Adding staff to cut costs, help recoveries

Intensive Care PT Pilot Gets Sickest Patients Moving

By Todd Neff

Movement is medicine.

Scads of research confirms the connections between physical activity and human health, and that they apply to the young and the old, the well and the sick. Movement even helps the very, very sick, including those being kept alive via lines and tubes in intensive care units.

That investment is funding a UCH quality improvement project launched on April 1. Kyle Ridgeway, PT, DPT, a student of the benefits mobility brings to intensive-care patients, is leading it. Research shows that spending days or weeks in bed ushers in a host of long-term problems, he said.

A few examples: even healthy, well-nourished patients lose 1 to 3 percent of their muscle strength per day in the ICU; three weeks of bed rest in healthy adults equates to a short-term decline equivalent to 30 years of aging; and, for the critically ill, weakness and cognitive impairment can persist five years after hospital discharge. Patients on bed rest who survive near-death experiences from sepsis and acute respiratory failure are also prone to depression and post-traumatic stress disorder, Ridgeway added.

“Bed rest is essentially the worst thing for almost any condition,” Ridgeway said. “If you get patients up and moving sooner, you can potentially get them off the ventilator sooner, out of the ICU sooner, and out of the hospital sooner all while improving their physical function, so it’s good for the hospital as far as cost and more importantly, better for the patient.”

Help is here. But hospital leaders needed a strong case to justify a staffing increase, said Timothy Wimbish, SLP, who directs the hospital’s rehabilitation services. The best way to make that case, he said, was to run a pilot in the MICU.

With help from the quality-improvement grant, the 24-bed MICU will deploy three full-time-equivalent (FTE) physical therapists (PTs) from Monday through Saturday — that’s compared to the usual 0.5 FTEs Monday through Friday. That 0.5 FTE number was overstated, too, said Danielle Sockolosky, PT, DPT, the hospital’s inpatient physical therapy supervisor. That’s because the MICU and the 36-bed...
Medical-Surgical Progressive Care Unit split the time over the entire zone, meeting needs in both units as they arose.

“There were times when the PT never made it to the MICU,” Sockolosky said.

**Trickle down.** Physical therapy staffing shortages put added stress on nurses who understood the value of getting patients moving but lacked the expertise as well as the time, said MICU nurse Chrissy O’Shea, RN.

“If we as nurses felt like a patient could benefit from PT, it could be one or two days until the consult,” she said.

Often, nurses took the initiative, O’Shea said. But even if a patient was strong enough to stand, it took two staff members to steady him or her. It was hard to find the time, particularly in the morning, when nurses are busy administering medications, doing assessments, rounding, turning and adjusting patients, and talking to families. As a result, nurse-led mobility sessions would wait until midday or late afternoon. Rarely would the patient make it out of the room.

A week into the pilot, that had already changed, O’Shea said. “Now, at 8 a.m., Becca over here says, ‘Can I get your patient out of bed?’”

“Becca” is Becca Medina, PT, DPT, one of the PTs fortifying the MICU staff during the pilot. She knows which patients are poised for PT, thanks to another aspect of the quality initiative. Rather than wait for a nurse or physician to request a PT consult, a PT consult has been added to the MICU’s admission order set.

“For the unit, it’s been a change in culture, following every single patient,” Medina said. “But a lot of the patients have been started early.”

Ridgeway said the move to make PT an integral part of MICU patient care doesn’t change the fundamental standing of PT.

“If you’re trying to save someone’s life, the first thing on your mind isn’t, ‘Where’s Kyle from PT?’” Ridgeway said.

**Better coverage.** The aim is to take the variability of PT consults out of the equation and get more patients seen. Based on a two-week survey on the unit done last summer, Ridgeway figures PT was receiving consult requests for about 40 percent of MICU patients but managed to serve only about half of those.

“We were only seeing 15 to 20 percent of the unit on a given day and probably could have been seeing 75 percent,” Ridgeway said.

Those low numbers partly reflected the time and collaboration required to engage in even the most basic mobilization with someone on life support, such as sitting up on the edge of the bed. In addition to PTs, respiratory therapists (for ventilator adjustments, say) and nurses are often involved. When Medina and other ICU PTs work with a patient, they need to mind or manage life-support equipment, lines and tubes, and other specialty equipment, all while assisting and monitoring the patient. The actual therapy demands a strong background in movement, pathophysiology, patho-exercise science, and more, Ridgeway said. Between planning and the actual therapy session, implementing a PT visit can take one to two hours, he said.

Medina and colleagues need to know when to push and when to back off, too. Pushing may be as simple as taking walks out of the room and down the hall to the solarium, a change of scenery which O’Shea said is “good for their mental and emotional state of mind, especially if they’ve spent weeks and weeks here.”

‘**Not today.**’ For patients, it can be tough at first. Armando Caban, 67, of Frederick happened to be visiting the MICU last week. The only indication that he had been a patient was a small post-biopsy bandage on his neck. Caban received a heart transplant at UCH in May 2014; before that, he had undergone open-heart ablation in a failed attempt to correct his atrial fibrillation. He remembers a PT approaching him in the ICU after that earlier procedure.

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“When they said they were going to make me get up out of that bed, my initial reaction was, ‘Not today, baby. ‘This ain’t happenin’,’ ” Caban recalled.

But he relented and was amazed by how much better he felt. Post-transplant, he willed himself to stand and walk to the door within a week of surgery.

“I think my health would not have come back,” he said. “It’s a real pivotal point, getting off that bed.”

Whether PT proves pivotal for the hundreds of MICU patients who will experience it during the pilot — and for the hospital’s bottom line — time will tell. A 2013 Johns Hopkins study showed that adding PT hours in the ICU paid off there. Experiences like Caban’s shows it can make a difference for patients. O’Shea, the MICU nurse, is just happy the pilot’s happening.

“I think this is amazing. I think it will benefit our patients mentally, physically and emotionally,” she said. “It should have happened like a million years ago.”

The MICU Physical Therapy Quality Initiative Team

The hospital’s MICU PT quality initiative has taken collaboration among PTs, nurses, physicians, respiratory therapists, occupational therapists, and management. A few of the players:

**MICU PT project leadership**
- Kyle Ridgeway, PT, DPT, project coordinator
- Danielle Sockolosky, PT, DPT, supervisor, inpatient physical therapy
- Matthew Gallagher, PT, DPT, manager, inpatient rehabilitation services
- Tim Wimbish, SLP, director, rehabilitation services

**Nurses**
- Mark Yoder, RN, MICU nurse manager
- Amy Hassel, RN, MICU associate nurse manager
- Pol-Andre Senecal, MSN, NP, CNS, ACNP, CCNS, MICU nurse educator

**Physicians**
- Ellen Burnham, MD, MICU medical director
- Mark Moss, MD, section head, Critical Care Medicine, CU School of Medicine

**MICU PT Team**
- Kyle Ridgeway, PT, DPT
- Rebecca Downey, PT, DPT
- Lauren Harper, PT, DPT
- Becca Medina, PT, DPT

**Back-up PTs**
- Beth Anne Fisher, PT, DPT
- Evan Haezebrouck, PT, DPT
- Erin Schnake, PT, DPT