A Clinical Nurse Leader Initiative: Promoting Mobility Among Long-Term Care Facility Residents

Ulyses Reamico
ulyses.reamico@gmail.com

Follow this and additional works at: https://repository.usfca.edu/capstone
Part of the Geriatric Nursing Commons, and the Other Nursing Commons

Recommended Citation
Reamico, Ulyses, "A Clinical Nurse Leader Initiative: Promoting Mobility Among Long-Term Care Facility Residents" (2017).
Master's Projects and Capstones. 621.
https://repository.usfca.edu/capstone/621

This Project/Capstone is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Master's Projects and Capstones by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.
A Clinical Nurse Leader Initiative:

Promoting Mobility Among Long-Term Care Facility Residents

Ulyses R. Reamico

University of San Francisco

N653 Internship: Clinical Nurse Leader

Summer 2017
A Clinical Nurse Leader Initiative:

Promoting Mobility Among Long-Term Care Facility Residents

Studies show that functional decline and deconditioning result from low mobility among elders in hospitals and long-term care facilities (Czaplijski, Marshburn, Hobbs, Bankard, & Bennett, 2014; Zisberg, Shadmi, Gur-Yaish, Tonkikh, & Sinoff, 2015). These are the outcomes that this author aims to prevent by practicing with the competencies and roles of a Clinical Nurse Leader (CNL). A CNL is a master’s level educated generalist that is prepared to lead changes in any organization (Jeffers & Astroth, 2013). This document summarizes this writer’s experience in initiating a microsystem improvement project.

This CNL project is being conducted in a 45-bed rehabilitation unit that is part of the Veterans Affairs Northern California Health Care System (VANCHCS). The patient age ranges from 20s to 90s and include Korean War, Vietnam War, Gulf War, and War on Terrorism veterans. Approximately 70 percent of the unit census is a mixture of patients admitted for rehabilitation after a stroke or after a musculoskeletal procedure such as total knee replacement, hip replacement, or amputation. The other 30 percent include patients admitted for rehabilitation after cardiac surgery or deconditioning, respite care, skilled nursing or wound care, and the younger veterans admitted for neurocognitive rehabilitation for post-traumatic stress disorder (PTSD) and/or traumatic brain injury (TBI). This population is at risk for functional decline, especially the elderly veterans who are not receiving skilled rehabilitation services. This CNL project will mitigate this risk through improved mobility assessment, activity referral, and access to poster-prompted exercises. These interventions are nursing-led but interdisciplinary team coordination and collaboration are needed for this project to be implemented as planned and for the changes to be sustained.
Clinical Leadership Theme

The global aim for this project is to improve access to activities promoting mobility within this writer’s microsystem. The CNL curriculum elements of Nursing Leadership, Care Environment Management, and Clinical Outcomes Management are the guiding elements for this project. In addition, the roles of Advocate, Team Manager, Risk Anticipator, and Clinician are the most utilized CNL roles. Functioning as the CNL, this writer will work in collaboration with interdisciplinary team members including, but not limited to, physical therapy (PT), occupational therapy (OT), restorative nursing program coordinator (RNPC), and unit staff nurses. The CNL competency that is mostly associated with this project is “to facilitate collaborative, interprofessional approaches and strategies in the design, coordination, and evaluation of patient-centered care;” [AACN], 2013, p. 17).

