

MOVE TO IMPROVE

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PURPOSE/PICO QUESTION

- To investigate and implement a unit-based practice change to improve nurse compliance with a nurse-driven patient mobility protocol, and to improve the rehabilitation process of patients.

PICO: In patients requiring respiratory support, will a nurse-driven mobility protocol, compared to a physician-driven protocol, improve nurse compliance to the protocol and improve patients rehabilitation process?

- P:** Patients requiring respiratory support
I: Nurse-driven mobility protocol
C: Physician-driven mobility protocol
O: Improve nurse compliance to the protocol & to improve patients rehabilitation process

METHODS

IS THIS FEASIBLE?

Evidence supports the positive effects of early mobility for ICU patients, we were interested in determining if a nurse driven protocol is feasible specifically for 2KS.

- Located protocol and placed a resource in each patient room on 2KS and at huddle board
- Education provided to unit staff to implement mobility protocol daily and to make it part of change of shift report
- Patient mobility was incorporated in the daily "huddle"
- Q2HR "Turn Team" was developed, charge RN w/o an assignment encouraged, added NEW 2KS PT/OT crew!
- Data was collected about patients mobility score and if he or she was mobilized accordingly each day, and reasons if and why they were not
- Survey sent with pre/post implementation questions regarding knowledge of mobility, and feasibility of nurse-driven protocol

EVIDENCE

- "Mobilization education was effective and increased nurses knowledge about the benefits of mobility for critical ill patients" (Messer, 2015).
- "...early activity is feasible and safe in respiratory failure patients" (Baily, 2007).
- "Early mobility leads to...minimizing complications of bed rest, promoting improved function for patients and promoting weaning from ventilator support. As a patient's overall strength and endurance improve it can lead to reducing length of hospital stay, reducing overall hospital cost, and improving pt.'s QOL" (Perme & Chandrashekar, 2009).

OUTCOMES

For 16 days data was collected, 2KS had 183 pts during this time. 68 pts were mobility level 2 -4, of the 68 – 85% were OOB and mobilized based on level.

- The other 115 pts were either level 1 pts or mobility was not assessed (new admit)
- 100% RNs said q2hr turns and ROM were done BUT compliance with charting T/R and ROM is low (march - 40%) so unable to determine complete accuracy
- Why not 100% compliance?

- Data was collected in march (flu season) high ECMO acuity (some had orders for no turns)
- Unstable patients (nurse judgment and based upon safety screening), multiple paralyzed pts, patient refusal, multiple new patients

SURVEY RESULTS

Question	Response	
Do you feel the protocol initiation has helped you to appropriately mobilize your patients more often?	60% Yes	40% No
Do you feel the scale chosen was appropriate for the patients on 2KS?	85% Yes	15% No
Do you feel the initiatives taken on 2KS (turn team, charge without assignment, huddle) assisted in ensuring proper patient mobility?	95% Yes	5% No
On a scale of 0 (least priority) to 10 (highest priority), how important was it to mobilize your patient?	Avg. 6 (Prior to implementation)	Avg. 8 (Post-implementation)

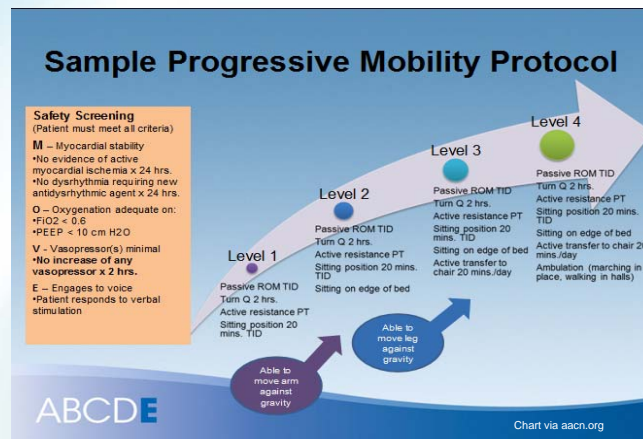
ADDITIONAL COMMENTS:

- Barriers to mobilization: Patient acuity (biggest concern), lack of assistance to mobilize patients, safety concerns, patient refusal to participate
- In ICU, mobility is not the priority, high acuity is an issue (common theme)
- Addition of PT to 2KS has helped dramatically with nurse-driven patient mobilization

CONSLUSIONS/IMPLICATIONS

- Additional research regarding a nurse- driven mobility protocol
- Increased education about mobility, and safety of mobilizing ICU/high acuity patients – education committee topic?
- Connecting with other hospitals that mobilize ECMO/high acuity patients
- Nurse developed mobility protocol in future?

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