Pathway Pearls

Early Mobilization: Defining & Doing

Sharing Tricks of the Trade

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Alberta Health Services
Strategic Clinical Networks

Learning Objectives

- Review best practice recommendations
- Define Early Mobilization
- Identify available resources to facilitate early mobilization
- Share site learnings on how to promote early mobilization so staff are confident
- Identify 2 Pathway Pearls to assist implementation

Outline

- Recommendations
- Definition of Early Mobilization
- Mobilizing Patients with COPD in Acute Care
  William Tung, PT, RAH PT Professional Practice Lead
- Group Discussion: Sharing Tricks of the Trade
- Wrap Up

Canadian Cardiovascular Society

To prevent delirium and functional decline in at-risk hospitalized seniors:

Promote sleep, cognitive stimulation, proper vision and hearing, and adequate hydration and nutrition, it also includes **early mobilization and bed mobility exercise in non-ambulatory patients.**

The intervention reduces the incidence of delirium and functional decline, and is also cost-effective.

Mobilizing Patients with COPD in Acute Care

- **“If you can’t breathe, you can’t function!”**

  Mary Massery PT

- COPD → Limitations (physical function, endurance, ADL independence, mobility, psychosocial, financial, etc.)
- AECOPD Management – medical management, interprofessional approach, maintain and optimize function
- Understanding the pathophysiology of COPD and its impact on patient functions
- Understanding the adverse effects of bed rest & immobility

Mobilizing Patients with COPD in Acute Care

- Early safe mobilization – is it just for patients with AECOPD?
- Know your patient well – “What matters the most?” “What are their goals?”

What to assess? What to do? When to start? When to stop?

Who should do that? Nursing, rehab, RT, family, friends

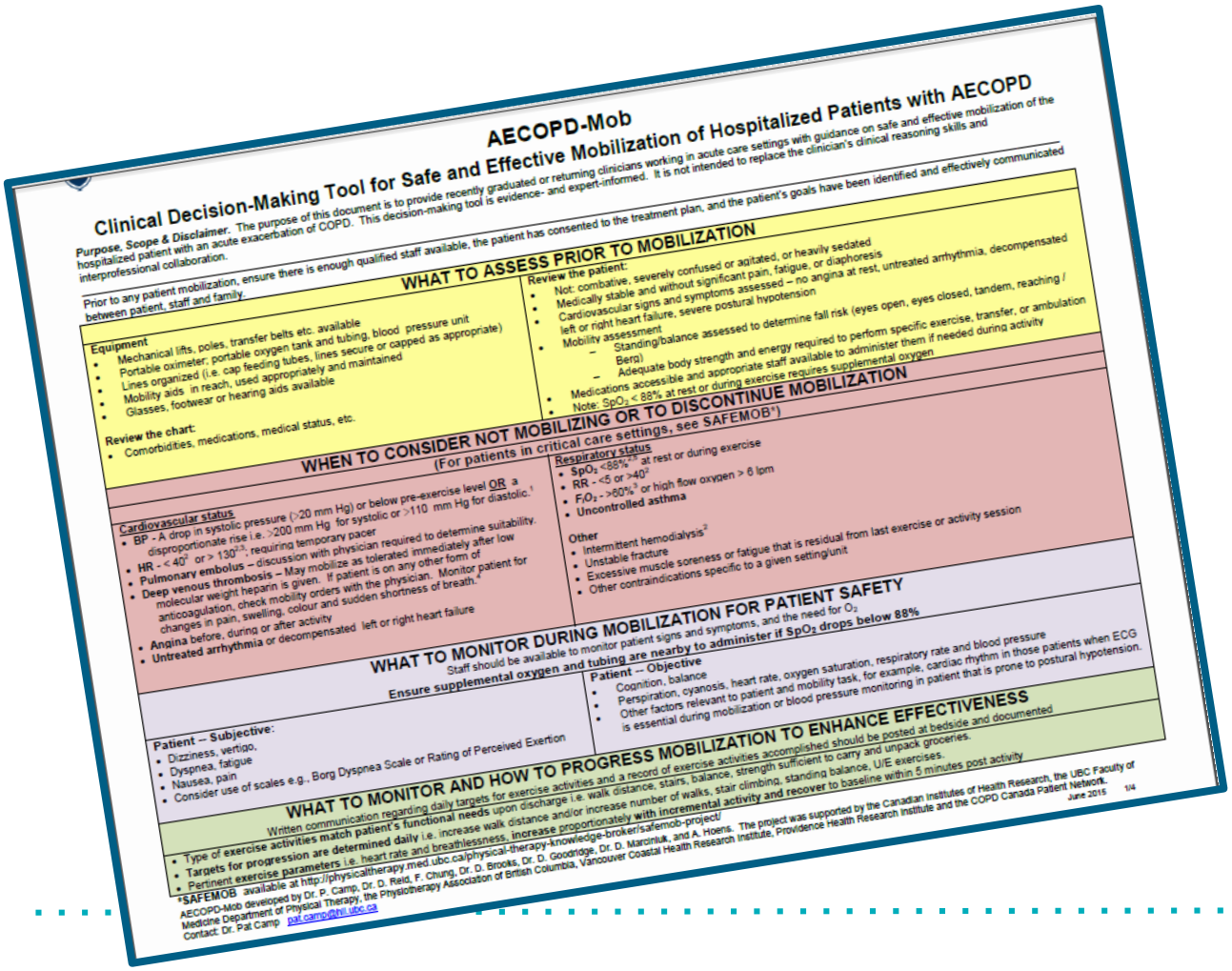
- Patient centered care & Team effort
- General vs. therapeutic mobilization
- Meaningful / purposeful mobilization

