchmarking and process change resources found externally.

Mobility Action Group Participant Spotlight: St. Luke's Hospital

Organization name and location	St. Luke's Hospital, *Maumee, OH*
Name and contact information for core mobility program personnel	• Leslie Szalkowski, leslie.szalkowski@stlukeshospital.com
Mobility Action Group highlights	• Interdisciplinary mobility group established • Walkers and gait belts in every room • Walking begins early (2 hours post-operatively)
What departments/roles are involved in your mobility program?	• The core group implementing the mobility program includes a patient educator, a physical therapist, a nursing technician, and a charge nurse.
What key change tactics has your hospital put into practice to increase mobility?	• Nursing, Nursing Techs, and Physical Therapy are currently responsible for walking patients, and have offered to formally educate patients on the importance of ambulation. • A walker and gait belt is present in every patient room. • Orthopedic and neurosurgery patients have orders to begin ambulating two hours after surgery and continue that every two hours.
How has your hospital implemented these change tactics?	• They plan to create a Mobility Tech role that will be primarily responsible for walking patients and collecting data, to help reduce the burden on other staff members. • They are working on decreasing the number of referrals to Physical Therapy by mobilizing patients earlier.
What tools or resources do you use to support the implementation of these change tactics?	• The Mobility Action Group Charter and Change Package was most useful.

Mobility Action Group Participant Spotlight: St. Peter's University Hospital

Organization name and location	St. Peter's University Hospital, *New Brunswick, NJ*
Name and contact information for core mobility program personnel	• Patricia Richards, prichards@saintpetersuh.com • Teresa Artz, tartz@saintpetersuh.com
Mobility Action Group highlights	• Using trained student volunteers to walk patients • Hallway markers used for walking landmarks
What departments/roles are involved in your mobility program?	• Clinical staff was initially engaged by the Chief Nursing Officer, who was very supportive of the mobility program. • IT staff was engaged early on to help with some of the technological challenges of tracking patients. • The Patient Experience and Infection Control departments were also involved. • The mobility program is discussed in monthly Orthopedics departmental meetings, as well as quarterly CJR Governors meetings and Falls Prevention meetings. • Student volunteers from local colleges walk patients.
What key change tactics has your hospital put into practice to increase mobility?	• The primary component of the mobility program is that patients are walked by trained student volunteers. The program currently has twelve volunteers. • Patients are given flyers introducing them to the mobility program. • Markers were placed on the hallway walls to indicate walking landmarks. • Icons were placed on patient boards in rooms to indicate mobility status.

How has your hospital implemented these change tactics?	• Once volunteers are trained and have walked their first couple of patients, they must demonstrate competency against a checklist to ensure they are safely ambulating patients. • Staff can reach volunteers via phone whenever a patient needs to be walked. • Volunteers are available to walk patients at least two hours each day, seven days a week. • Volunteers were also trained on the language and phrasing they were using that were impacting the number of walks patients were taking (e.g., emphasizing that the *doctor* had requested the patient be up and moving; not explicitly identifying themselves as a "volunteer").
What tools or resources do you use to support the implementation of these change tactics?	• The Safe Patient Mobility Assessment from the Mobility Action Group Charter and Change Package (Change Package) was modified to train volunteers, primary care providers, nursing assistants, and nurses as to how to move patients. • The Hospital Mobility Documentation page, also from the Change Package, was repurposed for volunteers to complete after walking patients. • The Discharge Functional Assessment from the Change Package was also utilized.

Mobility Action Group Participant Spotlight: The Valley Hospital

Organization name and location	The Valley Hospital, *Ridgewood, NJ*
Name and contact information for core mobility program personnel	• Joni Garbarini, jgarbar2@valleyhealth.com
Mobility Action Group highlights	• Interdisciplinary team building • Staff meetings to promote program • Standing orders for bed rest replaced with standing orders for mobility
What departments/roles are involved in your mobility program?	• The Geriatric unit staff were targeted to implement the program, led by a nurse practitioner. • Patients were walked by nurses, nurse aides, and physical therapists. • Physiatrists, Physical Therapy, Population Health, Case Management, and home care staff were present for the Mobility Action Group calls. They joined in the same room to facilitate teamwork.
What key change tactics has your hospital put into practice to increase mobility?	• Staff meetings were used to introduce and promote the mobility program within the hospital. • Standing orders for bed rest were replaced with standing orders for mobilization.
How has your hospital implemented these change tactics?	• The team has focused on documentation as a way to increase mobilization of patients. • Nurses identify which patients are eligible to be walked each morning during rounds; this is a somewhat "subjective" decision that depends on the patients' situations. • The hospital task force proposed to change the current bed rest orders within the electronic health record. This change was supported by administration and the Patient Safety Committee and is currently going to the Physician Advisory Committee for resolution.

What tools or resources do you use to support the implementation of these change tactics?	• The primary resource used was the Mobility Action Group Charter and Change Package. It helped them address challenges with documentation and prioritizing change tactics. The information presented in the Package was presented to staff during the team meetings mentioned above. • The data collection template was also utilized to drive implementation. • They have also learned from the brochures, checklists, etc. shared by other hospitals within the Mobility Action Group.

Mobility Action Group Participant Spotlight: UPMC Shadyside

Organization name and location	UPMC Shadyside, *Pittsburgh, PA*
Name and contact information for core mobility program personnel	• Susan Killmeyer, *Clinical Director,* (412) 623-4723 • Courtney Dube, *Director Rehab Services*, (412) 623-2587 • Cynthia Conte, *Unit Director,* (412) 623-4563
Mobility Action Group highlights	• Site-wide interdisciplinary Mobility Program involving nursing, PT, OT; augments existing HELP program • Use of dedicated full-time Mobility Aids (PCTs) to walk patients has made the program highly successful
What departments/roles are involved in your mobility program?	• The Mobility program is house-wide, including the ICUs. Nursing and PT/OT work together to mobilize patients to their highest functionality.
What key change tactics has your hospital put into practice to increase mobility?	• The hospital has utilized 2 PCT's (Mobility Aides) to consistently round on units to assist getting patients up for meals. In between meal times, they ambulate patients. Each Mobility Aide can ambulate up to 30 patients in one day.
How has your hospital implemented these change tactics?	• They did house-wide education on the Mobility program initially. The Mobility Aides were very successful during the daylight hours in mobilizing patients and staff saw an opportunity to extend these hours into the evening. They are now looking to add an FTE to support this work.
What tools or resources do you use to support the implementation of these change tactics?	• When they started the Mobility program, they educated on proper body mechanics and safe patient handling. They are using the AMPAC and the JHHLM for assessment and documentation. The Mobility Aides document on the patients that they are mobilizing.