

Mobility is Medicine: An Interdisciplinary, Quality Improvement Project

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Purpose and Rationale: New technologies in medicine have given rise to longer survival rates for hospitalized patients. Muscle, nerve and brain dysfunction result in major long term morbidities after an acute illness. Functional ability declines during the acute phase of a hospitalization due to higher acuity and multisystem failure: therefore, mobility has been ignored and discouraged. Prolonged bedrest is associated with functional decline, increased morbidity, mortality, length of stay, discharge disposition and cost of care. In alignment with the hospital's core values of safety, caring, integrity and excellence, a plan was developed to improve mobility and patient outcomes.

Research Questions: Upon further exploration of our current documentation of patient activity level, process of mobilizing patients, physical therapy referrals, and patient experience data, we concluded there was not a standardized approach or structure to optimizing a patient's functional status, while maintaining a safe environment. Through the development of an interdisciplinary progressive mobility algorithm, could we impact patient outcomes?

Synthesis of Review of Literature: Early mobilization is best practice and is instrumental in improving overall quality of life, physical function, and supporting the hospital's goals of cost containment. Best practice improves health outcomes and ensures safety for both patients and staff. Integration of these best practice strategies of early mobilization requires a paradigm shift of caregiver assessment and practice related to safe mobilization.

Methods/Procedures: An interdisciplinary team commenced and developed a progressive mobility algorithm. Our algorithm encourages progressive mobility with an assessment and a pass/fail metric in a standard sequence of increasing activity. Our team motto, is "every patient, every day" with an assessment by nursing and progression of patients; physical therapy is integrated as a member for those at highest risk or not meeting delineated milestones in algorithm. The algorithm was initially operationalized in the medical intensive care unit and was further refined and disseminated throughout the medical floors. Educational strategies included a contact hour lunch and learn, Medicine Grand Rounds, standard work groups and partnerships with front line staff to role model the algorithm, identify barriers, and audit our adherence.

Results:

By implementing a progressive mobility algorithm, could we improve mobility, length of stay and quality of life after an acute illness? After partnering with case coordination, occupational and physical therapy data was shared and trended. We are seeing a decrease in our length of stay and increased discharge

disposition to home, as well as less caregiver injuries. As we began our journey starting initial results showed an increase in physical therapy consults in the Intensive Care Unit toward mobilizing our patients. As we continue, we intend to follow the incidence of pressure ulcers, fall rates, time on vent, and readmission rates for chronic disease.

Conclusion: With an increase in chronic disease, improved technologies and therapies, improvement in functional status and quality of life has become an increasingly important focus. An ingrained medicine culture of “rest” is no longer best practice and has proven to be detrimental and a significant contributor of morbidity and mortality. An interdisciplinary approach engendered practice changes with education, sharing, and continued vigilance, will result in an overall improvement in our patient outcomes.