Pathway Pearls: Early Mobilization

An example:

UBC AECOPD Mob

Co-developed by UBC Dept of PT and other authorities



AECOPD-Mob

Clinical Decision-Making Tool for Safe and Effective Mobilization of Hospitalized Patients with AECOPD

Purpose, Scope & Disclaimer. The purpose of this document is to provide recently graduated or returning clinicians working in acute care settings with guidance on safe and effective mobilization of the hospitalized patient with an acute exacerbation of COPD. This decision-making tool is evidence- and expert-informed. It is not intended to replace the clinician's clinical reasoning skills and interprofessional collaboration.

Prior to any patient mobilization, ensure there is enough qualified staff available, the patient has consented to the treatment plan, and the patient's goals have been identified and effectively communicated between patient, staff and family.

WHAT TO ASSESS PRIOR TO MOBILIZATION

Equipment
- Mechanical lifts, poles, transfer belts etc. available
- Portable oximeter; portable oxygen tank and tubing, blood pressure unit
- Lines organized (i.e. cap feeding tubes, lines secure or capped as appropriate)
- Mobility aids in reach, used appropriately and maintained
- Glasses, footwear or hearing aids available

Review the chart:
- Comorbidities, medications, medical status, etc.

Review the patient:
- Not: combative, severely confused or agitated, or heavily sedated
- Medically stable and without significant pain, fatigue, or diaphoresis
- Cardiovascular signs and symptoms assessed – no angina at rest, untreated arrhythmia, decompensated left or right heart failure, severe postural hypotension
- Mobility assessment
  - Standing/balance assessed to determine fall risk (eyes open, eyes closed, tandem, reaching / Berg)
  - Adequate body strength and energy required to perform specific exercise, transfer, or ambulation
- Medications accessible and appropriate staff available to administer them if needed during activity
- Note: SpO_2 < 88% at rest or during exercise requires supplemental oxygen

WHEN TO CONSIDER NOT MOBILIZING OR TO DISCONTINUE MOBILIZATION
(For patients in critical care settings, see SAFEMOB*)

Cardiovascular status
- BP - A drop in systolic pressure (>20 mm Hg) or below pre-exercise level OR a disproportionate rise i.e. >200 mm Hg for systolic or >110 mm Hg for diastolic.[1]
- HR - < 40[1] or > 130[2,3]; requiring temporary pacer
- **Pulmonary embolus** – discussion with physician required to determine suitability.
- **Deep venous thrombosis** – May mobilize as tolerated immediately after low molecular weight heparin is given. If patient is on any other form of anticoagulation, check mobility orders with the physician. Monitor patient for changes in pain, swelling, colour and sudden shortness of breath.[4]
- **Angina** before, during or after activity
- **Untreated arrhythmia** or decompensated left or right heart failure

Respiratory status
- SpO_2 <88%[2,3] at rest or during exercise
- RR - <5 or >40[2]
- F_iO_2 - >60%[3] or high flow oxygen > 6 lpm
- **Uncontrolled asthma**

