“Prevention of Functional Decline using a Nurse Driven Mobility Protocol”

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ABSTRACT
Hospitalization poses a risk for altered functional status due to acute illness and decreased mobility. Use of prolonged bed rest, physical restraints, use of devices such as Foley catheters and intravenous lines can contribute to decline in function. We identified opportunities for improvement and bedside nurses and techs as the key transformation agents able to implement the needed changes. The project goals were to develop a nurse driven protocol that would provide the nursing staff with tools and resources to assess functional status, mobility level and implement a mobility plan. The Program was called “STEP IN”: • Support independence • Train for care at home • Encourage ADL • Prevent functional decline • Interdisciplinary approach • No exclusion, No excuses

METHODS AND MATERIALS
An interdisciplinary team developed a nurse driven mobility protocol for patients on a medical unit. The team created a protocol that incorporated assessment of functional status using the Modified Barthel Index and the Get up and Go test. An algorithm was created to implement three different mobility levels based on the assessment:

RESULTS
The implementation of the nurse driven mobility protocol resulted in substantial improvements in all of the outcomes that were measured. We compared 6 months of outcomes for the same time period in the previous year.

DISCUSSION
Even though our results are encouraging, we had and still have challenges. The greatest of all has been to create a shift in the unit culture from relying on Physical Therapy (PT) to “walk” our patients to take ownership of mobility and prevention of functional decline. Not all patients meet criteria for PT referral but all of them need to be mobilized. Even for the patients being treated by a physical therapist, the care should be continued beyond the 30 minute session they are able to provide.

Some other barriers identified were:
• Nurses delegating mobility to the patient care technician.
• Staff’s fear that mobilization will increase fall rate.
• Suboptimal documentation of mobilization by nursing staff.
• Bed rest orders on admission without further reassessment, even though patient condition changed.
• Bed rest orders without a justification or a timeframe for discontinuation if appropriate.
• Electronic generated reports that were not concurrent and accurate.
• Leadership not holding staff accountable if mobilization did not improve.
• Leadership sub estimating complexity of program implementation and resources needed.
• Lack of resources to collect and monitor data concurrently.
• Competing priorities.

CONCLUSION
Implementing a nurse driven protocol can be challenging but the benefits of reducing fall rates, readmission rates and length of stay far exceeded our goals. Mobilization is an intervention that is basic to nursing but not always seen as a priority in all of the tasks that nurses are required today. The data reveals that mobilization is as important and potentially more so than any other intervention that we provide. Staff buy in, leadership support and multidisciplinary collaboration are vital for the success of a nurse driven mobility program.

REFERENCES