Sample - Safe Patient Handling & Mobility (SPHM): Patient Mobility Assessment & Check

Also refer to Patient Dependency Assessment Definitions and Algorithm - attached

Purpose: The SPHM mobility assessment and check tool is used to help determine what SPHM equipment or assistive devices should be used to assist the patient to mobilize safely while promoting rehabilitation goals. Assessment of a patient's mobility prior to any activity is critical to preventing patient and staff injury.

When to conduct a mobility check:

- RNs assess every patient on admission, once/shift, with any change in clinical condition **and**
- RN, CNA (as delegated) or Physical Therapist perform a SPHM check **before** any patient activity such as transferring a patient to and from a bed to chair, chair to toilet, chair to chair, vehicle to chair, or ambulation.

Where to document: *(EXAMPLE)*

- In EPIC - in CNA Daily Care - document dependency level; SPHM equipment and slings needed and all other comments/needs in the 'Sticky Notes' or 'Comments' section
- Communicate patient's SPHM dependency and equipment needs at daily huddles/shift change and
- On the patient's white board and
- As needed between caregivers (all disciplines).

Before you perform the SPHM assessment/check:

1. Check Care Plan; activity orders/weight bearing restrictions; history of falls; history of violence or risk of violence; recent high-risk medications etc. Check protocol for equipment and sling use for patients with spinal injuries, orthopedic related conditions, post abdominal/cardiac or lumbar surgery; pain, fragile skin, devices that may be attached to the patient etc.

2. Prepare work space to remove clutter etc. and gather all equipment, supplies and caregivers needed.

3. Explain activity to patient e.g. "I am going to assess your mobility to determine how much assistance you'll need when moving/ambulating and equipment I'll need to use so we can keep you safe"

Instructions: To determine patient's dependency level and SPHM equipment needed evaluate the patients cognitive and physical abilities as described starting at Step 1. The patient must complete each step of the assessment/check successfully before *moving to the* next step.

NOTE:

- **You must receive training** in proper use of equipment, and safe work practices before lifting or moving patients
- This assessment/check are guidelines for performing patient mobility tasks—always use **clinical judgment** when determining the appropriate method (equipment and # caregivers) to move or lift your patient safely
- **Encourage** patient to use typical mobility aids or devices during assessment and while hospitalized (walker, cane, equipment)
- **Communicate** to the patient throughout the task
- **Check** the patient's dizziness, vertigo, ability to follow commands etc., at each Step
- **Increase** amount of caregiver assistance if:
    - The patient weight is >300lbs or BMI >50 and/or
    - The patient is combative and/or

- Help with line/attached device management is needed.

Refer to the Bariatric SPHM Algorithms in SPHM Resource Guide for more information about bariatric considerations.

- **Use ergonomic best practices**:
  - Use neutral body postures as much as possible
  - Raise bed to between knuckles to waist and
  - Don't reach past mid-line of the patient or bed when performing in bed SPHM tasks.
  - Use 'Tip and Tuck' technique to place slings yellow, SLIPPs, Hovermatts and change bed linens etc.

For more information and help:

Refer to the ABC Hospital SPHM Resource Guide; Unit SPH champion; physical therapist or SPH program managers

- Visit the SPHM webpage at
- Refer to the ABC Hospital SPHM Resource Guide
- Talk to your unit SPHM champion, physical therapist or SPH program managers_____
- Clinical questions? Contact_____SPHM clinical consultant

References:

Boynton, T., Kelly, L., Perez, A., Miller, M., An, Y., and Trudgen, C. (2014). Banner Mobility Assessment Tool for Nurses: Instrument Validation. *American Journal of Safe Patient Handling and Movement,* 4(3), 86-92.