Statement of the Problem

As previously stated, hospitalized individuals and people living in a long-term care facility are at risk of functional decline. After conducting a microsystem assessment, this author found that only 67 to 76 percent of the unit population (30-34 patients) were engaging in exercise or mobility activities. Contributing factors to the low number of patients engaging in exercise activities include elements of equipment/material issues, staffing issues, mobility processes, and other patient aspects (see Appendix A). Further analysis and mapping of the current process starting from admission revealed that some patients “slip through the crack” and may not be referred to mobility activities (see Appendix B). This is especially true when a patient is discharged from skilled rehabilitation services when his/her progress plateaus, but has to stay in the facility due to placement issues. The actual discharge from the facility may take days, weeks, or months after PT/OT discharge depending on the issue that arises.
Another focus group for this project are the patients being admitted for respite care, skilled nursing care, and hospice care. These are the patients who do not routinely receive rehabilitation services. The microsystem where this project is being implemented has a “restorative culture”. This culture was the driving force in the restarting of the facility Restorative Nursing Program. The program is consisted of nursing interventions that promote the highest mobility function of patients in performing activities of daily living (ADL). With the hiring of a restorative coordinator, all patients are assessed for restorative needs upon admission. Nevertheless, the respite, skilled nursing, and hospice patients may also end up not engaging in mobility activities if 1) they refuse to participate in restorative care, 2) independent with activities or 3) fail to satisfy restorative admission criteria (see Appendix B). The purpose of this project is to increase the number of patients participating in exercise especially from this group. The improved process (see Appendix C) will include referral and encouragement from PT/OT and restorative nursing team of the utilization of the poster-guided exercise course (see Appendix D).

Project Overview and Methodology

One of the qualities of a high performing clinical microsystem that this CNL project mostly aligns with is patient focus. As previously mentioned, the main target population of this project are those who do not receive skilled therapy. But since the posters will be on the unit hallways, any patient will have access to the exercises including the independent ones, as well as the ones receiving PT/OT and restorative services. Staff nurses will also be able to use the posters as a distraction activity intervention for patients having anxiety or other behavioral problems. The exercises are not designed to produce drastic improvement on mobility but rather to “maintain” or prevent the decline of the patients’ baseline mobility from their admission or
discharge from PT or OT.

The goal behind this project is for all patients to have access to a mobility/exercise activity to maintain their mobility throughout their stay in the unit. This project encompasses interdisciplinary collaboration starting with the design of the posters that involves staff nurses, PT, OT, and restorative team members. Its implementation assures that all patients will have access to activities that promote mobility and is in keeping of the military/veteran culture of “no one gets left behind.” With this project, the writer aims to increase the number of patients participating in exercise to 80 percent of the full census or at least 36 patients by July 31, 2017.

The change theory guiding this project is Kurt Lewin’s change model (as cited in Mitchell, 2013). Lewin’s change model stages – unfreezing, moving, and refreezing accurately describes the stages this project needs to undergo to be successful. Unfreezing was performed during the microsystem assessment and ended with the identification of the need for improved referral process and the need for improved access to mobility activities. The moving stage includes the improvement of the admission and mobility activity referral, development and installation of the poster-guided exercises, initiation of use of the interventions, and evaluation and adjustments of these interventions. It is during this stage that the writer will conduct an audit of the number of patients performing exercise. This project is effective if at least 80 percent of the patient population are participating in mobility/exercise activities. Also, this writer will gather patient and staff feedback during this stage. Through a survey, this writer can confirm if the predicted increased patient and staff satisfaction are attained. Lastly, refreezing stage starts when no further changes to the interventions are needed and after at least 80 percent of the unit population are engaging in mobility/exercise activities. The improved referral process and the use of the poster-guided exercises will be sustained in the unit.
Rationale

The data gathered during microsystem needs assessment led this writer to initiate this project. The unit patient roster, PT/OT roster, and restorative care roster were audited three times to record the number of patients who engage in exercise or mobility activities. During the needs assessment, this number ranges from 30 to 34 out of the total unit population of 45. The audits were performed at least three days apart to account for the changes in the unit population with the discharges and new admissions. In addition, the assessment of the admission process revealed the need for additional exercise/mobility option for the patients (see Appendix A and Appendix B). Patients are more likely to engage in activities when the activity options are presented to them compared to when the options are not discussed or offered at all. For this project, mobility activity or exercise is defined as activities such as walking, stretching, or weight-based training, or combination of such activities, performed by a resident for at least fifteen minutes per session.

