

ORIGINAL ARTICLE

Organisational Structures and Early Mobilisation Practices in Intensive Care Units: A 1-Day Point Prevalence Study in Malaysia

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ABSTRACT

Introduction: Despite the availability of evidence supporting the safety, feasibility, and benefits of early mobilisation (EM) in critically ill ICU patients, the practice of EM is still low in most ICUs worldwide, including Malaysia. **Objectives:** To determine the level of EM practices and the association between ICU organisational structure and EM practices in critically ill ICU patients in Malaysia. **Methods:** A 1-day point-prevalence study was undertaken in six teaching hospitals in Malaysia. A total of 13 physiotherapists in charge of ICU were recruited as study coordinators. They completed three forms on (i) patient's demographic and clinical information, (ii) highest level of mobilisation performed on their patients in the last 24 hours and (iii) ICU organisational structure. **Results:** ICU physiotherapists from all six teaching hospitals participated, providing data on 74 critically ill ICU patients. All of the physiotherapists indicated that EM protocol was available in their ICU and the three most commonly available equipment for transfer and mobilisation were special bed (10 [77%]), special chair (9 [69%]) and tilt table (6 [46%]). Mobilisation out-of-bed occurred in 21 (28%) patients with the highest level of mobilisation was marching on spot at the bedside. No patient was made to walk on the survey day. There were significant associations between EM practices and ICU physiotherapist placement, staff involved and type of ICU (all $p < 0.001$). **Conclusion:** The practice of EM in critically ill ICU patients in Malaysia is still low. Dedicated ICU physiotherapist and the involvement of a multidisciplinary team facilitated EM practices.

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INTRODUCTION

Early mobilisation (EM) of critically ill patients, although it is not a new concept, is an Intensive Care Units (ICU) intervention that is beginning to receive significant attention from ICU multidisciplinary team members. The Malaysian Society of Intensive Care (1) defines EM as any physical activity to be begun by a patient 24 hours to 48 hours after ICU admission in the absence of contraindications. It includes activities such as in-bed mobilisation (rolling side-to-side, sitting in bed), range of motion exercises, transfers, sitting, standing, and walking (2). To date, literature supporting the safety, feasibility, and benefits of EM is increasing. The incidence of adverse events following EM were reported to be between as low as 1-2% (3) and as high as 21% (4),

depending on the number and events each study used to define adverse events. The most frequent events reported were physiological changes (e.g., oxygen desaturation, heart rate changes, disconnection of tubes and catheters and postural hypotension) that mostly resolved after a short rest without requiring any additional medical intervention. EM has also been found to be able to reduce the incidence of ICU-acquired weakness, improve functional capacity, shorten the mechanical ventilation days and increase the rate of discharge (5).

Despite the availability of evidence supporting the safety, feasibility, and benefits of EM in critically ill ICU patients, the practice of EM is still uncommon in most ICUs worldwide. In a point prevalence study on ICU mobility practices in Australia and New Zealand, Berney et al. (6) found that, of their 498 ICU patients, only 89 (18%) were made to walk, and none of these patients were mechanically ventilated despite 45% of their patients were on mechanical ventilation. In another point prevalence study in the United State ICUs, Jolley

et al. (7) found that (i) the prevalence of ICU mobility was only 32%, with more non-mechanically ventilated patients receiving ICU mobility than mechanically ventilated patients (48% vs 26%) and (ii) only 90 (16%) of mechanically ventilated patients achieved out-of-bed mobility with walking was only done in 23 (4%) patients. In Malaysia, data reporting the levels of mobilisation in the ICU is limited. In a study on ICU EM practices among nurses (8), bed mobility was still the standard nursing care in the ICU, reported by the majority of the ICU nurses, with supine positioning (88%) being the most common practice followed by side (70%) and fowler/semi fowler (68%) positions. In-bed exercises were done by less than 20%, and standing and walking were done by as low as 11% of the ICU nurses. In our previous study conducted among 100 ICU physiotherapists from 45 hospitals in Malaysia (9), we also found that despite most ICU physiotherapists believed that EM is important and beneficial to critically ill ICU patients, the four most common physiotherapy treatment techniques used in the ICU were still chest physiotherapy (83%), passive range of motion exercises (78%), active range of motion exercises (68%) and bed mobility (54%).

