Early Mobility in the ICU

Why it matters, a step-by-step progression, the safety screen before and stop criteria during a session, team roles, equipment and documentation

WHAT YOU WILL DO

- Screen every patient for mobility each shift, usually after the sedation (SAT) and breathing (SBT) trials.
- Pick the highest safe step, plan it with PT, OT and RT, and secure lines and the airway before you move.
- Watch the patient and monitor during the session; stop when a stop criterion appears.
- Document the highest level reached and how the patient tolerated it, and hand off the plan.

Why: ICU-acquired weakness affects about 25 to 50% of critically ill patients, and bed rest is a major risk factor. In the 2025 PADIS update, more mobility than usual care cut ICU-acquired weakness (9 fewer per 100 patients) and shortened ventilation and delirium by about a day each.

BEFORE YOU START: THE SAFETY SCREEN

The Hodgson 2014 expert consensus sorts each finding into green (low risk, go ahead), yellow (possible after discussion with the team) or red (high risk; senior ICU staff decide). The most cautious color wins.

SYSTEM	GREEN: GO	YELLOW: DISCUSS FIRST	RED: SENIOR ICU DECISION
Respiratory	ETT or trach secured; FiO_2 ≤0.6, PEEP ≤10, SpO_2 ≥90%, RR ≤30	FiO_2 >0.6, PEEP >10, RR >30, vent dyssynchrony, inhaled NO	Prone; SpO_2 <90% or HFOV (out of bed)
Cardiovascular	MAP at target on no or low support; HR <120	Moderate vasopressor support, rate 120–150, lactate >4 mmol/L, DVT/PE	Out of bed: high or rising vasopressor support, MAP below target, ongoing ischemia. Any: IV antihypertensive for emergency; bradycardia needing drugs or pacing
Neurologic	RASS −1 to +1; CAM-ICU negative, or positive and follows commands (in bed)	RASS −2 or +2; delirium not following commands	RASS >+2; ICP out of range with active treatment; uncontrolled seizures; spinal precautions
Other	Femoral venous or arterial lines, CRRT, chest tubes, drains	Fever despite cooling, suspected bleeding (out of bed)	Uncontrolled bleeding; unstable pelvic, spine or long-bone fracture; femoral sheath (out of bed)

SAFETY Not automatic stops: a ventilator, a stable low-dose vasopressor, or a femoral venous or arterial line. PADIS 2018 says mechanical ventilation and vasoactive infusions are not barriers when the patient is otherwise stable. Femoral sheaths, IABP and femoral ECMO cannulae are different: no hip flexion or out-of-bed activity.

STEP UP ONE LEVEL AT A TIME

Steps follow the milestones of the ICU Mobility Scale (0–10).

STEP	WHAT IT LOOKS LIKE	WHAT IT NEEDS
1. In-bed exercise	Rolling, bridging, active or assisted limb exercise, bed cycle	Opens eyes to voice; screen green or yellow-cleared
2. Sitting at the edge of bed	Feet on the floor, sitting with some trunk control	Lines and tubes with slack; watch for orthostasis
3. Standing	Weight through the feet, with help or a stand aid	Follows commands; legs bear weight; gait belt, 2 staff
4. Bed-to-chair transfer	Steps or pivots to the chair	Stands steadily; chair placed close
5. Marching in place	At least 4 steps, lifting alternate feet	Tolerates standing; portable oxygen ready
6. Walking	With 2 helpers, then 1, then a walker, then alone	Portable monitor; vent or oxygen; chair follows

STOP THE SESSION IF

- HR <60 or >130; SBP <90 or >180; MAP <60 or >100 (PADIS 2018).
- RR <5 or >40; SpO_2 <88%; ventilator dyssynchrony; concern for airway security.
- New or symptomatic arrhythmia, chest pain with concern for ischemia, or any change in level of consciousness.
- Fall, bleeding, line or device removal or malfunction, or distress the patient reports or you see.

TEAM, EQUIPMENT AND DOCUMENTATION

- Nurse: screen, time sedation and pain medicine, manage lines and monitor. PT and OT: plan and progress the activity. RT: airway, ventilator or oxygen.
- Equipment: gait belt, walker, sit-to-stand or ceiling lift, chair, portable monitor, portable ventilator or bag with PEEP valve, oxygen with more reserve than the session needs.
- Document the highest level reached (an IMS score if your unit uses it), vital signs before, during and after, tolerance, and any event.

CALL FOR HELP WHEN

- The patient falls or is lowered to the floor.
- A line, drain or the airway is pulled or dislodged.
- SpO_2 stays below 88% after you stop and sit or lie the patient down.
- A new arrhythmia, chest pain or hypotension does not resolve with rest.

CHECK YOUR UNIT POLICY

Units set their own vasopressor limits, who may mobilize a ventilated patient, lift rules and the mobility scale they chart. Check your unit protocol before the first session.