Barriers to physical activity in long-term care facilities include lack of access to equipment or space (Benjamin, Edwards, Ploeg, & Legault, 2014). This project is an answer to these barriers. The major intervention in this project is the utilization of the poster-guided exercise course along the unit hallways. The cost associated with this intervention is minimal. The posters will be adapted from another Veterans Affairs facility and so the Medical Media department is expected to print the posters. Taking the salary of the multidisciplinary team members involved into consideration, the projected cost is $1,350 at the average salary of $45 per hour. The low cost, fairly easy implementation, and accessibility are some of the strengths of this intervention (see Appendix E).

The primary aim and benefit of the poster-guided exercise it to prevent functional decline
among patients. While this project is not intended or designed to prevent falls in the writer’s microsystem, a study shows that exercise is effective in preventing falls in long-term care facilities (Silva, Eslick, & Duque, 2013). Thirty to fifty percent of falls in health care facilities cause patient injuries that lead to additional 6.3 days of hospital stay and an average cost of $14,000 per fall (The Joint Commission, 2015). Financial savings through medication savings are also expected from this project since the posters can be utilized as non-pharmacological intervention for pain, anxiety, and other behavioral issues.

**Literature Review**

The literature searches relevant to this project were conducted on CINAHL Complete, PubMed, Cochrane Database of Systematic Reviews, and Google Scholar. The PICO search strategy included the use of keywords *mobility, exercise, long term care facility,* and *hospital.* Inclusion criteria include articles written in English language, published between 2012 and 2017, and limited to peer-reviewed articles. Six articles highlighting the benefits of exercise and maintenance of mobility among hospitalized adults and adults living in long term care facilities were selected for this review.

Zisberg, Shadmi, Gur-Yaish, Tonkikh, and Sinoff (2015) performed a prospective cohort study with 684 participants aged 70 and above to investigate the role of hospitalization processes with functional decline. The authors found 41.2 percent of the participants (n=282) reported functional decline by the time of their discharge. Low mobility during hospitalization was among the reasons identified for the functional decline in addition to poor nutrition and poor continence care. This study shows the importance of encouraging and maintaining patient mobility during hospitalization or stay in a health care facility.

Boltz, Resnick, Capezuti, Shuluk, and Secic (2012) conducted a prospective,
observational study in an urban hospital to study the effects of function-focused care (FCC) in
the prevention of functional decline among hospitalized adults. Ninety-three patients aged 70 and
above participated in this study. The authors described FCC as nursing care practice wherein the
nurses engaged the patients in care activities such as taking medication, eating, bathing, dressing,
and walking rather than performing most of the care themselves such as encouraging a patient to
walk and use the commode versus providing a bedpan or urinal. The authors concluded that FCC
was instrumental in preventing functional decline. This study supports this writer’s project since
it emphasizes the importance of nursing in the prevention of functional decline among
hospitalized elderly. The FCC, while not specifically called as such, is being practiced in this
writer’s rehabilitation unit. Furthermore, the restorative care program, which will be supported
by this writer’s project, is a more organized and evaluated FCC.

Czaplijski, Marshburn, Hobbs, Bankard, and Bennett (2014) wrote an article detailing the
improvement of mobility facilitation in an 861-bed medical center using interdisciplinary team
approach. The team developed the Greenville Early Mobility Scale (GEMS) which is a mobility
scale intended to be used each shift. The use of GEMS empowered the nurses to promote early
mobility rather than waiting for PT or OT evaluation, which could be delayed up to 48 hours
after admission. This article supports the importance of early mobility as well as stresses the
importance in utilizing interdisciplinary team in designing and implementing a successful
mobility program.

Silva, Eslick, and Duque (2013) conducted a systematic review and meta-analysis on the
effects of exercise for falls and fracture prevention. Their study was specific for the effects of
exercise in long term care facilities. Application of their selection criteria yielded twelve
randomized controlled trials (RCTs) that involved a total of 1,292 participants. These authors
found that exercise was an effective preventive intervention for falls in long term care facilities especially when there was variety in the exercises and were conducted at least two to three times a week. They also found that exercise did not prevent fractures among the study population.

