Mobility as Medicine: Early Mobility Made Easy

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Outline

- Patient mobilization doesn't have to be complicated
- Benefits to early mobilization
- SPH education in the nursing curriculum
- Mobility status assessments
- Tips and tricks for mobilizing your patient

SPH: Current state (for most hospitals)

- Lack of role clarity between nursing and PT/OT
- Low level of confidence with mobilization outside PT/OT/rehab
- Mismatch between pt presentations and mobility equipment available
- Not all facilities ‘plan for mobility’

Before you get the Golvo….

Or whatever you call it….

Are you a lazy clinician like me?

- Do you hate going to get the mobile lift?
- Does messing around with slings get you down?
- Are you also terrified of dropping your patient?
- Then you are in the right place!

There's a middle ground

- It's not a dichotomy between leaving the patient in bed and getting them walking
- Using your patient's existing mobility
  - Makes it easier for you
  - Empowers them
  - Gets them moving faster

How often do you see…

- ‘Under arm’ or ‘hook arm’ transfers?
- The caregiver doing it all for the patient?

If your patient can help you

- The mobility assessment is your no. 1 tool
- Understand **how much** they can help you
- Learn these tips and tricks and combine them with patient input to mobilize your patient without a whole lot of messing around, safely

Early Mobility

The benefits and the evidence

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How to define early mobility

- Usually involves mobilization within 48 hours of admission for critical care patients
- Post CABGs, ortho surgery etc., usually assess to mobilize on day 0
- Depends on presentation and care protocols
- The aim is to get them up and moving ASAP

Contraindications to mobilization

- Paralyzed and sedated
- On high doses of vasopressors / unstable / low MAP
- FiO2 >0.8
- In an acute neurological event (CVA, SAH, ICH)
- Not responsive to verbal stimuli
- Unstable #s
- Grave prognosis / palliation
- Insitu femoral dialysis catheter
- Open abdomen
- Confusion / delirium / unable to follow commands

Evidence for early mobilization programs

- The evidence on the whole suggests many benefits:
- Reduced length of stay
- Discharge to home instead of SNF
- Increased likelihood of return to full independence
- Shorter duration of delirium
- More ventilator free days (Brahmbhatt et al 2011)
- Reduced incidence of hospital acquired pneumonia
- Limited impact on outcomes for stroke patients

Patient Mobilization and the Nursing Curriculum

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Training usually includes…

- How to use the mobility assessment tool
- Indications and contraindications to mobilization
- Fall prevention
- Using SPH equipment
- Not every hospital delivers training which integrates these topics

Painting nurses into a corner

- Current curriculum for many institutions leaves nurses feeling like they have 3 options for the moderate assist patient:
  - Don’t mobilize the patient
  - Mobilize them with SPH equipment
  - Call the PT/OT and make them deal with it

Show them how to help the mod assist patient

- This patient can assist with mobility tasks
- Let's do a mobility assessment on our fake patient

Mobility assessment tools

- Banner Mobility Assessment Tool (BMAT)
- Get up and Go / Timed Get up and Go
- Stratify
- Tinetti

Banner Mobility Assessment Tool for nurses

Nurses have found that the Banner Mobility Assessment Tool (BMAT) is an effective resource for performing a bedside assessment of patient mobility.

Test	Task	Response	Fail = Choose most appropriate equipment/device(s)	Pass
Assessment Level 1 Assessment of: • Trunk strength • Seated balance	**Sit and shake:** From a semi-reclined position, ask patient to sit upright and rotate* to a seated position at side of bed; *may use bedrail.* Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake, making sure patient reaches across his/her midline.	**Sit:** Patient is able to follow commands, has some trunk strength; caregivers may be able to try weight-bearing if patient is able to maintain seated balance longer than 2 minutes (without caregiver assistance). **Shake:** Patient has significant upper body strength, awareness of body in space, and grasp strength.	**MOBILITY LEVEL 1** • Use total lift with sling and/or repositioning sheet and/or straps. • Use lateral transfer devices, such as roll board, friction-reducing device (slide sheets/tube), or air-assisted device. ***Note:** If patient has **strict bed rest or bilateral non-weight-bearing** restrictions, **do not proceed** with the assessment; **patient is MOBILITY LEVEL 1.***	Passed Assessment Level 1 = Proceed with Assessment Level 2.
Assessment Level 2 Assessment of: • Lower extremity strength • Stability	**Stretch and point:** With patient in seated position at side of bed, have patient place both feet on floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten knee, then bend ankle/flex and point toes. If appropriate, repeat with other leg.	Patient exhibits lower extremity stability, strength and control. **May test only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).**	**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.	Passed Assessment Level 2 = Proceed with Assessment Level 3.
Assessment Level 3 Assessment of: • Lower extremity strength for standing	**Stand:** Ask patient to elevate off bed or chair (seated to standing) using 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.	Patient exhibits upper and lower extremity stability and strength. **May test with weight-bearing on only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).** **If any assistive device (cane, walker, crutches) is needed, patient is Mobility Level 3.**	**MOBILITY LEVEL 3** • Use non-powered raising/stand aid; *default to powered sit-to-stand lift if no stand aid is available.* • Use total lift with ambulation accessories. • Use assistive device (cane, walker, crutches). *Note:* Patient passes Assessment Level 3 **but requires assistive device** to ambulate or **cognitive assessment** indicates poor safety awareness; ***patient is MOBILITY LEVEL 3.***	Passed Assessment Level 3 **AND no assistive device needed** = Proceed with Assessment Level 4. ***Consult with physical therapist when needed and appropriate.***
Assessment Level 3 Assessment of: • Standing balance • Gait	**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 tasks. Assess for stability and safety awareness.	Patient exhibits steady gait and good balance while marching and when stepping forward and backward. Patient can maneuver necessary turns for in-room mobility. Patient exhibits safety awareness.	**MOBILITY LEVEL 3** If patient shows signs of unsteady gait or ***fails* Assessment Level 4**, refer back to **MOBILITY LEVEL 3;** ***patient is MOBILITY LEVEL 3.***	**MOBILITY LEVEL 4** MODIFIED INDEPENDENCE **Passed = No assistance needed to ambulate;** use your best clinical judgment to determine need for supervision during ambulation.

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

What I'm about to show you…

- Isn't totally consistent with the BMAT
- Is about helping maximize mobility
- Can help navigate the 'chair effect' (think about putting patients back to bed)
- Makes it easier to help a patient mobilize

Lie to sit on edge of bed (Level 1)

- Raise head of bed slightly
- Position feet over the edge of the bed
- Bring to side lying then push up on hand

Stretch and point (Level 2)

- Not too many tips here!
- Make sure air mattresses are deflated

Sit to stand (level 3)

- Lower bed until feet are flat on floor
- Use a walking frame as default starting point
- Nose over toes
- Lift bottom off bed before attempting full stand
- Block one knee if required

March on the spot (Level 4)

- Weight shift side to side
- Watch for hip and knee extension
- Step over to chair and march in front of it
- If attempting distance ambulation: take a wheelchair

Should I use a gait belt?

- Prone to misuse
- Ordinarily intended for slide/ pivot transfers
- End up being used as ‘handles’ and the caregiver takes some of the patient’s weight
- A number of regulators recommend against providing them

In summary…

- Your patient can help you if you know how to help them
- Simple tips and tricks can help maximize the patient's mobility
- Keeping it simple helps keep everybody moving
- Early, maximized mobility helps optimize patient outcomes
- Appropriate assessment and graduated mobility helps this happen safely

Questions?

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