Implementation Of An Early And Aggressive Mobility Program
For Patients In The ICU

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AUTHORS (LAST NAME, FIRST NAME): Evans, Daniel J.¹

AUTHORS/INSTITUTIONS: D.J. Evans, Rehabilitation, Hahnemann University Hospital, Philadelphia, Pennsylvania, UNITED STATES

Purpose: Patients within the ICU, especially mechanically ventilated patients, have received limited PT services in the past due to misperceived beliefs about medical contraindications, limited ability to participate and questionable benefits for the patients. Our goal was to implement an early and aggressive mobility program for this patient population. In order to meet this goal we constructed an interdisciplinary model to identify, evaluate, treat patients and communicate effectively with all team members.

Description: In order to implement a program we dedicated a PT exclusively for the ICU and began attending daily rounds with the Medical ICU (MICU) team to identify patients. During the daily rounds, each patient is discussed with a brief summary of current medical issues. At this time a patient is identified as a candidate for mobility. The medical team is advised on exclusion criteria for patients. Once a patient is identified there is a discussion with nursing to identify when sedation interruptions are planned, medications that may affect mobility and potential equipment sensitivities. PT evaluation/progression: PT evaluation includes all relevant tests and measures including but not limited to MMT, cognitive assessment, sensation testing, and balance assessment. Patients are typically seen daily and progress from Long sit/Supine Ther Ex→ EOB sit/activities→ Standing/Standing activities→ Ambulation. Length of time at each level varies depending on the individual patient’s tolerance. Classification: After PT sessions, the patient is classified into an activity level corresponding with the Johns Hopkins University High Level of Mobility (JH-HLM). This number is predominantly displayed in the patients’ rooms for use by the
nursing staff to allow for safe transfers while allowing for maximum mobility of the patient.

**Summary of Use**: Prior to the implementation of the program an average of 3 PT sessions were performed a month in the MICU. After 18 months an average of 87 patients per month are being seen. Patients also demonstrated an ability to participate by performing transfers and higher levels of mobility as demonstrated by average JH-HLM scores of 4.3 for patients not on the ventilator and 2.4 for patients on the ventilator. Patients also demonstrated a significant need for PT with AM-PAC Basic Mobility Inpatient Short form scores of 8.3 for ventilated patients and 13.2 for non-ventilated patients. Finally we were able to reduce the MICU length of stay from 4.84 to 4.11 days, a 15% decrease. With an interdisciplinary approach an early mobility program can be developed to change the ICU culture. No one individual/group has a large increase in responsibilities but rather an even distribution amongst providers with the PT as the leader.

**Importance to Members**: The information regarding our early mobility program is a crucial tool in developing programs in other ICU's throughout the country. During our implementation there was limited information available. Our experience can help others who are seeking to implement an early ICU program.