HOW TO PREPARE ADULT PATIENTS FOR REHAB

PROMOTING MOBILITY AND FUNCTIONAL RECOVERY

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OBJECTIVES

- Discuss that "rehab" DOES NOT only equal skilled therapy interventions
- Understand the importance of mobility and the harms of immobility
- Discuss the impact all have on supporting a patient's rehab course
- Discuss nursing role in progressive mobility
- Understand when skilled therapy *is* and *is not* indicated
- Discuss considerations when preparing your patient for mobility
- Review tips for preparing your patients for PT/OT visit

WHAT DOES "REHAB" MEAN?

Rehabilitation is the process of enhancing or restoring functional ability and quality of life to people with physical impairments or disabilities. (13)

Skilled therapy provides a block of time of interventions to address specific deficits

Routine mobility with nursing staff throughout the rest of the day is a vital part of a patient's rehab. (4, 5, 6)

WHY IS THIS IMPORTANT?

In hospitalized patients, immobility increases risk of many complications:

Delirium, weakness, depression/apathy, falls, contractures, constipation, skin breakdown, blood clots, pneumonia, confusion, *Hospital acquired disability*. (1,2,3)

Hospital acquired disability: The loss of at least 1 activity of daily life (ADL) during hospitalization that the pt could do prior to onset of illness. (2)

BENEFITS OF ROUTINE MOBILITY

Increases the patient's chance to DC directly home (1, 2, 4, 5, 6)

Allows therapy to focus on the patient's primary impairments such as balance, weakness, cognition

Improves functional recovery and return to meaningful tasks

Reduces length of stay, incidence of post intensive care syndrome, and other medical complications (1,2, 5, 6, 8)

Reduces probability to readmit to ICU (4)

ROLES

- Rehab starts the moment the patient enters the hospital and involves the patient and their family, providers, nurses, CNA's, therapies, etc.
    - Patient/Family- Goals and decision making and advocacy for mobility
    - Provider-Medication and activity order parameters and fostering the expectation of mobility
    - RN-Routine mobility assessment and activity plan based on assessment (Morse scale, and Safe Patient Mobility check)
    - OT-Assess and provide rehab for deficits impacting independence with ADL's and IADL's. Address vision and cognitive deficits.
    - PT-Assess and provide rehab for deficits impacting balance, strength, ambulation and function.

FAMILY ROLE

Important part of patient's overall care team (4)

Involvement can improve patient/family satisfaction, reduce symptoms of PTSD, and reduce symptoms of delirium (3)

Educate family on:

- Role of rehab and importance of routine mobility
- Indication and technique for ROM/positioning
- Delirium mitigation
  - Sensory stimulation: pictures from home, items of comfort, music, etc
- Encouraging independence with ADL tasks
- Generally, rehab prefers to include family in our sessions when able- especially if plan to return home

NURSING'S ROLE IN PROGRESSIVE MOBILITY

- Initiate activity and mobility per nursing assessments
- Provide passive range of motion (PROM) to extremities during patient positioning and hygiene
- Provide supportive positioning to prevent contractures and skin breakdown, minimize edema and pain
- Enable the patient and/or family to perform as much activity and ADLs as able during the day
- Use equipment to facilitate mobility (mechanical lift equipment, cardiac chair, etc)
- Request therapy services when indicated

WHEN IS SKILLED THERAPY INDICATED?

- PT is indicated when :
  - Difficulty mobilizing despite routine attempts with nursing
  - Acute neurological change (stroke, SCI, TBI)
  - Prolonged immobility
  - Acute injury, surgery, or fall especially with weight bearing or ROM restriction
    - Not expected to improve through regular medical course/routine mobility
- OT is indicated when:
  - Difficulty managing ADL's as compared to baseline
  - Change in cognition or vision impacting self-care or ability to engage/complete daily tasks (may include hospital acquired delirium)
  - Splinting, new UE dysfunction
  - Acute neurological change (stroke, SCI, TBI)
- Therapy is most appropriate when the patient is alert and able to participate (RASS –1 to +1), unless the need for therapy is splinting, bracing, caregiver training, or assessment of severe TBI

WHEN IS SKILLED THERAPY NOT INDICATED?