Another study showing evidence of the effectiveness of exercise in prevention of fall was conducted by Tzeng and Yin (2014). They found that exercise is an effective fall prevention intervention especially when used in addition to standard fall prevention interventions such as routine fall-risk assessment, low bed position, use of non-slip footwear, locking of bed brakes, and maintaining call lights within patients’ reach. Lastly, Stubbs, Schofield, and Patchay (2014) presented that enhanced mobility activity could be used as non-pharmacological intervention for pain among patients who suffers from chronic musculoskeletal pain. These studies are relevant to this writer’s project since the project aims to encourage early and continuous mobility of patients with similar health issues in a similar microsystem.

**Timeline**

This project was started in late May and is projected to be fully implemented by the first week of August (see Appendix F for Gantt chart of project timeline). The first intervention portion of this project has been initiated with the restorative care coordinator encouraging independent mobility activities to patients found to be independent with activities during the admission assessment. Once the exercise posters are installed, in addition to the restorative coordinator, the staff nurses, OT, and PT staff are expected to start referring patient and encourage patients in utilizing the poster for the duration of their facility stay as applicable (see Appendix C). The refreezing stage of this project is expected by the end of August.

**Expected Results**

The primary expected result is the attainment of the project goal of increasing the number
of patients that are participating in mobility or exercise activities. The multifactorial interventions starting from admission, involvement of multidisciplinary team, and the availability to all patients will greatly contribute to the achievement of this goal. Successes of interventions or treatments are more likely when they are patient-centered (Flagg, 2015) and when there is interdisciplinary collaboration (Graham, 2012).

Another initiative recently rolled out in this microsystem is the use of the Banner Mobility Assessment Tool (BMAT) (see Appendix G). Also called bedside mobility assessment tool, BMAT is used to assess for mobility level and consequently for needed equipment or device and was found to have high validity (Boynton et al., 2014). The BMAT is being utilized by the staff nurses and is part of the admission assessment. The BMAT scores are posted on the patients’ white boards and are primarily utilized as guide for the staff when assisting the patients on their ADLs. This writer aims to capitalize more on the BMAT by instructing the staff nurses to encourage residents to ambulate around the unit or to use the poster-guided exercises as applicable for the patients found to have BMAT level 3 or 4 upon admission. These are the clients who are able to ambulate with supervision (level 3) or independently (level 4).

After the full implementation of the project, all patients that are discharged from PT or OT services but are awaiting facility discharge are expected to continue to participate in mobility/exercise activities throughout their stay in the unit. With the improved mobility assessment starting from admission, patients who are not eligible to receive skilled therapy from Physical Medicine and Rehabilitation Services (PMRS, PT/OT department) such as respite patients will have improved access to mobility activities. These improvements will result to patients maintaining their baseline or acquired (through PMRS sessions) mobility levels throughout their stay in the unit.
Nursing Relevance

As presented in this paper, maintaining patient mobility during hospital or long term care facility stay have many benefits including, but not limited to, reduced incidence of falls and improved pain management. The interventions inherent in this project are low cost and are easily adaptable to any unit. For example, the Pull Forward, Push Back exercise from a wheelchair (see Appendix D) may not be appropriate on a Medical-Surgical hallway. The exercise could be replaced with arm exercises. Another poster with head and neck exercises could be installed 15 feet away to promote ambulation between the exercise stations. The posters could be adapted to have unit specific/appropriate exercises. Once the posters are installed, no additional costs are needed to sustain the intervention.

In the report *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine (IOM) (2010) recommended for nurses to lead changes and practice to the full extent of their education. This project will fulfill the recommendation, as nursing will be in the forefront from the development of the interventions up to its implementation. The nursing process will be utilized starting from the assessment of the patient, diagnoses like impaired mobility, and the application and evaluation of the intervention.

