



## Early mobilisation: In-bed mobilisation and regular turning helped to achieve early mobilisation out of bed



**In-bed mobilisation, reducing complications**



**Reduced moving and handling risks for staff**



**Pre-admission mobility level regained before discharge**

### Introduction

Lynda\* (age 52) was admitted to hospital for treatment of cellulitis. She weighed 155kg and had the following comorbidities / past medical history:

- **Bilateral leg ulcers**
- **Lymphoedema**
- **Heart murmur**
- **Cardiovascular disease**
- **Previous myocardial infarction**

Prior to admission Lynda was mobile with a rollator for short distances and used a wheelchair for longer distances. She was able to mobilise using both independently.

Lynda was initially nursed on an emergency trolley, but this was unsuitable for her as it wasn't wide enough, and she couldn't mobilise from it. She was transferred onto a bariatric bed and surface, but remained bed bound for several days whilst she was too unwell to mobilise.

*\*Lynda is not the patient's real name*

### Clinical Challenges

Lynda's mobility prior to admission was limited, and there was a danger of it deteriorating further, possibly long-term, if she didn't start to mobilise in hospital quickly.

Lynda's skin was extremely vulnerable; she already had cellulitis and leg ulcers, so it was very important that she was turned regularly in bed for pressure redistribution. However, this would present a challenge to caregivers, who would need to find a way to be able to do this to keep both them and Lynda safe.

Mobilisation was a challenge, especially when Lynda was bed bound.



## Medstrom's Clinical Advisor commented:

"I arranged for the **bariatric equipment to go to Accident and Emergency** while Lynda waited for a bed to become available on a ward, as it was clear that **it was needed as soon as possible**. I trained the staff looking after her how to use the equipment and did the same on the ward when she was transferred. I always make sure the staff know how to use the equipment, so they can **gain the most benefit from it as quickly as possible**."

## Patient objectives

- **Treat cellulitis**
- **Prevent further skin breakdown**
- **Get mobility back to pre-admission baseline**

## Introduction of Medstrom's Bariatric Equipment Package

A bariatric bed and surface were provided to help prevent complications of immobility, skin breakdown and exacerbation of comorbidities. The equipment was selected to give as much in-bed mobility as possible whilst also reducing moving and handling risks for caregivers:

**MMO 8000 Bed:** This bed has a platform width of 110cm (a standard bed is about 20cm narrower). A cardiac chair position is achieved with one button, with the backrest and knee section rising simultaneously. The upright chair position provides gravitational benefits to the body, helping to decrease complications of immobility

The bed controls can be used to achieve frequent, multiple positional changes without having to perform manual handling tasks. This benefits the patient, giving in-bed early mobility. It also benefits the staff by reducing moving and handling risks.

The high height of the platform (83cm) provides a safe height for 98% of UK adults to work from without twisting or stooping, also reducing manual handling risks.<sup>1</sup>

The bed is able to be programmed to stop at the patient's optimum egress height, with their feet flat on the floor.<sup>1</sup> This, along with the platform low height of 21cm, allows more patients to safely mobilise more quickly.

**TurnCair 1000 Low Air Loss Surface:** This provides a high specification of support surface for pressure redistribution, plus a TurnAssist feature that enables safe and dignified handling of patients and reduces manual handling risks. The low air loss therapy helps to cool skin and remove excess moisture, which helps to prevent skin breakdown.

The surface has an AutoFirm mode, which inflates the cells to their maximum height. This helps with mobilisation from the bed, as the patient will be sitting on the mattress rather than being enveloped in it.

The bed and mattress combination was very beneficial for Lynda and her caregivers, especially while she was confined to bed. The AutoFirm mode on the mattress, along with the programmed optimum egress height on the bed, allowed easier and safer mobilisation when Lynda was well enough to get out of bed. Lynda remained in hospital for a total of 14 days. She was bed bound for the first five days, but then started to mobilise to a chair, initially with the help of physiotherapists. Five days later, she was independently mobilising.

All objectives for Lynda had been met; the cellulitis had improved enough for her to be medically fit for discharge and there was no further skin breakdown. Her mobility was back to her pre-admission baseline.





**Fit for discharge**



**Complications prevented**



**Mobility back to baseline**

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## Summary

The bed and surface combination played a key part in keeping Lynda mobile throughout her hospital stay. While she was confined to bed, the electric controls helped her to move and sit upright. The mattress assisted with turning her regularly which helped to prevent skin breakdown and reduced manual handling for her caregivers.

Once Lynda was able to mobilise, the bed and surface helped her to do so safely. She got back to baseline mobility seven days after first getting out of bed, which was an excellent achievement. Early mobilisation helped to reduce deconditioning and helped recovery, allowing her to go home as mobile as she was before admission.

### References

1. Martindale D (2021). Calculating bed height for hospital patients using popliteal measurement. Nursing Times [online]; 117: 10.



**To discover more about Medstrom's range of solutions for dignified plus-size patient care and enhanced support for caregivers, contact Medstrom's Bariatric Product Specialists 24/7/365 on:**

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