Considering the complexity of factors influencing the EM practices in critically ill ICU patients, exploring possible factors such as individual, team, ICU organisation, and structure may facilitate the design of implementation strategies to translate knowledge and research evidence into clinical practice. On this background, this study aims to determine the level of EM practices and association between ICU organisational structure and EM practices in critically ill ICU patients in Malaysia.

METHODS

This study used a 1-day point prevalence study undertaken in six different teaching hospitals in Malaysia between May and June 2023. Data on organisational structure and mobilisation practices in the ICU were collected by 13 study coordinators appointed in each study site (i.e., 2-3 physiotherapists in each setting depending on the number of ICUs available). To avoid bias in the information on mobilisation practices, the data collection date was blinded to the study coordinator, but two reminders were sent a month and a week before the actual date of data collection. Ethical approvals were obtained from Universiti Teknologi MARA (UiTM) (FERC/FSK/MR/2022/0250), Hospital Al-Sultan Abdullah (500-PJI [18/4/28]), Hospital Universiti Sains Malaysia (USM/JEPeM/KK/23020183), Hospital Sultan Abdul Aziz Shah (JKEUPM-2023-155), Sultan Ahmad Shah Medical Centre (IREC 2023-027), University Malaya Medical Centre (MREC UMMC: 2023210-12132) and Hospital Canselor Tuanku Muhriz (JEP-2023-122).

Participants

A purposive non-probability sampling method was used to include participants in the study. The eligibility criteria

for recruitment of participants were ICU patients aged 18 years and above and admitted to the participating ICU within 24 hours starting at midnight on the survey day. Those who have had a recent fracture, restless, receiving continuous renal replacement therapy (CRRT), or had absolute contraindications to mobilisation (e.g., susceptible/ known dissecting aneurysm, high intracranial pressure, active intracranial bleed, unstable spinal or pelvic injuries) were excluded from the study.

Survey Content

The study coordinators were briefed on the data collection procedure through Google Meet and were sent an envelope containing (i) a consent form for the study coordinators, (ii) eligibility criteria for patients' selection, (iii) patient demographics (age and gender) and clinical information (e.g., admission diagnosis, reason for ICU admission, number of days in ICU, levels of respiratory support [if presence]) form, (iv) ICU organisation and structure form and (v) the 10-ICU mobility scale. The information included in the ICU organisation and structure form were (i) ICU type (e.g., general, surgical, neurological, medical and trauma), (ii) number of ICU beds available and total of ICU beds occupied, (iii) clinician ordering mobilisation, (iv) staff involved in mobilisation, (v) the availability of ICU clinical protocols (e.g., analgesia, pain and sedation monitoring, delirium assessment, protocol-based weaning, daily wake-up and spontaneous breathing trial, adjusted sedation and early mobilisation), and (vi) the availability of mobility equipment (e.g., special bed or chair, lifting device, rollator, rolling boards, high table, portable ventilator or hoist). The highest level of mobilisation performed in the 24 hours prior to the day of the data collection was charted using the 10-ICU mobility scale. Mobilisation activities were divided into in-bed and out-of-bed activities, with scores from zero (no activity, lying in bed) to two (passively move to chair) were categorised under in-bed activities while scores from three (sitting over edge of bed) to 10 (walking independently without a gait aid) were categorised under out-of-bed activities.

Statistical Analysis

Statistical analyses were performed using the Statistical Package for Social Sciences (SPSS, version 27, SPSS Inc., Chicago, IL, USA) with $P < 0.05$ to indicate statistical significance. Descriptive statistics were expressed as Mean \pm SD or Median [Interquartile range]. Chi-square tests were used to determine the association between ICU organisation and structure and early mobilisation practices in critically ill ICU patients.

RESULTS

A total of 13 ICU physiotherapists participated in the study (Table 1a). A majority of the physiotherapists were female (10 [77%]), had up to a Diploma level of education (8 [62%]) and worked less than a year in the ICU (7 [54%]). Data collected in the present study

involved 18 ICUs and 74 patients. The characteristics of the 18 ICUs are shown in Table Ib. The most participated ICU was the general ICU (11 [61%]), while the least participated ICUs were Medical and Trauma ICUs. The Mean \pm SD age of the patients was 57 ± 16 years, and the majority were mechanically ventilated (41 [56%]) (Table Ic).

