Director's Forum – NICU Mobility (w/ET tube) Feedback – June 2026

Original Questions:
For those with a NICU:

1. Is there a mobility plan/protocol in place for intubated infants (ET)?
2. Are intubated patients stratified by risk levels based on medical stability/risk for unplanned extubation?
3. If mobilizing/transferring infants with ET tubes…
   A. Who is involved (PT, OT, RN, RT, etc.)?
   B. What positioning devices are being used and how/where (i.e. tumbleform on bed with rails up)?
   C. What "restraints" are used to prevent the child from grabbing the ET (or other lines/leads) while they are up? Is there a product/method that you have found to be effective?

ORG A

1. Nursing developed an "Endotracheal Tube Bundle" that limits mobilization of certain "high risk" infants with ET tubes
2. Yes, we have moderate and high extubation risk that is noted within the EHR and on the room door frame with labeled yellow (mod risk) or red (high risk) magnets. That doesn't automatically mean that they can't be mobilized/transferred/held.
3.
   A. We have traditionally had PT or OT in charge of lifting/transferring the patient along with (2) other staff. One manages the ET and the other manages other lines/leads and equipment. That has typically been (2) RN or an RN and an RT.
   B. Tumbleforms, Boppy - typically on the bed with rails up
   C. We have used mittens, swaddles, dandles, blankets, etc. to keep infants from grabbing their ET when not actively engaged in therapy session and just being monitored while upright. Depends on level of sedation, acuity, agitation, etc.

ORG B

1. We do not have a specific mobility plan protocol however our NICU therapy team worked with nursing to develop a *decision tree* based on safety for holding and high risk factors to consider.

2. yes we use our *decision tree map* and *work specifically with bedside RN* to determine safety on that given day and parental ability to cognitively understand and meet the required demands involved with holding a medically complex baby with multiple lines and tubes.

3. Again determined by bedside RN and medical team could be 2 RN's and or an RN and RT as well as PT and OT. Positioning devices often depend on stability of infant, size of infant, and could include SPRY/Zflow, or boppy for holding and we do use tumble forms for older babies with ETT and this is done only with therapy and therapist is always directly at bedside with infant throughout. *We don't use any restraints with infants in tumble forms we are directly there and always monitoring hand movements.* Typically use dandle wrap or snug swaddle when holding. Nothing is guaranteed effective 100%

Director's Forum – NICU Mobility (w/ET tube) Feedback – June 2026

ORG C

1. Is there a mobility plan/protocol in place for intubated infants (ET)? Nothing formal in the NICU besides having *2 sets of hands*
2. Are intubated patients stratified by risk levels based on medical stability/risk for unplanned extubation? Not in the NICU, the CCU has a more formalized risk level.
3. If mobilizing/transferring infants with ET tubes…
    A. Who is involved (PT, OT, RN, RT, etc.)? Can be any combination of the options. Preference for RN or RT if concern for extubation or getting in parent lap just for safety or need for re-intubation.
    B. What positioning devices are being used and how/where (i.e. tumbleform on bed with rails up)? We use infant seats (high chairs with the legs taken off so the chair can be put into the bed with the rails up or tumbleforms). *If we are leaving the infant in the chair, multiple factors have to be considered regarding level of sedation, stability of tube, state of infant, comfort level of RN.*

What "restraints" are used to prevent the child from grabbing the ET (or other lines/leads) while they are up? Is there a product/method that you have found to be effective? No official restraints, we will use a blanket or if they have immobilizers on their arms for line protection, that typically can help maintain line safety.

ORG D

1. Is there a mobility plan/protocol in place for intubated infants (ET)?

- Yes - Logistics include the following:
    - Needs *Neonatology team approval* in advance
    - Requires *at least 2 people* (PT/PT and RN/RT)
    - Typically initiated at 36+ weeks, but can be as early as 34 weeks
    - Timed with cares

2. Are intubated patients stratified by risk levels based on medical stability/risk for unplanned extubation?

- Yes - as mentioned before, each mobility plan is on a case by case basis, depending on the infant's status each day, and communication with RN's on whether infant is in an appropriate state for early mobility (not too sedated or too agitated), and that there are no new medically complex findings that might be a contraindication.
- In addition, to ensure safety, we have defined the following roles:
    - RN is responsible for ET tubing
    - Therapist will support and move the baby (to maintain safety of airway)
    - At no time should the therapist be stabilizing the ET tube
    - Therapist can assist with positioning at end of session

Director's Forum – NICU Mobility (w/ET tube) Feedback – June 2026

Additional safety measures are as follows:

- ET tube suction requires baby to be returned back to crib surface
- RN and Therapist can determine together when breaks are needed for rest or suctioning
- Awareness of shut down state as a result of stress vs tolerance for prolonged sitting

3. If mobilizing/transferring infants with ET tubes…
   A. Who is involved (PT, OT, RN, RT, etc.)?
   - *Requires at least 2 people* (PT/PT and RN/RT)

   B. What positioning devices are being used and how/where (i.e. tumbleform on bed with rails up)?
   - In general, we are only *sitting with Therapist and RN/RT* and *not using additional equipment*. If it is determined that an infant would benefit from additional developmental positioning equipment while intubated, this could be a *Boppy pillow and would be only during supervised therapy time* with 2 person (therapist / RN/RT) working on transfer together

   C. What "restraints" are used to prevent the child from grabbing the ET (or other lines/leads) while they are up? Is there a product/method that you have found to be effective?
   - All early mobility activities are *staffed throughout session by at least 2 individuals*. This is case by case, with *hands typically covered with mitts/socks* or *fold over outfits* at start and end of session and then *hands more open during session* to encourage active supervised grasping / raking activities for sensory input and fine motor encouragement.