Summary Report

This writer’s global aim was to improve the facility clients’ access to activities promoting mobility. This was accomplished after the installation of the par course exercise posters on the main unit hallway, but not without challenges. Initially, this writer intended for the posters to be installed in the unit by the first week of July. Since the posters were being adopted from another facility, e-mail was the primary means of communication between this writer and the collaborating staff. This posted another challenge since the file for the posters was too large to be
attached to e-mail. Consequently, the file was saved into a compact disc that was sent via interdepartmental mail. This writer did not receive the file until the second week of July due to the backlog from the observance of Independence Day.

Time constraint was the main barrier that this writer identified in completing this project on time for the semester. The shortened summer semester, the challenges in coordinating outside of the microsystem, and some family health issues all contributed to this writer’s inability to keep up with the original project timeline. Fortunately, the interdisciplinary team in this writer’s microsystem found only slight revisions were needed to the posters. A caution sign (see Appendix H) was developed per interdisciplinary team recommendation to be installed along with the posters. The posters and caution signs were installed along the unit’s main hallway on July 24, 2017.

Despite being two weeks behind the original projected full implementation of the project, the data collected at the end of July showed that 84 percent (n=38) of the unit population were engaging in mobility activities. This could be attributed to the improved referral to activities by nursing staff and the restorative coordinator during admissions, which were part of the process improvement initiated during the fourth week of the project (see Appendix F). Two weeks after full implementation, the average number of residents participating in mobility activities remained at 84 percent, thus accomplishing the project specific goal of 80 percent (see Appendix I). While these data looks promising and in line with what was projected, this writer believes that longer evaluation of the interventions are warranted before this project could be called a success. Since this writer works in the microsystem, the continuous evaluation and adjustments of the project is included in the timeline, which goes beyond the summer semester time frame (see Appendix F).

The changes from this project have high sustainability. The microsystem is a long-term
care facility and a rehabilitation unit so improving resident access to mobility activities is aligned with the organization’s mission. Furthermore, the recent changes in the microsystem such as the use of the BMAT and the “restorative culture” make the nursing staff and the facility restorative coordinator suited to be champions of the changes. Lastly, staff and resident feedback has been very positive including from the director of nursing who expressed interest in adapting the par course exercise poster to the other two units in the facility.

Conclusion

As presented in this paper, hospitalized individuals and people staying in long-term care facilities are at risk of functional decline and general health deconditioning. The studies discussed and presented in this paper demonstrate the importance in maintaining mobility status in mitigating the risk for the negative outcomes. With the data available thus far, the project presented in this paper show that improving the mobility assessment, referral process, and access to activities could help maintain patient mobility during their stay in the health care facility. Lastly, evident in the studies presented in this paper and with this author’s project, nursing plays a major role in maintaining the mobility status of patients.
References


https://doi.org/10.1111/jgs.13193
Appendix A

Fishbone Diagram
Appendix B

Flowchart of Current Process
Appendix C

Flowchart of Improved Process
Appendix D

Sample Exercise Poster

CLC Par Course for Daily Exercise

Pull Forward, Push Back

1. Sitting, park chair arm's distance from the rail REACH FORWARD towards the rail

2. PULL FORWARD towards the wall

3. PUSH BACK away from the wall

4. Pull FORWARD towards the wall

5. PUSH BACK away from the wall Bend at the waist and LOOK DOWN AT THE FLOOR FOR A DEEPER STRETCH of arms, back and waist

6. PULL FORWARD towards the wall Repeat sequence
Appendix E

SWOT Analysis of Poster-Guided Exercises

**Strengths**
- Promote/encourage mobility activities
- Low Cost
- Interdisciplinary collaboration
- Accessible to all

**Weaknesses**
- Length of time needed to finalize and install posters
- Use of poster is contingent to individual motivation

**Opportunities**
- May be used as distraction activity for patients with cognitive/anxiety issues
- Can be adopted and adjusted with unit-specific exercises