Table I: Details of ICU physiotherapist, characteristics of the participated ICUs and patients

Variable	Mean \pm SD	n (%)
a) Physiotherapist (n=13)		
Age, years	34 \pm 5	
Gender, F		10 (77)
Education level	Diploma	8 (62)
	Bachelor's degree	5 (38)
ICU training years	2 \pm 3	
Duration working in ICU	< 1 year	7 (54)
	2-5 years	5 (39)
	> 10 years	1 (8)
Physiotherapy	Permanent	5 (38)
	Rotational	8 (62)
b) ICU structure (n=18)		
Type of ICU	General	11 (61)
	Surgical	2 (11)
	Neurological	3 (16)
	Medical	1 (6)
	Trauma	1 (6)
Total ICU bed	19 \pm 9	
ICU beds occupied	12 \pm 5	
c) ICU patients (n=74)		
Age, years	57 \pm 16	
Gender, M		44 (59)
Weight (kg)	73 \pm 24	
Airway types	Mechanical Ventilation	41 (56)
	Non-Invasive Ventilation	29 (39)
	Room Air	4 (5)

ICU organisation and structure

The organisation and structure of the participating ICU in relation to mobilisation are shown in Table II. All of the ICU physiotherapists (13 [100%]) indicated that the practice for mobilisation planning was done during the morning round, and early mobilisation protocol was available (13 [100%]) in their ICU. Special beds (10 [77%]), special chairs (9 [69%]) and tilt tables (6 [46%]) were the three most commonly available equipment in the ICUs. The respondents (i.e., ICU physiotherapists) also indicated that physicians were the most frequent clinicians ordering mobilisation but the least involved in mobilisation (Fig.1).

Early mobilisation practices in the ICU

The level of mobilisation was classified into in-bed activities (ICU mobility scale 0-2) and out-of-bed activities (ICU mobility scale 3-10) (Fig. 2). In-bed mobilisation occurred in 53 (72%) patients, with nearly one-third of these patients (17 [23%]) not being mobilised at all (ICU mobility scale 0). Mobilisation out-

Table II. ICU activities and equipment to facilitate early mobilisation

Description	n (%)	
Availability of clinical protocols in the ICU	Early mobilisation	13 (100)
	Adjusted sedation	12 (92)
	Analgesia first approach	12 (92)
	Pain and sedation monitoring	12 (92)
	Delirium monitoring	12 (92)
	Protocol-based weaning	12 (92)
	Daily wake-up trial	11 (85)
	Daily wake-up and spontaneous breathing trial	11 (85)
Availability of transfer and mobilisation equipment	Special bed	10 (77)
	Special chair	9 (69)
	Standing boards (Tilt table)	6 (46)
	Lifter	5 (38)
	Rollator	2 (15)
	Other (hoist)	1 (8)
	Standing (high table)	0 (0)
	Mobile ventilation	0 (0)
	Rolling boards	0 (0)

Data is presented as n (%). Abbreviations: ICU, Intensive Care Unit.

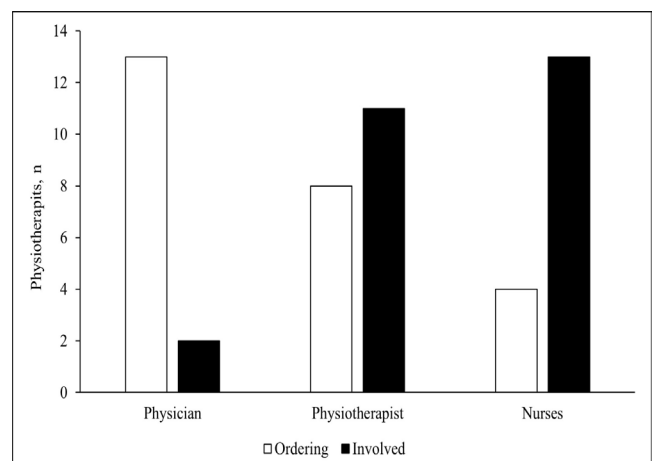


Fig.1: Number of respondents indicating the frequency of clinician ordering and involved in early mobilisation in the ICU.