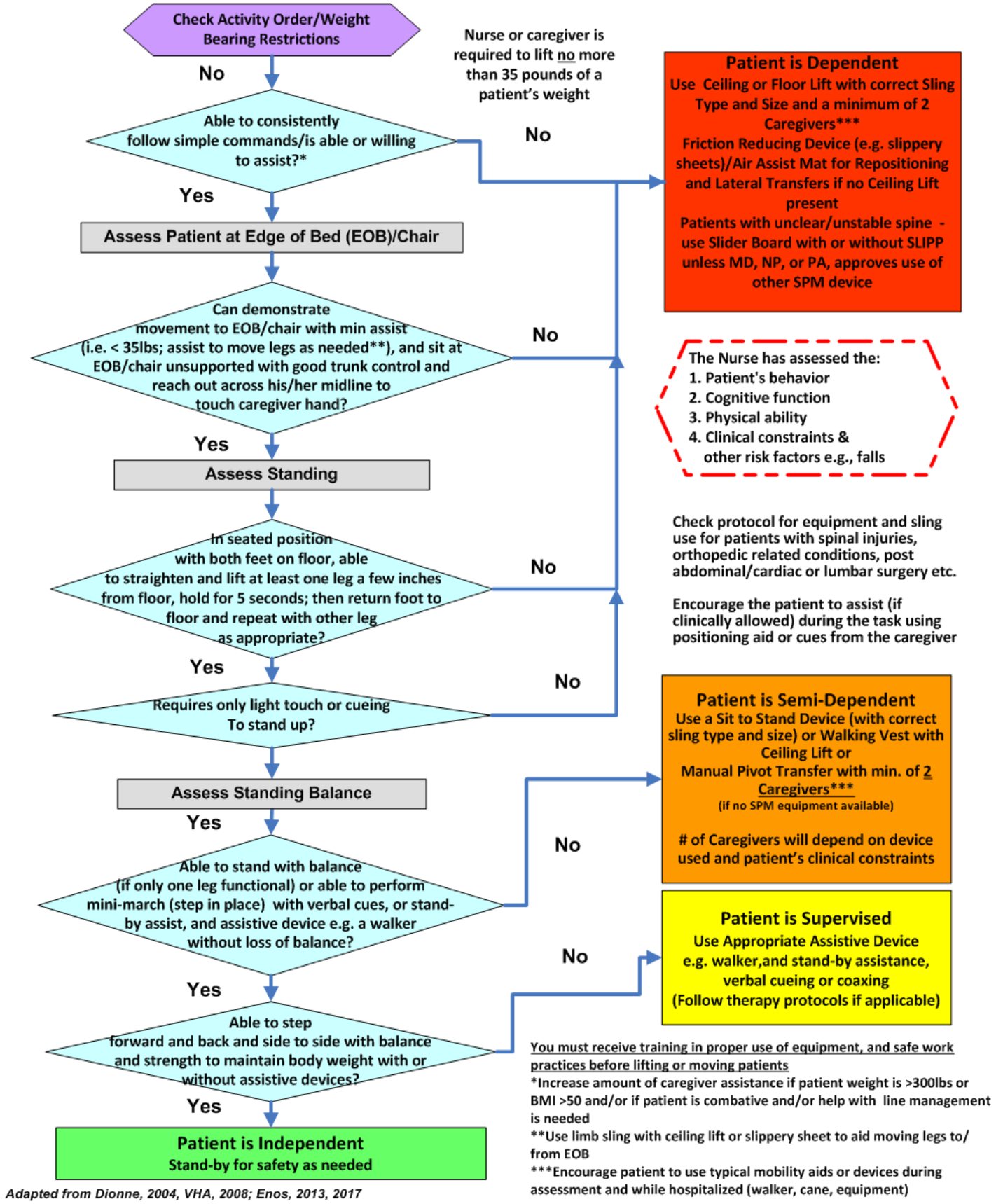
Dionne M. Bariatric patients: protect them and yourself. Bariatric Today. 2004;1(1):22-25.

Nelson A. *Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement.* Developed by the Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration and Department of Defense 2001 Updated 2005.

