Mobility Clinical Practice Standard

Sunnybrook Health Sciences Centre		Policy No:	CLS-371
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Issued By:	Best Practice Steeting Committee		
Approved By:	Interprofessional Quality of Care		

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POLICY STATEMENT

It is a standard of practice at Sunnybrook Health Sciences Centre to minimize risks associated with hospitalization by enhancing and maintaining a persons' optimal functional ability through early and sustained mobilization. As demonstrated in the literature, the purpose of early and sustained mobilization is to prevent de-conditioning and to optimize patient/residents strength and functional status. This standard and the implications for practice pertains to the following inpatients units at Bayview Site: B4, C2, C4, C5, C6, CGMU, D2, D3, D4, D5, D6, Veterans Centre and Holland Centre. In the Veterans Centre and for some patients at the Holland Centre, a person's optimal functional ability is enhanced and maintained through daily mobilization activities that complement the lived experience of the residents / patients who reside there.

All interprofessional team members are oriented to the mobility standard of care and are expected to engage in regular education to enhance their understanding and knowledge related to evidence-based mobility assessment and interventions.

Interprofessional team members are to engage patients/residents and their families in discussions regarding the importance of mobilization and identify their concerns and needs. Families are supported to encourage and assist patients/residents with mobility activities as appropriate for their mobility level.

POLICY DEFINITIONS

Ambulation refers to walking and other upright weight-bearing activities that result in a change of location.

Mobility is any movement of the person's body. It can include active or passive motion, and can range from actions to move a limb or assume a sitting position in bed, to participating in bathing or grooming, sitting in a chair, toileting, showering, and assisted or independent ambulation.

Mobility Level A1 defines persons who are able to ambulate independently (with or without a gait aid).

Mobility Level A2 defines persons who are able to ambulate with supervision or assistance of another person (with or without a gait aid).

Mobility Level B defines persons who are able to stand to transfer from bed to chair.

Mobility Level C defines persons who cannot stand to transfer to a bed or chair.

Optimal mobility refers to the persons' maximum capacity for mobility which is individualized and assessed daily For example: if a patient is deemed Level B capacity, their optimal mobility activity would be to stand to transfer to a chair.

In the Veteran's Centre, **optimal mobility** refers to the persons' maximum capacity for mobility which is deemed safe for the resident.

PROCEDURE

1. **MOBILITY ASSESSMENT**: All patients/residents are assessed for their mobility level (A1, A2, B, or C) by a nurse or other appropriate member of the health care team, within 24 hours of admission (see Early Mobilization Algorithm, Appendix A.) See #5 below for **Documentation** requirements.

2. **DESIGNING MOBILITY PLAN OF CARE**: Members of the interprofessional team work with patients/residents and/or their families to design a plan of care to optimize mobility and functional status that is consistent with the patient's/resident's wishes and treatment plan. Each patient/resident has a documented mobility goal(s) and a progressive plan of care with daily mobility activities designed to achieve this goal. Progress with mobility is monitored and discussed with the patient/resident to identify ongoing issues and concerns. Mobility plans are updated daily to support the progression toward optimal mobilization. The plan is also updated with any change in health status and communicated at interprofessional rounds, transfer of accountability and transitions through the continuum of care. See #6 below for **Monitoring & Evaluation** requirements. In the Veterans Centre, an interprofessional care plan is created when there is potential to improve the number of mobility activities and/or the residents/patients mobility status. Mobility levels and/or plans are reassessed with any change in health status and reviewed quarterly to support the resident's/patient's concerns and the progression towards optimal mobilization. The resident's/patient's mobility status is communicated at interprofessional rounds, transfer of accountability and transitions through the continuum of care.

3. **SUPPORTING MOBILIZATION**: All team members contribute to daily mobilization by supporting patients/residents to achieve a minimum of 3 core mobility activities per day based on the assessed mobility level and ability of the patient/resident. In acute care, specially trained mobility volunteers are engaged to encourage mobilization and ambulation of appropriate patients under the direction of the clinical team.