Other
- Intermittent hemodialysis[2]
- Unstable fracture
- Excessive muscle soreness or fatigue that is residual from last exercise or activity session
- Other contraindications specific to a given setting/unit

WHAT TO MONITOR DURING MOBILIZATION FOR PATIENT SAFETY
Staff should be available to monitor patient signs and symptoms, and the need for O_2
Ensure supplemental oxygen and tubing are nearby to administer if SpO_2 drops below 88%

Patient – Subjective:
- Dizziness, vertigo,
- Dyspnea, fatigue
- Nausea, pain
- Consider use of scales e.g., Borg Dyspnea Scale or Rating of Perceived Exertion

Patient – Objective
- Cognition, balance
- Perspiration, cyanosis, heart rate, oxygen saturation, respiratory rate and blood pressure
- Other factors relevant to patient and mobility task, for example, cardiac rhythm in those patients when ECG is essential during mobilization or blood pressure monitoring in patient that is prone to postural hypotension.

WHAT TO MONITOR AND HOW TO PROGRESS MOBILIZATION TO ENHANCE EFFECTIVENESS
Written communication regarding daily targets for exercise activities and a record of exercise activities accomplished should be posted at bedside and documented

- Type of **exercise activities match patient's functional needs** upon discharge i.e. walk distance, stairs, balance, strength sufficient to carry and unpack groceries.
- **Targets for progression are determined daily** i.e. increase walk distance and/or increase number of walks, stair climbing, standing balance, U/E exercises.
- Pertinent **exercise parameters** i.e. heart rate and breathlessness, **increase** proportionately **with incremental activity and recover** to baseline within 5 minutes post activity

*SAFEMOB available at http://physicaltherapy.med.ubc.ca/physical-therapy-knowledge-broker/safemob-project/

AECOPD-Mob developed by Dr. P. Camp, Dr. D. Reid, F. Chung, Dr. D. Brooks, Dr. D. Goodridge, Dr. D. Marciniuk, and A. Hoens. The project was supported by the Canadian Institutes of Health Research, the UBC Faculty of Medicine Department of Physical Therapy, the Physiotherapy Association of British Columbia, Vancouver Coastal Health Research Institute, Providence Health Research Institute and the COPD Canada Patient Network.

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"You treat a disease, you win, you lose.
You treat a person, I guarantee you, you'll win, no matter what the outcome!"

- From the movie Patch Adams (1998)

Early Mobilization Documentation

Transition to Community Care Orders

Chronic Obstructive Pulmonary Disease (COPD) Transition to Community Care

1. Select orders by placing a (√) in the associated box
2. For more information, see Clinical Knowledge Topic ***Chronic Obstructive Pulmonary Disease*** http://insite.albertaheatlhservices.ca/13198.asp

Date *(yyyy-Mon-dd)*	**Time** *(hh:mm)*

Consultations (For all consultations, utilize the most appropriate available health care provider(s) at your site to deliver services)

- ☑ Ambulate – Early Mobilization (*done within 48 hours*)
- ☐ Dietitian Referral to assess and treat IF food intake is poor
- ☐ Respiratory Therapy Referral to assess Home Oxygen requirements
- ☑ Pharmacy Consult to optimize respiratory medication therapy
- ☑ Physiotherapy and/or Occupational Therapy Referral to screen for the following as necessary

COPD Admission to Discharge Checklist

Admission Date *(yyyy-Mon-dd)*	Time *(hh:mm)*

Activity	Completed			
Patient Education	**Yes**	**No**	**N/A**	**Initial**
1. Provide 'Patient Education Resource Package' – Review with patient/caregiver				
a) COPD Medications				
b) Inhaler Technique				
c) COPD: Learning to Breathe Easier				
d) COPD: Avoiding Your Triggers				
e) Pneumococcal / Influenza Vaccines				
f) Tobacco use; assess, provide brief intervention, and tobacco cessation support resources.				
Patient Demonstration				
2. Patient demonstrates adequate inhaler technique				
Prior to Discharge ***Review results, where relevant, and ensure appropriate follow-up***				
3. Early mobilization *(done within 48 hours by any discipline)*				
4. Review and optimize respiratory medication				

Admission to Discharge Checklist

Participants are encouraged to participate in session talks.

If you would like to email your question, please send to:

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