SESLHD GUIDELINE COVER SHEET

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FUNCTIONAL GROUP(S)	Allied Health Nursing and Midwifery Surgery, Perioperative, Anaesthetics
KEY TERMS	Early ambulation, mobility, patient outcomes, postoperative complications, venous thromboembolism
SUMMARY	This guideline will provide clinicians across the SESLHD with evidence and guidance to implement early mobilisation practices with postoperative patients with the aim to improve clinical outcomes and prevent postoperative complications.

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Health
South Eastern Sydney
Local Health District

Postoperative Mobilisation

Section 1 - Background

Immobilisation in hospitalised patients can lead to events such as venous thromboembolism (NIHCE, 2010; Clark et al, 2013), hospital acquired pneumonia (Clark et al, 2013), pressure injuries and loss of functional mobility (Clark et al, 2013; Perme & Chandrashekar, 2009; Michota, 2009). Mobilisation can decrease the risk of these events in addition to decreasing anxiety and depression, improve patients' satisfaction and provide benefits to physical function (Kalisch, Lee, Dabney, 2014). For those who undergo a surgical procedure, lack of mobility can also reduce time to bowel function and increase constipation in the presence of opioid use for pain control.

While early ambulation following surgery is considered best practice, there is little evidence or consistency regarding what point in time early ambulation commences and the degree in which ambulation is escalated. Authors (Kalisch & Xie, 2014; Pashikani & Von, 2012) have recommended that organisations have a specific ambulation program to increase ambulation in hospitalised patients.

Planned mobilisation from four hours of return to ward after the surgical procedure, seeks to increase functional mobility. Encouragement and assistance would be given to the patient. If the patient has a pre-existing disability or if the nursing staff unsuccessfully attempts to sit the patient out of bed that patient would be referred to the physiotherapist.

Scope:

Prescribed (as per protocol) ambulation occurs soon after surgery excluding those who underwent surgery on the exception list: patients who undergo lower limb or back surgery, neurosurgery, plastic surgery or grafting to lower limbs, cardiothoracic and vascular surgery. If a surgeon does not want their patient commencing early ambulation (opt out), as per protocol, this should be documented on the eMR SurgiNet postoperative instructions.

Clinicians should use clinical judgement to assess and consider the patient's fall risk prior to initiating the protocol. Ontario Modified Stratify falls risk screen should be documented on admission on the Admission and Discharge Risk Assessment Tool (ADRAT) and should be re-assessed postoperatively according to SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care and local clinical business rules.

Section 2 - Responsibilities

Surgeons are responsible for:

- Indicating mobilisation instructions (if they deviate from this guideline) via the operation report.
- Preoperative patient education regarding expectations for mobilisation.

Registered and Enrolled Nurses are responsible for:

- Preoperative patient education regarding importance of early mobilisation
- Postoperative patient education regarding importance and expectations for mobilisation
- Assessing a patient's fitness to implement the mobilisation guideline
- Implementing the mobilisation guideline with postoperative patients
- Consulting physiotherapists if protocol is unsuccessful on initial attempt.

Physiotherapists are responsible for:

- Consulting with and assessing complex patients or those who are unsuccessful in mobilisation attempts
- Providing education to patients regarding the importance of early and ongoing ambulation.

Section 3 - Postoperative Mobilisation Guideline

If treating teams *do not* want patients to be ambulated as per the following protocol, they should opt out by indicating these instructions on the operation report.

This protocol excludes patients who have had the following surgery:

- back surgery
- neurosurgery
- plastic surgery to lower limbs
- cardiothoracic surgery
- vascular surgery

Day of Surgery

Following the last set of hourly postoperative observations (4/24 after RTW)

• Sit out of bed for 10-20 minutes if vital signs are within 10% of baseline
• If patient is unable to tolerate sit on edge of bed with feet on the floor and encourage them to do heel raises with feet supported on the floor.

Day 1 Post Op

• Mobilise to shower
• Sit out of bed for 2 hours in the morning and 2 hours in the afternoon
• Walk 50m in the morning and afternoon

Day 2 Post Op

• Sit out of bed for 3 hours in the morning and 3 hours in the afternoon
• Walk 100m the morning, afternoon and evening

Day ≥3 Post Op

• Sit out of bed for 4 hours in the morning and 4 hours in the afternoon
• Walk 100m four times

***NB:* If issues/difficulties with activities of daily living (ADLs) are identified, patients should be referred to the occupational therapy team to provide the appropriate support for safe and optimal mobilisation.**

Section 4 - Documentation

- Operation Report (if surgeon wishes to opt the patient out of the protocol)
- Patient's Medical Record (outcomes and variances of the mobilisation protocol should be documented in):

  eMR (Progress Notes)

  OR

  Patient Progress Notes

Section 5 - References

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- Rindsland, S. (2021) Early mobilisation: risk factors, complications and costs. Nursing Times [online]; 117: 4, 22-24

Revision and Approval History

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March 2023	1	Minor review. Links and references updated. Section 3 - *Day of Surgery* information updated. Approved by Executive Sponsor.