4. **MOBILITY EXPECTATIONS**: Patients/residents with specific mobility limitations due to medical/surgical conditions or their treatment plan will have mobility and/or positioning directions specified in the doctor's orders. Unless contraindicated or through lack of consent, minimum expectations for patient/resident mobility within a 24 hour period include the following:

Mobility Level A1:

Patients/residents who are able to ambulate independently (with or without a gait aid) will ambulate at least three times daily.

Mobility Level A2:

Patients/residents who are able to ambulate with supervision or assistance of another person (with or without a gait aid) will ambulate at least three times daily.

Mobility Level B:

Patients/residents who are able to stand to transfer from bed to chair/ wheelchair (with or without assistance) will get up in a chair/commode three times daily or achieve standing position from a chair three times daily.

In the Veterans Centre, residents who are level B will get up to chair/wheelchair daily and stand up a minimum of 2 times or self propel in wheelchair.

In addition to the above activities A1, A2 and B level patients/residents will be encouraged to:

- Participate in personal care to the greatest extent possible
- Use the bathroom/commode chair for toileting
- Eat meals sitting in a chair/wheelchair
- Complete active range of motion exercises
- Self propel in wheelchair

Mobility Level C:

Patients/residents who cannot stand to transfer will be mechanically lifted to a chair at least once daily. As well, they will have active/ passive repositioning every 2 hours.

In addition, they will be encouraged to:

- Participate in personal care to the greatest extent possible
- Sit upright in bed / side of the bed or in chair during meals
- Stand with support, if able
- Perform active/passive range of motion exercises daily 3 times daily
- Self-propel in wheelchair

5. **DOCUMENTATION**

   The reported pre-admission mobility status is documented in the health record on admission or during the pre-admission process. The mobility level (A1, A2, B, or C) and the number of achieved mobility related activities are documented daily in the health record. Interprofessional team members are responsible for documenting the mobility related activities carried out with the patient/resident and the patient/resident responses. The activities facilitated by the mobility volunteers (for acute care) and/or family members are captured in the health care record by nursing.

