Mobilization

The reasons for early mobilization are to increase respiratory endurance; to prevent general deconditioning; to prevent critical care myopathy/neuropathy; to reduce ICU delirium; to improve psychological well-being; and to reduce ventilator days, ICU days, and hospitalization days. The goal is ultimately to improve functional independence at hospital discharge.

Patients with a good functional status two weeks prior to hospitalization are eligible for inclusion in the early mobilization program. As a rule, most patients in the MICU and MSU will be candidates for mobilization.

Contraindications to mobilization:

- Shock (MAP < 65, extreme bradycardia or tachycardia, need for vasopressors)
- $FiO_2 \geq 60\%$ or PEEP ≥ 10
- Intracranial hypertension
- Active hemorrhage
- Coma, stupor, or agitated delirium
- Intra-aortic balloon pump, open sternum, open abdomen, or other specific reason for bedrest. These should be few and far between. Most bedrest orders are done reflexively and are not justified. Remove them whenever possible.

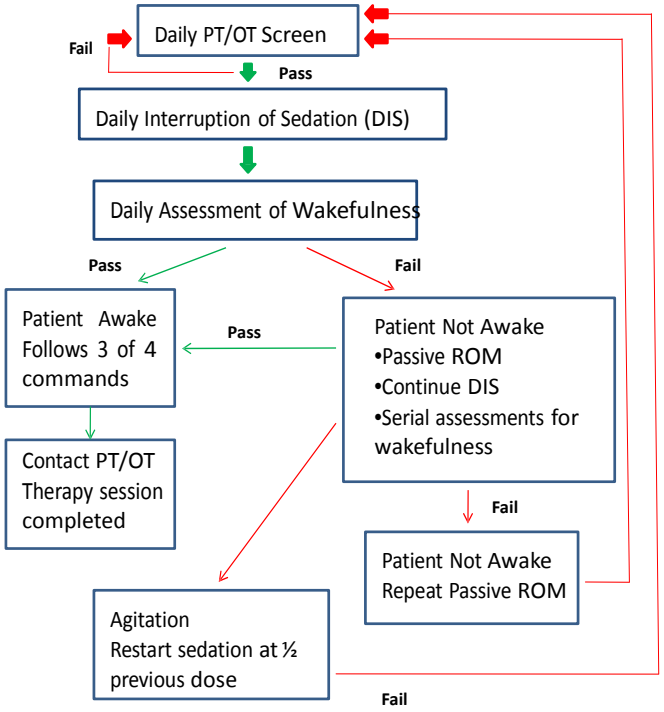
Notice that an endotracheal tube is **not** a reason to stay in bed. Our ventilators have batteries and can be pushed behind the patient while he walks. Even if he can't walk, the ventilator tubing is long enough to let him sit in a chair or stand up beside the bed.

How This is Done:

The ICU attending and/or fellow will meet with the physical and occupational therapists prior to rounds every day. Together, they decide who is a candidate for mobilization. Even if PT/OT is not able to work with the patient that day, the ICU nursing staff should get him out of bed into a chair at least twice daily, unless there is a specific contraindication.

Below is the outline of the procedure for daily assessment of mobilization in the ICU patient:

William Owens, MD
Associate Professor of Clinical Medicine
University of South Carolina
william.owens@uscmed.sc.edu



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Associate Professor of Clinical Medicine
University of South Carolina
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