- General mobility
- The docs want to "clear" them for DC
- "They just haven't been out of bed yet"
- They have stairs
  - Yes, sometimes this is an appropriate reason to request PT. For example, if they have a new WB restriction or balance deficit. However, if there is no deficit with ambulation and no obvious reason stairs should be difficult, then no need
- Medical inappropriateness
  - RASS above or below –1 or above +1 (except in assessment of severe TBI), hemodynamic or respiratory instability, unaddressed fractures or injuries

PREPARING THE PATIENT FOR MOBILITY

- Activity orders-
  - Spines cleared and/or bracing in orders, fractures/injuries addressed/stabilized, WB orders up to date
- Discuss mobility plan with patient/family
  - Set expectations: all patients, when not contraindicated, will routinely mobilize. Mobility is just as important towards recovery as some of the patient's medications
  - This significantly helps prepare the pt and family for rehab and return to function.
    - Pt should expect to get out of bed for 2-3 walks, up to chair for meals and up for toileting if/when able

PREPARING THE PATIENT FOR MOBILITY

- Pre medicate (pain, anxiety, Parkinson's, baclofen/tone, BP, nausea, etc) when needed
- Move forward with Safe Patient Mobility Check
    - Can't get out of bed yet? What can we do?
        - Sit edge of bed, take medications, brush teeth, use lift later for up to chair
            - Order PT per delegation protocol or request provider place order
- Environment set up-helpful tools
    - Chair availability and location in room with or without chair alarm
    - Walker or other AD
    - Lift sling if needed
    - Wheelchair follow if needed
    - Lines consolidated/minimized, O2 tank if needed
    - Second person, if needed

PREPARING THE PATIENT FOR THERAPY

Your mobility assessment reveals your patient needs skilled therapies (PT/OT)

You've placed orders per delegation protocol or have requested the provider place orders

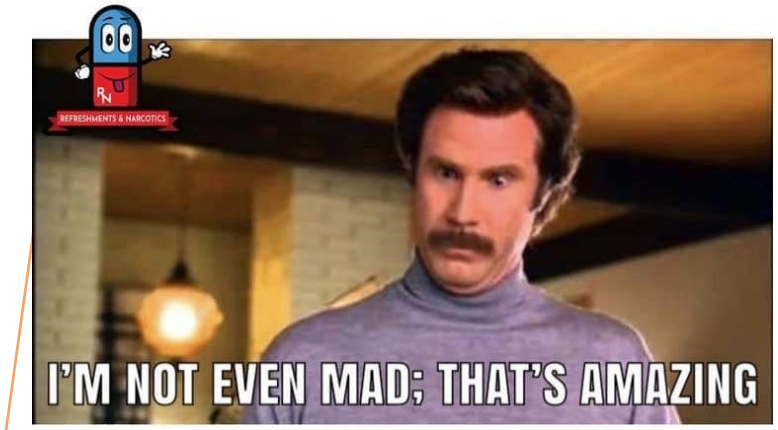
Now what?

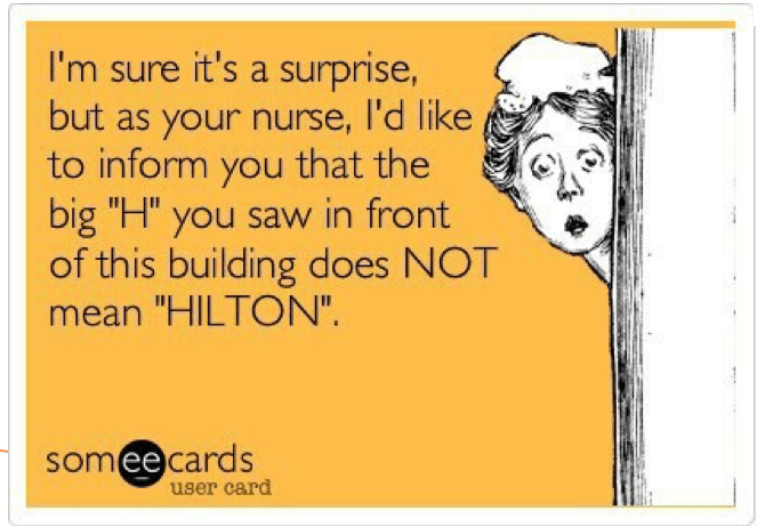
- Check for assigned therapist
- Consider contacting therapist for:
  - Optimal timing of pre-medication (pain/anxiety) or other cares (bowel program), planned procedures. Consolidate/minimize lines
- ICU: consider if appropriate, need to be present for line management, adjusting vasoactive medications, adjusting/managing respiratory devices (or calling RT)

Therapists can provide updated recommendations for continued routine mobility/activity

QUESTIONS?

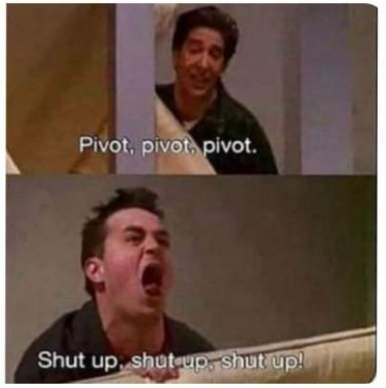
When you give your patient Ativan, dilaudid, norco, Benadryl, and seroquel all within an hour and they still don't sleep all shift





Two person hoyer transfer

Expectation vs. Reality



THANK YOU!

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