

# Early Mobility

Section Editor: seat open

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**Disclaimer:** This protocol is an educational reference intended to support — not replace — institutional policy, pharmacy and therapeutics review, and individual clinical judgment. Verify current dosing, contraindications, and local formulary/practice constraints before adopting into an EMR or using in patient care.

## Overview

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Prolonged bed rest drives delirium, functional decline, and longer ventilator/ICU/hospital stays. The foundational 2009 Schweickert trial showed that pairing daily sedation interruption with early physical and occupational therapy — starting from initiation of mechanical ventilation — improves functional outcomes and reduces delirium duration. The current PADIS guideline (2025 focused update) continues to suggest enhanced mobilization/rehabilitation over usual care. This is fundamentally a **nurse-driven, multidisciplinary program**, not a therapy-department add-on: nursing mobilizes patients even on days PT/OT also sees them.

# Steps

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## 01 Screen for Eligibility Every Day

- Initiate/continue the mobility protocol when the patient is hemodynamically stable.
- Use a defined safety screening algorithm before each attempt (e.g., new/unstable arrhythmia, active myocardial ischemia, escalating vasopressor requirement, unstable fracture, uncontrolled ICP concerns, or evolving respiratory failure are reasons to hold, not permanent exclusions).

## 02 Align with Sedation and Delirium Management

- Minimize sedative use and interrupt sedation daily — this is Step 4 of the companion [Sedation and Analgesia](sedation-analgesia.md) protocol, and the two are meant to run together.
- Assess RASS and screen for delirium (CAM-ICU/ICDSC) before a mobilization attempt, and address delirium as part of the plan, not a separate track.

## 03 Use a Nurse-Driven Protocol

- Mobility should not wait solely on a physician order or on PT/OT availability — nursing initiates per protocol once the daily screen (Step 1) passes.

## 04 Mobilize at Least Twice Daily

- If PT/OT is consulted, nursing staff continue to mobilize the patient **1–2 additional times per day** on top of formal therapy sessions — nursing mobility is additive, not a substitute waiting on therapy scheduling.

## 05 Tailor the Mobility Level to Current Capacity

- Use a progressive mobility algorithm (e.g., passive range of motion → sitting at the edge of bed → standing → chair transfer → ambulation) selected by the day's screening result, not a fixed target applied to every patient regardless of status.

## 06 Use a Multidisciplinary Structure — Consider a Dedicated Mobility Role

- A "mobility tech" or designated PCT role — a bridge between rehabilitation services and nursing, trained and guided by therapy staff, taking assignments from both nurses and therapists — measurably increases mobilization rates. One unit's before/after comparison after adding mobility techs showed ambulation-within-24-hours rates rising from roughly 69% to 74–75%, and within-48-hours from roughly 86% to 88–89%.

## 07 Make Mobility Visible on Rounds and at Handoff

- Discuss mobility status for every patient during multidisciplinary rounds, documented in real time in the EMR.
- RN reports current mobility status at shift change and at any transfer to another unit.
- Post the mobility screening/progression algorithm visibly on the unit.

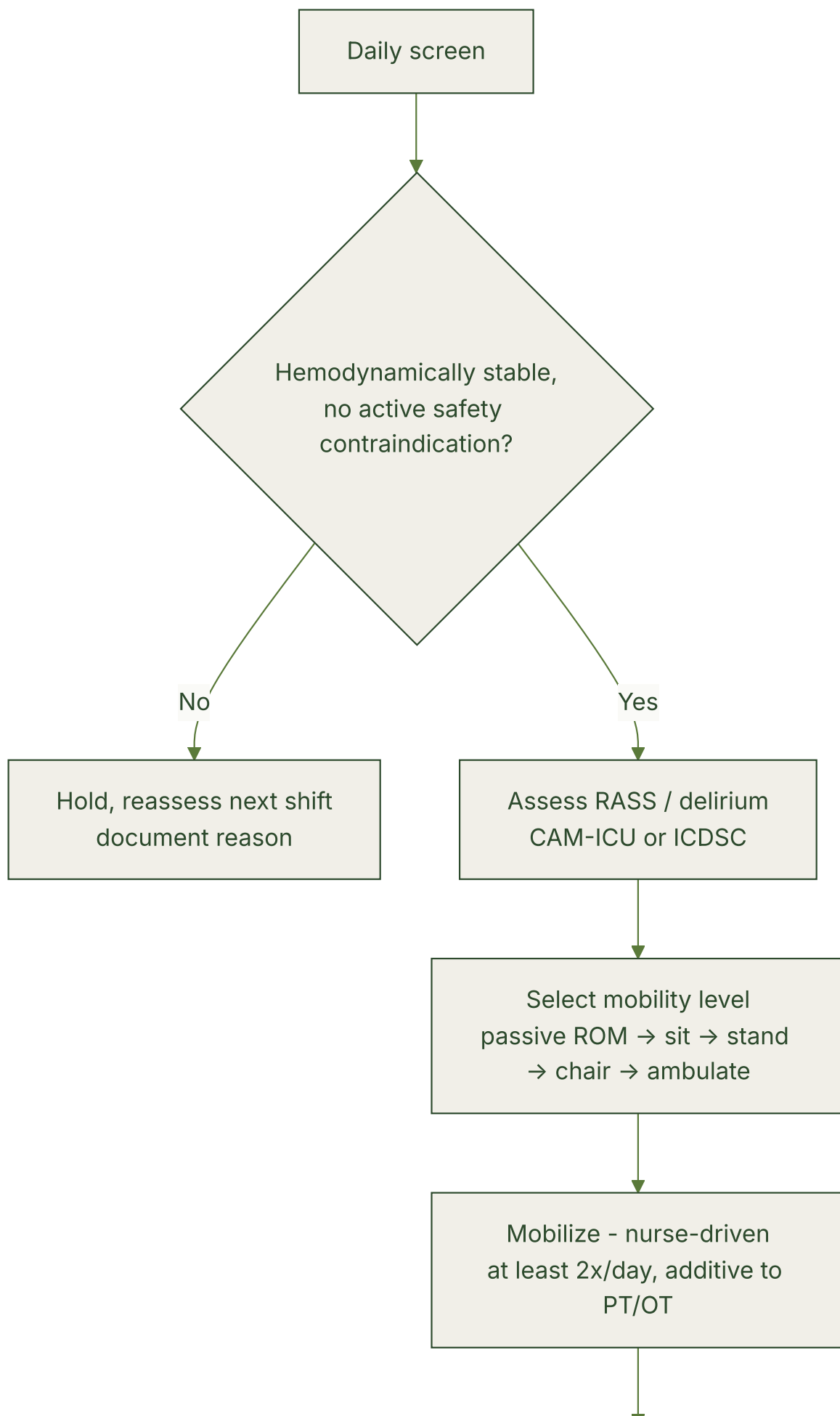
## 08 Build for Sustainability, Not Just Rollout