**Threats**
- Increased hallway traffic/activity may hinder other nursing activities
- May be dismissed as "just a poster"
### Appendix F

**Project Timeline**

#### Schedule for Implementation

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Start: May 21</th>
<th>Start: June 4</th>
<th>Start: July 2</th>
<th>Start: August 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct microsystem assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyze data and develop global aim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with PT, OT, and Restorative Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulate PICO question and conduct literature search</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWOT analysis of poster-promoted exercise course</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyze and develop process map</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate change in mobility assessment and activity referral with the Restorative Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with Nurse Manager and staff nurses to discuss planned interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinate with SFVA staff to acquire copy of posters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with PT, OT, and Restorative Nursing to update exercises and finalize posters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinate with facility Medical Media Department to have posters printed and installed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate use of interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess effectiveness of intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct staff and patient feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous evaluation and adjustment of intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend**

- Planned
- Progress
# Appendix G

## Banner/Bedside Mobility Assessment Tool (BMAT)

<table>
<thead>
<tr>
<th>Test</th>
<th>Task</th>
<th>Response</th>
<th>Fail = Choose Most Appropriate Equipment/Device(s)</th>
<th>Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Level 1</td>
<td>Sit and Shake</td>
<td>From a semi-reclined position, ask patient to sit upright and rotate* to a seated position at the side of the bed; may use the bedrail. Note: Consider patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across their midline.</td>
<td>MOBILITY LEVEL 1: Use total lift with sling and/or repositioning sheath and/or straps. Use manual transfer devices such as roll board, friction reducing slide sheet/duckbill, or air-assisted device. <strong>NOTE:</strong> If patient has 'strict bed rest' or bilateral 'non-weight bearing' restrictions, do not proceed with the assessment. Patient is MOBILITY LEVEL 1.</td>
<td>Passed Assessment Level 1 = Proceed with Assessment Level 2.</td>
</tr>
<tr>
<td>Assessment Level 2</td>
<td>Stretch and Point</td>
<td>Patient in seated position on the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten the knee, then bend the ankle/foot and point the toes. If appropriate, repeat with other leg.</td>
<td>MOBILITY LEVEL 2: Use total lift for patient unable to weight-bear on at least one leg. Use sit-to-stand lift for patient who can weight-bear on at least one leg.</td>
<td>Passed Assessment Level 2 = Proceed with Assessment Level 3.</td>
</tr>
</tbody>
</table>
| Assessment Level 3 | Stand | Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patient's cognitive ability, including orientation and CAM assessment if applicable. | MOBILITY LEVEL 3: Use non-powered raising aid; default to powered sit-to-stand lift if no stand aid available. Use total lift with ambulation accessories. Use assistive device (cane, walker, crutches). 
- For ≤ 3 seconds  
- For > 3 seconds  |
| Assessment Level 4 | Walk | Ask patient to march in place at bedside. Then ask patient to advance step and return each foot. Patient should display stability while performing task. Assess for stability and safety awareness. | MOBILITY LEVEL 4: MODIFIED INDEPENDENCE. Passed = No assistance needed to ambulate; use your best clinical judgment to determine need for supervision during ambulation. | Passed Assessment Level 3 AND no assistive device needed = Proceed with Assessment Level 4. Consult with Physical Therapist when needed and appropriate. |

*Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt in the patient's ability to perform the task.*

---

Original: 2011; revised: 2/17/12, 3/20/12, 3/27/12, 3/19/12, 4/19/12, 5/10/12, 5/9/12, 6/20/2013
Appendix H

Caution Sign

Do not attempt this exercise if you had previous injuries and have not been cleared by your medical provider to do such activity.
Appendix I

Pre- and Post Implementation Data

Patients Involved in Mobility Activities

Before: Average Census = 45
- 24 (56%)
- 11 (24%)
- 4 (9%)
- 5 (11%)

After: Average Census = 44
- 24 (55%)
- 7 (16%)
- 8 (18%)
- 5 (11%)