Veterans Health Administration and Department of Defense Safe Patient Handling Algorithms 2008 and 2014.

SPHM Program: Patient Mobility Check

Assessment of a patient's mobility prior to any activity is critical to preventing patient and staff injury and should be performed on admission, once/shift, with change in condition and before any patient activity such as transferring a patient to and from a bed to chair, chair to toilet, chair to chair, or vehicle to chair or ambulation. This Algorithm should guide, but not replace, clinical judgment.



Adapted from Dionne, 2004, VHA, 2008; Enos, 2013, 2017

You must receive training in proper use of equipment, and safe work practices before lifting or moving patients

*Increase amount of caregiver assistance if patient weight is >300lbs or BMI >50 and/or if patient is combative and/or help with line management is needed

**Use limb sling with ceiling lift or slippery sheet to aid moving legs to/ from EOB

***Encourage patient to use typical mobility aids or devices during assessment and while hospitalized (walker, cane, equipment)

Safe Patient Mobilization Program

Patient Dependency Assessment Definitions and Algorithm

To determine patient's dependency level, read the descriptions for each level/category below. Pick the level/category that has one or more statements that best characterize your patient's physical and/or cognitive function. A dependency assessment needs to be completed and documented on admission; once during a shift (either 8 or 12 hours); and with any change in clinical condition. A mobility check (see *Patient Mobility Check Algorithm*) should be **completed prior to every patient transfer**.

Dependent

1. **Not able to consistently follow simple commands or is unable or unwilling to assist**
2. Nurses or caregivers have to lift or support **more than** 35 pounds of a patient's weight or the amount of assistance offered by the patient is unpredictable
3. **Not able** to get to edge of bed (EOB) or chair with minimal assist (i.e. < 35lbs)
4. **Not able** to sit unsupported at EOB or chair with good trunk control and reach out across his/her midline to shake caregiver hand
5. In seated position at EOB or chair with both feet on the floor, is **not able** to straighten and lift *at least* one leg a few inches from the floor and hold for 5 seconds (count to 5)
6. **Not able** to stand up with only light touch or cueing

* Note: If patient is not able to consistently follow simple commands due to cognitive issues but is able to mobilize on own, check ability to stand and mobilize as described below

** Check and follow activity orders/weight bearing restrictions before performing assessment

Semi-Dependent

7. **Able** to consistently follow simple commands and is cooperative
8. Requires nurses or caregivers to lift or support **no more** than 35 pounds of patient's weight
9. **Able** to get to edge of bed (EOB) or chair with minimal assist (i.e. < 35lbs), sit unsupported at EOB or chair with good trunk control and reach out across his/her midline to touch caregiver hand
10. In seated position at EOB or chair with both feet on the floor, is **able** to straighten and lift *at least* one leg a few inches from the from the floor, hold for 5 seconds (count to 5)
11. **Able** to stand up with only light touch or cueing
12. **Not able** to stand with balance (if only one leg functional) or perform mini-march (step in place) with verbal cues, or stand-by assist, and assistive device e.g., walker without loss of balance

Supervised

13. **Is able** to consistently follow simple commands and is cooperative
14. Meets step 7 and can complete steps 9, 10, & 11 above
15. **Able** to stand in place with balance and no more assistance than verbal cues, stand-by assist, or assistive device e.g. a walker
16. **Able** to perform mini-march (with assistive device) with no more assistance than stand-by assistance
17. **Not able** to step forward and back and side to side with balance and strength to maintain body weight ***with or without*** with assistive devices

Independent

18. **Is able** to follow simple commands, is cooperative and has no cognitive deficits
19. Meets step 7 and can complete steps 9, 10, & 11 above
20. Can complete steps 15, & 16 above **with no** assistance
21. **Able** to step forward and back and side to side with balance and strength to maintain body weight with no assistance. **For long distance ambulation** – able to walk around unit for increased activity tolerance with supervision/assistance as needed.