DIVISION OF ACUTE CARE SURGERY

Surgical Intensive Care Unit Mobility Practice Management Guideline

I. Purpose

To utilize a multi-disciplinary approach to the mobilization of critically ill patients in the Surgical Intensive Care Unit

II. Recommendation

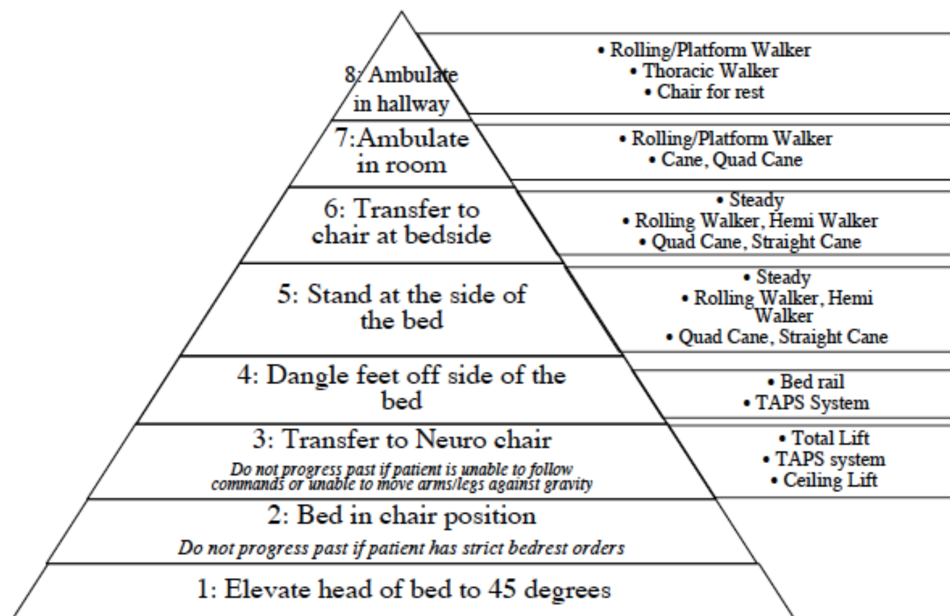
The Society of Critical Care Medicine's (SCCM) Pain, Agitation and Delirium (PAD) Guidelines[3] recommend a focus on analgesia and a reduction in use of sedative medications along with routine delirium monitoring.

III. Process

Upon the start of each shift, the nurse will refer to the Safety Screen below to evaluate the patient's appropriateness for mobilization.

- Neuro: Brain death, ICP >15, active seizure, neuromuscular blockade, spinal cord injury
- Cardiovascular: Infusion of two or more vasopressors, MAP <65, SBP <90 or >170, active myocardial infarction or unstable arrhythmia
- Respiratory: Unstable airway, Ventilator FiO2 >70%, PEEP > 15, Bi-vent or VDR settings
- Miscellaneous: Comfort Care, presence of femoral sheath, order for bedrest

The nurse will communicate the pass or fail of the Safety Screen during multi-disciplinary rounds. The Critical Care team during rounds will formulate a mobility goal for the patient based on the pyramid below.



Starting at Level One, the bedside team will progress the patient in a step-like manner up the pyramid to the goal established during rounds. If the patient develops a limitation to

mobilization, including, but not limited to, hemodynamic instability, nausea, or pain control, the bedside team will assist the patient to the prior level of mobility, notify the critical care team of the limitation, and re-attempt mobility after 30 minutes of rest.

Authors:
Rachel D. Appelbaum, MD
SICU Critical Care Intensivist

Michael C. Smith, MD
SICU Critical Care Intensivist

Carolyn Ragland, DNP, AGACNP-BC
Nurse Practitioner

Revised June 29, 2023