- Start with **small tests of change**: pilot with one carefully selected patient, review and revise the protocol, then expand — this builds momentum and credibility faster than a unit-wide day-one launch.
- Embed early mobility (and a PT/OT consult) as a default component of the mechanical ventilation order set, so it doesn't depend on someone remembering to order it separately.
- Sustain with recurring multidisciplinary team meetings (e.g., every 2 weeks) focused on troubleshooting, and watch specifically for practice lapse during periods of increased census or acuity — that's when this tends to slip first.

# Algorithm

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Document mobility status  
report at rounds + shift  
change

## EMR Order Set

### PHYSICIAN ORDERS

- Early mobility order embedded by default in the mechanical ventilation order set.
- PT/OT consult order.

### NURSING ORDERS

- Structured daily safety-screening checklist (not free text).
- Mobility level documentation each shift, tied to the progression scale in Step 5.
- RASS/delirium screen check immediately before mobilization attempt.

**Build notes** — mobility level and the safety-screen result should be structured flowsheet fields so the ambulation-within-24/48/72-hours metric (Step 6) can be tracked automatically across units, the way the before/after mobility-tech comparison data was generated locally.

## Adoption Notes

- Roll out via small tests of change rather than unit-wide from day one — select an initial patient likely to succeed, refine the protocol based on what actually happens, then expand.
- Evaluate whether a dedicated mobility tech/PCT role is feasible — the local before/after data above is a strong local argument for the staffing investment if volume supports it.



- Roll out together with [Sedation and Analgesia](sedation-analgesia.md) and [Weaning](mv-weaning.md) — early mobility is one leg of the ABCDEF bundle, not an independent initiative.
- Confirm sustainability structure before declaring success: is a physical therapist assigned to the ICU, is mobility included in the standard ventilator order set, does multidisciplinary mobility rounding continue a year later?

## Success Metrics & Monitoring

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Process: percentage of eligible patients who received the mobility intervention, and percentage ambulated within 24/48/72 hours. Outcome: ventilator days, ICU length of stay, hospital length of stay, incidence and duration of delirium, and adverse events during mobilization. Track via nursing flowsheet data and the critical care database; review at recurring (e.g., biweekly) multidisciplinary team meetings during rollout, then monthly.

## Suggested Reading

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- 1 Lewis K, Balas MC, Stollings JL, et al. A Focused Update to the Clinical Practice Guidelines for the Prevention and Management of Pain, Anxiety, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult Patients in the ICU. *\*Crit Care Med\**. 2025;53(3):e711–e727. doi:10.1097/CCM.0000000000006574. Current guideline basis for "enhanced mobilization/rehabilitation over usual care" — same source cited in the companion Sedation and Analgesia protocol.
- 2 Schweickert WD, Pohlman MC, Pohlman AS, et al. Early physical and occupational therapy in mechanically ventilated, critically ill patients: a randomised controlled trial. *\*Lancet\**. 2009;373(9678):1874–1882. PMID: 19446324. Foundational RCT pairing daily sedation interruption with early PT/OT from the start of mechanical ventilation.

- 3 Agency for Healthcare Research and Quality (AHRQ) Safety Program for Mechanically Ventilated Patients. Nurse-Driven Early Mobility Protocols. AHRQ Pub. No. 16(17)-0018-52-EF, January 2017. Source of the nurse-driven-protocol structure, mobility-tech role, and sustainability framework in this protocol.
- 4 Morandi A, Brummel NE, Ely EW. Sedation, delirium, and mechanical ventilation: the "ABCDE" approach. *\*Curr Opin Crit Care\**. 2011;17(1):43–49. PMID: 21169829. Source of the ABCDE bundle integration point in Step 2.

## Revision History

| VERSION | DATE       | EDITOR                          | SUMMARY                                                                                                                   |
|---------|------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 0.1     | 2026-07-19 | FunctionalHealth editorial team | Initial version grounded in the local AHRQ nurse-driven early mobility slide deck plus the current PADIS guideline update |

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