A three-part series from an Interview with an International Thought Leader in Early Mobility

Part Two: Overcoming Barriers to Early Mobility with Dr. Dale Needham

Early Mobility in the Intensive Care Unit is safe and beneficial for patients. However, there are many barriers that can be challenging to overcome. Dr. Needham is the senior author on a recent review of barriers and strategies to help integrate Early Mobility into routine clinical care.


Change is hard, but when quality of care and life-changing patient outcomes are at stake, we must find ways to make it happen in our facilities. This feature will highlight some practical solutions to help you identify and remove barriers to implementing Early Mobility in YOUR facilities.

This recent review separated out contra-indications (non-modifiable barriers, such as unstable fractures), and then categorized modifiable barriers into prospectively defined barriers that were based on specific criteria (such as ventilator settings) and perceived barriers (without defined criteria) based on team meetings, staff interviews or personal reflection.

“28 unique patient-related, structural, ICU cultural and process-related barriers were identified, with patient-related barriers being the most commonly reported. Over 70 strategies were identified to help overcome them.”

To address barriers, it is important to first commit to the change, then systematically identify the barriers, and use SMART goals to begin overcoming them.

SMART goals are important because they are:
- Specific: consider what, who, and how;
- Measurable: the change must be readily recognized;
- Achievable: the goal must be realistic with the available human and financial resources;
- Relevant: the “change team” must believe in the goal to be engaged in the process and to “own” the goal;
- Timely: a timeline for achieving the goal is needed to ensure accountability.
The Barriers outlined in this review article are separated into four groups; Patient-related, Structural, ICU Cultural, and Process-Related.

This feature article also provides an extensive review of strategies that have been empirically demonstrated to improve mobility, as well as strategies proposed by at least one study as being important in addressing barriers to mobility. We hope that this information will help with your Early Mobility program by learning what other facilities have done to successfully overcome barriers to achieve change.

**Patient-Related Barriers have 3 main categories:**
- Physical barriers, such as severity of illness, hemodynamic and respiratory instability, ventilator asynchrony, pain, poor nutrition, and obesity
- Neuropsychological barriers, such as sedation, delirium, agitation, patient refusal or lack of cooperation/motivation, fatigue
- ICU devices and equipment, such as lines, tubes, and drains

In the article, a more comprehensive list of specific strategies are provided with references, and we encourage you to read the entire article, for a more in depth review.

The most common strategies identified were use of stepwise approaches and protocols, including clear criteria for safety and start/stop parameters, proper patient screening, pain management, light sedation and sedation vacations according to the ABCDEF bundle (now including F for family involvement).

**Structural Barriers**
These barriers included limited staffing and time, and a lack of a protocol or structured program, and limited equipment to assist with mobility interventions.

Strategies that can help overcome these barriers include additional staffing, development of protocols, safety criteria and inter-professional champion(s), education and proper training on early mobility and equipment, and additional work on cost-justification of staffing or equipment to assist with mobility.

**Cultural Barriers**
These barriers included lack of mobility culture, including low level of buy-in and low prioritization of early mobility, lack of a multidisciplinary approach and culture, lack of staff knowledge and expertise about risk and benefits of immobility/mobility, and lack of patient/family knowledge.

Strategies in this category included development of inter-professional champions, education, goal sharing, regular team meetings, structured quality improvement processes to promote culture change, and proper screening of patients.
Importantly, commit to the change! There are strategies to overcome every barrier that has been identified. Depending on your facility, some strategies will work better than others. For example, some facilities have found that additional staffing in the ICU improved Early Mobility practices, while others found that even with expanded staffing, they needed additional strategies to overcome barriers.

This featured article provides a great resource for your team to start setting goals and progressing your Early Mobility program to the next level to improve outcomes for YOUR patients.

If you have not already registered, register NOW to attend the 5th Annual Johns Hopkins Critical Care Rehabilitation Conference (November 3 – 5, 2016 in Baltimore, MD)

www.Hopkinsmedicine.org/OACIS/ICURehab

Watch this space for the last part in this series!

Part III: Technologies and advances in ICU rehabilitation

For more on the interview with Dr. Needham, you can also read part I in the series “The time is NOW!” by scrolling through the features on EarlyMobility.com home page.