



# Early Mobilization: development, opportunities and challenges

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An interview with Carsten Hermes, health care consultant, specialized nurse for anesthesia and intensive care and health business graduate.



## “Early Mobilization should be a quality indicator all over the world”

Carsten Hermes

Mr. Hermes, you are a member of the German Network for Early Mobilization of ventilated ICU-patients. Could you briefly outline the previous development of early mobilization?

In a way early mobilization has always been an integral part of intensive therapy. Even back in the 1960s German specialists were publishing textbooks on physiotherapy and mobilization of intensive care patients, even if some parts of this knowledge were lost between then and now. Hospital management basically followed one of two possible lines of thought, either, ‘Humans should move, therefore patients should move as well’ or ‘a patient can only really rest if he or she is actually resting’. But I would say that by the mid-90s, early mobilization had well and truly arrived in nursing and in medicine; 1995 with spontaneous breathing trials and 1999 with spontaneous awakening trials.

Which countries were on the forefront regarding this subject?

The Americans started with pilot studies, so it stands to reason that it was an American nurse who first published papers on the movement of intubated patients. As of 2001, the subject was very much ‘en vogue’ in German-speaking regions (Germany, Austria, Switzerland), and at this point the idea of mobilizing mechanically ventilated ICU patients at a very early stage underwent a proper scientific work-up.

Peter Nydahl, a German nurse – and now expert for early mobilization –, came across one of these articles of the American nurse, was immediately taken with the idea and promptly got in touch with her. His first question was, “How did you fixate the tube?”. Such practicalities are of course very important in the real world. This contact was the impulse for him to drive this topic and to found the German Network for Early Mobilization of ventilated ICU-patients.

What is the status quo on ICUs: Which patients are mobilized, and how?

Thanks to the work of the German Network, the entire concept as well as its safety is no longer questioned. The only question now is how to implement it properly. Regarding specific patient groups, I would say that there are really only very few cases of patients who could not be mobilized; for instance, very instable patients whose immediate survival is at the absolute forefront of priorities: acute poly trauma patients, acute reanimated patients, with severe hypothermia, certain neurological patients, with massive hemorrhages or high cerebral pressure. However, the German guideline defining early mobilization clearly states that it could be initiated in virtually every patient within 72 hours.

With respect to the “how” of early mobilization: First of all I would like to point out that “mobilization” does not equate to “is able to run around the bed”. Obviously not all patients will manage to accomplish that. Rather, mobilization is adapted to a patient's individual situation. For instance, in comatose patients we might only perform very simple or even only passive mobility exercises. The German Network for early mobilization of ventilated ICU-patients offers a step-by-step framework that hospitals may adapt to the respective situations.



### In what way is an early extubation beneficial for using early mobilization?

Early extubation is a goal we generally aim for, as it minimizes side effects and adverse events such as infections. In addition, conducting mobilization without tube is of course always a bit easier than with tube, and less experienced personnel might have fewer concerns if a patient has already been extubated. It is however perfectly feasible to mobilize even intubated patients in a secure manner.

### Are there any major international differences in early mobilization?

The principle is more or less the same everywhere. I would say that Germany is one of the few countries that actually have a detailed definition of early mobilization, the US by contrast have no such definition. Across the pond, they understand early mobilization as just that, something that starts early, but the exact chronological definition was first established in a guideline published by the German Association of Scientific Medical Societies (1, in German).

I would also say that there are differences regarding the proportion of physiotherapists and nurses with an academic degree, which is far higher in countries other than Germany; for example, there are almost no physiotherapists without degree in Scandinavian countries, and Germany needs to catch up in this respect. Yet other countries have installed so-called mobilization teams consisting of nurses and physiotherapists. In Germany, only one such team exists, at the University Clinic of Munster. Here, the team is subordinated to the head of nursing, its sole responsibility is mobility and mobilization, and the team leader is a nurse. At this point in time, I don't think one could speak of one comprehensive model. However, I see Germany as forerunner of early mobilization, together with Austria, Switzerland, the Benelux countries, the UK, Australia and North America.



### What would you say are the most important tools in early mobilization?

The entire hospital has to come to view early mobilization as a sort of “culture” to adhere to. It is quite useless if you only have individual nurses trying to implement early mobilization on individual wards. Secondly, you need a good interdisciplinary teamwork with everyone involved. Next, experience and knowledge are important. That is to say, even if I pass on my knowledge to a beginner, it is quite another matter for this beginner to perform these measures him- or herself on a very ill patient. You have to step away from the drawing board if you want to learn to perform early mobilization and pick up the most important skills from experienced colleagues instead: How do I stand next to the bed, how do I go about handling the patient, what is the best way to prepare the cables and the bed. All of us have our own tips and tricks, and mutual learning is one of the most important aspects of imparting knowledge.



Would you say that the support of early mobilization is adequate at the moment?

I think the situation is getting better and better, due in part to the excellent, continuous educational work of interdisciplinary working groups such as the German Network for Early Mobilization and the German Interdisciplinary Association of Intensive Care and Emergency Medicine (DIVI). The aim should be that early mobilization is seen as important quality indicator in hospitals all over the world.

Mr. Hermes, many thanks for the interview.

What are the main problems in the implementation of early mobilization?

The proper training of staff takes time and space, all which cost money, of course. Another obstacle is that while studies have shown the benefits of such concepts – e.g. reduced ventilator time, reduced mortality, improved well-being (including those of nurses, I might add) – there is no way to predict, prove or calculate the exact economical benefit for individual patients.

To pose the question in reverse: Which structures and measures support early mobilization?

An appropriate culture of the departments and wards, solid teamwork with other professional groups, a sensible mixture of technical assisting devices and of course sufficient staff – qualitatively and quantitatively. By that I mean that early mobilization does indeed rely on technical aids such as bed-lifters, but it will only be successful with experienced, motivated staff. One example: Bed-lifters are extremely useful in early mobilization, but enough staff has to be on hand to use these aids in the appropriate manner. Technical assisting devices support the nursing staff, but they cannot and must not replace our colleagues.

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