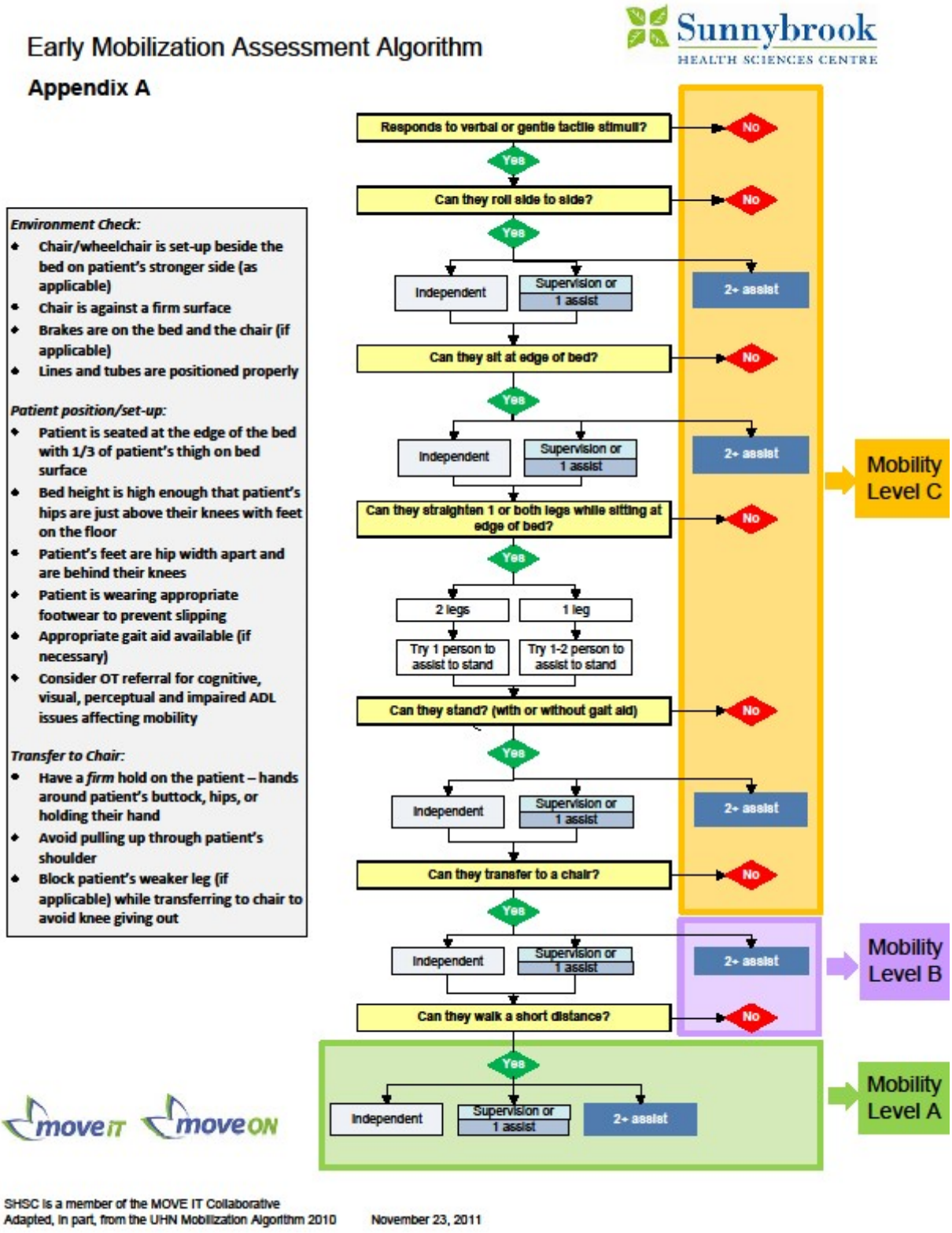
6. **MONITORING AND EVALUATION**

   Primary outcomes include the percentage of direct observation of “out of bed” activities among patients and residents, chart audits to measure compliance with documentation of mobility level and achievement of a minimum of 3 mobility activities per day to meet the standard of care for mobility. Audit results are posted on individual units and shared with leadership to provide prompt feedback to measure how practice compares with the expected standard of care.

APPENDICES AND REFERENCES:

APPENDIX

Adapted from Owensboro Medical Health System



REFERENCES

Covinsky K, Pierluissi E, & Johnston C (2011). Hospitalization-associated disability "She was probably able to ambulate, but I'm not sure". JAMA, Vol 306(16).

Fisher S, Yong-Fang K, & Graham J (2010). Early ambulation and length of stay in older adults hospitalized for acute illness. Arch Inter med/vol 170(22).

Graf C (2006). Functional decline in hospitalized older adults: it's often a consequence of hospitalization, but it doesn't have to be. AJN. Vol 106 (1) 58-67.

Hughes R. (2008). Patient safety and quality: an evidence-based handbook for nurses. Rockville (MD): Agency for healthcare research and quality. Publication No: 08-0043.

Landefeki C, Palmer R, & Kresevic D. (1995). A randomized controlled trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. N Engl J Med 332: 1335- 1344.

Pashikanti L & Van Ah D. (March/April 2012). Impact of early mobilization protocol on the medical-surgical inpatient population: an integrated review of the literature. Clinical Nurse Specialist. Vol 26(2) 87-94.

Shah H, Donabauer C, Sargant L, Schumacher K & Young R. (April 2011). An innovative approach to improving functional mobility on a hospitalist unit. Journal of Hospital Medicine. Conference: Hospital Medicine 2011. HM 2011 Grapevine, TX United States.

Tucker D & Molsberger SC. (2004). Walking for wellness: a collaborative program to maintain mobility in hospitalized older adults. Geriatric Nursing: 25(4): 242-245.

Zisberg A, Shadmi E, Sinoff G & Gur-Yaish, N. (2011). Low mobility during hospitalization and functional decline in older adults. JAGS 59: 266-273.

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