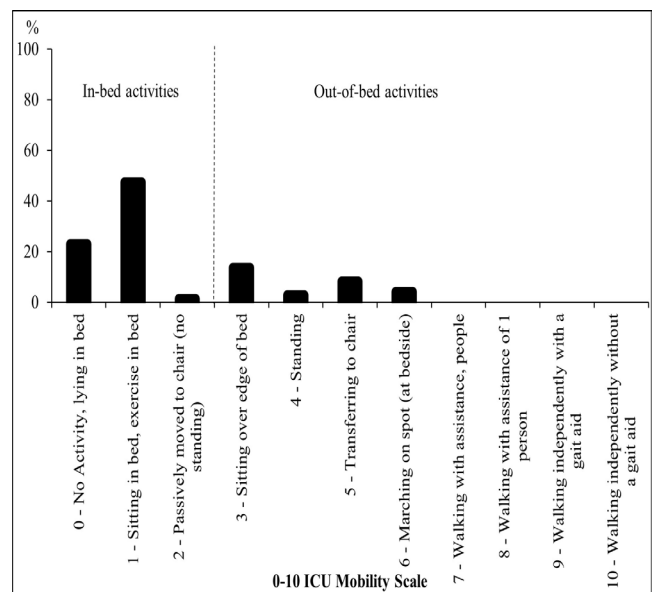


Fig. 2: The early mobilisation practices in critically ill ICU patients.

of-bed occurred in a total of 21 (28%) patients, with the highest level of mobilisation reported on the survey day was marching on the spot (ICU mobility scale 6). No patient was made to walk on the survey day.

Association between ICU organisation and structure and early mobilisation practices in critically ill ICU patients

Factors that were found to have a significant association with EM practices were ICU physiotherapist placement (permanent vs rotational), staff involved in patient mobilisation and types of ICU (all $p < 0.001$).

DISCUSSION

This one-day point prevalence study reports the ICU organisational structure and EM practices in critically ill ICU patients. A total 13 physiotherapists from all six teaching hospitals in Malaysia participated in the study providing data from 18 ICUs and 74 patients.

ICU physiotherapists, ICU characteristics, ICU patients and EM practices

The ICU training of healthcare providers plays a critical role in their understanding of the importance of EM and the appropriate techniques to implement EM. The majority of the physiotherapists in the present study reported having ICU training of 2 ± 3 years. In a systematic review that evaluated the literature related to mobilisation of critically ill ICU patients, Adler & Malone, (10), found that physiotherapy training can effectively facilitate early mobilisation practices in the ICU, thus contributing to achieving mobility milestones for ICU patients. ICU training is essential for physiotherapists to effectively and safely manage the complex needs of critically ill patients. Proper training ensures that physiotherapists can safely assess patients, identify any contraindications to therapy, and implement appropriate mobilisation techniques without compromising patient safety.

The number of beds in the ICU may also have an impact on EM practices. In the present study, we found an average of 12 ICU beds occupied at a time. The number of physiotherapists in charge of the ICU was between one and two per hospital. In other words, in most Malaysian settings, the physiotherapy-to-ICU patient ratio was 1:6. Generally, a high number of ICU patients or a high physiotherapy-to-patient ratio may suggest high challenges in implementing EM. In this study, we found that physicians were the most frequently reported clinician ordering mobilisation (13 [100%]), followed by physiotherapists (8 [62%]) and nurses (4 [31%]). This result is in line with a study by Alaparthy et al. (11) that explained the majority of the respondents required referral from medical staff for physiotherapy service in the ICU. This may suggest that most of the time, EM must wait until an official order from the physician. This dependency can potentially slow down the mobilisation

process and limit the physiotherapist's ability to provide timely interventions. On the contrary, a study in Brazil revealed that physiotherapists were considered as an independent practice in which they can decide when to start mobilisation. This might explain the higher prevalence of EM practices in the Brazilian study (12) than the present study.

The weight of a patient also plays a crucial role in determining the feasibility, safety, and effectiveness of EM interventions. In the present study, we found that the mean weight of patients in participating ICUs was 73 ± 24 kg. Heavier patients may present technical challenges during mobilisation, as moving and transferring them require more effort and specific handling techniques. According to Potter et al. (13), patient weight was identified as barriers to EM delivery. Healthcare providers may need additional equipment, such as hoists or specialised beds, to safely mobilise heavier patients. In this study, we found the most common equipment used within the ICU was a special bed to support mobilisation (10 [77%]). However, none of all teaching hospitals reported using a high table, rolling boards and mobile ventilation. Lack of equipment can also serve as a barrier to EM practices in the ICU, especially in mechanically ventilated patients (14).

