

Mobility Enhancement Protocol

Purpose

The purpose of this protocol is to provide health care providers with an understanding of the importance of mobility in elderly patients who have delirium or are at risk for developing delirium during their hospital admission. Additionally, it will provide an approach to caring for the mobility needs of these patients, with a focus on prevention of immobility.

Introduction

Physical activity has long been recognized as an important aspect of patient well being, yet many elderly hospitalized patients suffer significant functional decline despite resolution of the condition for which they were admitted. This physical deconditioning, contributes to the frequency with which older patients are admitted to nursing homes.

Muscle mass and muscle strength are reduced with aging, along with a progressive loss of aerobic capacity (Creditor, 1993) Therefore these age related changes combined with the physiological effects of bedrest and hospitalization, produce a cascade of dysfunction and dependency for many elderly hospitalized patients. Decline in mobility can start within 2 days of hospitalization, therefore it is imperative to promote physical activity immediately upon admission (Lazarus, Murphy, Coletta, McQuade & Culpepper, 1991) Muscle weakness from a few days of bedrest can require weeks of recovery for the elderly person.

Many authors site immobility as a direct risk factor for delirium (Meager, 2000). Additionally, a lack of physical activity can lead to decubitus ulcers, aspiration pneumonia and incontinence, which can contribute to further functional decline. Patients who have delirium often present as confused, agitated or somnolent and therefore may be confined to bed or chair. Elderly delirious patients are often at risk for falling and restraints used in this population contribute significantly to lack of ROM and immobility. Therefore elderly delirious hospitalized patients, are amongst the highest risk group for functional decline. Therefore, it is paramount to prevent the cascade to dependency in these patients. Often, the maintenance of normal activities of daily living e.g. (feeding, grooming, toileting and walking) will prevent symptoms of aggression, agitation, and frustration and may alleviate the need for aggressive treatments.

Definition of Associated Terms

Mobility

Mobility is the ability to move joints and the body. It can be helpful to further classify mobility as:

- a. Bed Mobility: ability to move and position oneself in bed

- b. Wheelchair mobility: moving from place to place aided by a wheelchair
- c. Mobility with a walking device: walking with the assistance of a cane, walker or crutches
- d. Independent mobility: ability to move from place to place without assistance

Immobility

Immobility indicates the inability to move the joints of the body in a functional manner.

Individuals at Risk

All patients who have delirium are at risk for becoming immobile during the course of their illness, particularly those who show symptoms of dehydration, sedation, falling or agitation, which is often treated with chemical or physical restraints.

Who would benefit from the use of this protocol?

Patients who have predisposing physical disability
Patients with delirium who are dehydrated, somnolent or agitated

Initial Assessment

Before a care plan can be devised with appropriate interventions an initial assessment and risk appraisal must be completed. The physical and occupational therapist can help with this.

Basic Physiologic measures: Vitals plus orthostatic blood pressure, upper and lower body strength (ability to move arms and legs, roll side to side, sit on edge of bed unsupported)

Cognitive Function: alertness and orientation, behaviour

Vision and visual /spatial assessment

Falls Risk Assessment Tool and selected interventions

Interventions

All interventions must be directed by the patients/families expressed concerns and evaluated regularly.

1. Minimise use of immobilizing equipment (catheters, IV poles, physical restraints)
2. Communicate with the physical and/or occupational therapist if weakness, gait and balance impairments are noted.

Ambulatory patients:

1. Regular ambulation to washroom and unit activities
2. Encourage daily supervised ambulation(3x daily if possible)
3. Provide suitable mobility aids when necessary and ensure proper footwear is used (communicate with physical therapist for assessment).

Non-ambulatory, bed or wheelchair bound patients:

1. Full range of motion exercise of upper and lower limbs TID if possible during patient care (washing, changing etc.)
2. Avoid restraints if possible (see Addressing Psychomotor Agitation Protocol)

Evaluation

Outcome indicators may include:

Achievement of patient selected activity levels

Maintenance of pre-hospitalised activity level

Return to prior living environment e.g. home, retirement home

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