



Case study: Improving prompt mobilisation after surgery
Ulster Hospital
Sarah Lockhart, Trauma and Orthopaedic Team Lead Physiotherapist

Background

Our physiotherapy team underwent a lot of change during 2017 and when the 2017 NHFD data identified that we were below average in key performance indicator (KPI) 4 “prompt mobilisation after surgery”, we decided to look more closely at:

- how many patients were successfully mobilising on day 1 post-surgery
- how many were not successfully mobilising on day 1 post-surgery
- the barriers to patients mobilising on day 1 post-surgery.

With a new working environment and a very new team, we had an opportunity to reestablish our working practices and set a clear goal to improve this figure for future reports.

Aim

We wanted to increase the number of patients who successfully mobilised on day 1 post surgery and ensure we provided an effective and efficient service that was meeting national standards. We wanted to why patients were unable to mobilise and to promote education for patients and families on the benefits of early mobilisation to ultimately improve patient experience.

Process

We worked with the wider multidisciplinary team (MDT) to ensure that everyone was aware of our objective and create a culture where this was the norm. We also wanted to ensure that all members of the team reinforced a day 1 mobilisation expectation to our patients from the point of admission. Our physiotherapists and physiotherapy assistants collected the data and our fracture outcomes nurse cross-checked this with our NHFD data.

We started by reviewing the existing guidelines and standards, to clarify the definition of ‘mobilisation’ and what exactly can be considered ‘mobilisation’. This was helpful for us to do at the start of the process to ensure standardised reporting of data.

We then audited data on 100 primary hip fracture patients. The physiotherapy team collected information for each patient on surgery fixation type; what time their surgery ended versus what time physiotherapy was assessed on day 1; their ASA score; if the patient successfully mobilised on day one; and if not, why not. We found it important to ensure staff members had protected time and could continue their focus during the data collection period

After analysing the data, we found that the primary causes of patients not mobilising were:

- Hypotension
- Pain
- Patient confusion / post-op delirium
- Inappropriate seating in the new ward environment and inaccessible hoists.

As a result we undertook a number of changes.

- staff training and raising of awareness throughout the MDT of the expectation that patients would get out of bed on day 1. This included encouraging staff to review patients later in the day if they were unable to mobilise on the first attempt.
- Promoting 'Day 1 mobilisation' to patients and families from the point of admission this reduced the number of patients who refused to mobilise or participate in the assessment and ensured families had brought appropriate footwear in advance.
- Sharing our results with our anaesthetic colleagues; which meant they took postoperative pain and hypotension as issues to review within their own audits and protocols.
- Working with orthogeriatricians to optimise patients pre-operatively to minimise risk of hypotension and delirium.
- Ensuring the availability and accessibility of assistive equipment, e.g. hoists and raised chairs.
- Investigating various options to improve the availability of appropriate seating – we have since purchased chair raisers, for example.

Outcomes

We were pleased to see we have achieved a 20% improvement in KP14 on NHFD data, from 58% in 2017 to 78% in 2018.

We found that reviewing the definitions of mobilisation at the beginning of the project was pivotal – this focussed staff on post-op mobilisation and highlighted our role in promoting it. Taking baseline data and looking beyond the statistics into the barriers to mobilisation allowed us to understand more about the factors which we could affect for change.

We continue to seek improvements, having recently piloted a 'Hip Fracture Pathway' using posters in patient rooms and an accompanying booklet given to patients and families. We have since found that this has even improved other aspects of patient care, such as more timely removal of catheters.

We have created a culture where patients and their families anticipate and expect mobilisation on day 1 and are more prepared for the arrival of physiotherapy staff. The issues identified with seating provided in our new building have influenced the procurement process for another new building which is soon to open – our experiences, and the resulting limitations on our patient care, has been recognised and is being taken forward.

Although this work started as a physiotherapy project, it has taken the support of a very wide MDT to realise these improvements. Communicating with the wider team was essential – there were a number of factors which as physiotherapists alone we could not have changed, but as a multidisciplinary team, we could. We did not anticipate that what started as a small audit would have become a project which influenced future buildings and procurement, and that would initiate a review of the pre- and intra-operative management of patients. We have been fortunate to have support from all our MDT colleagues to facilitate the project and to embed changes which are sustainable.