EM practices in critically ill ICU patients

In this study, we found that in-bed mobilisation (ICU mobility scale 0-2) occurred in 53 (78%) patients, with nearly one-third (17 [23%]) of these patients not being mobilised at all (ICU mobility scale 0). Mobilisation out-of-bed occurred in a total of 21 (28%) patients, with the highest level of mobilisation reported on the survey day was marching on the spot (ICU mobility scale 6). No patient was made to walk on the survey day. These findings may suggest a low level of EM practices among ICU physiotherapists in Malaysia. The findings in the present study were also consistent with that found in an earlier study conducted among ICU physiotherapists in West Malaysia. The prevalence of in-bed and out-of-bed mobilisations reported in Yean et al. (15) were 66% and 15%, respectively.

ICU organisational structure and EM practices

Factors that were found to have a significant association with EM practices were ICU physiotherapist placement (permanent vs. rotation), types of ICU, and staff involved in patient mobilisation. This result was in line with the study from Bakhru et al. (16) that suggested ICU with dedicated physiotherapy services were 2.4 times more likely to practice EM in critically ill patients. Other than that, a quality improvement study from Needham et al. (17) also described the presence of dedicated ICU therapists to enhance access to mobilisation. This can be due to dedicated ICU physiotherapists having more time in the ICU, and they might receive more comprehensive and detailed training specific to the ICU environment.

In this study, we also found that staff involved in patient mobilisation, including physiotherapists, nurses, physicians, healthcare assistants, and students, also had a significant association with EM practices. The presence of a multidisciplinary team involving physicians, nurses, physiotherapists, and other healthcare professionals is crucial to optimise EM in ICU. They are responsible for setting goals, monitoring progress, and adjusting the mobilisation plan based on the patient's needs. Nonetheless, it is equally vital for the team to communicate effectively to exchange information and ensure everyone is on the same page regarding the goals of each patient. Tadyanemhandu et al. (18), in a study that evaluated the organisational structures of ICUs in South Africa, concluded that standardisation of practice between multi-professionals can be improved through individualised clinical protocols and guidelines. In the present study, all respondents reported having clinical protocols in their respective hospitals, with EM protocol being the most prevalent (13 [100%]). This may also suggest that the awareness of EM practices in critically ill ICU patients in teaching hospitals in Malaysia is high. The type of ICU significantly affects EM practices. The unique patient populations in each type of ICU and specialised medical requirements give rise to diverse approaches for EM. Adler & Malone (10), in their systematic review, also indicated the different requirements for patient mobilisation in medical and surgical ICUs. In medical ICUs, patients often have complex medical conditions, which may require more cautious and tailored mobilisation approaches. On the other hand, surgical ICUs may have patients with specific postoperative needs, potentially affecting the timing and intensity of EM. To improve EM outcomes, a multidisciplinary team of healthcare professionals should collaborate closely to plan personalised mobilisation approaches that cater to each patient's unique needs, medical status, and safety concerns.

CONCLUSION

In conclusion, the prevalence of out-of-bed mobilisation in ICU settings remains low in Malaysia. Several factors have been identified as significant contributors to EM of critically ill ICU patients. One critical factor identified was the presence of dedicated physiotherapy services within the ICU. Additionally, the type of ICU and its unique characteristics were also associated with EM practices in the ICU, which influence early mobilisation practices. Lastly, the involvement of a multidisciplinary team comprising nurses, physicians, and other healthcare professionals is instrumental in promoting EM. Collaboration among different specialties facilitates a coordinated approach to patient care and ensures that everyone is aligned with the goals of EM to improve patient outcomes. Improving EM practices in Malaysian ICUs is vital. Improvement can be achieved by emphasizing the importance of dedicated physiotherapy services, optimizing resources in different

ICU types, and promoting effective collaboration among healthcare professionals. Such efforts will lead to better patient outcomes and improve critical care standards in Malaysia.

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