**Impaired Physical Mobility Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my diagnoses related to impaired physical mobility:** | List all diagnoses or conditions that relate to impaired physical mobility, or indicate if there are none. |
| **I am allergic to these things:** | List all known allergies and sensitivities, or indicate if there are none. |
| **The goal of this Healthcare Plan is:** | [ ]  I will maintain or improve my ability to walk during the ISP year.[ ]  I will maintain or improve my strength and coordination during the ISP year.[ ]  I will improve tolerance of alternative positions during the ISP year.[ ]  I will not experience worsening contractures during the ISP year.[ ]  I will perform activities of daily living with the greatest independence possible for the duration of the ISP year.[ ]  Describe any other goal related to managing my skin integrity. |
| **Progress in the past year:** | Describe the status of my health for the past year related to impaired physical mobility. |
| **In an EMERGENCY****Call 911 IMMEDIATELY if I:****🡪 lose consciousness (become unresponsive);****🡪 fall and hit my head or you suspect I have broken bones****🡪 Describe any additional instructions specific to impaired physical mobility here.** |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL****I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| [ ]  I can move around safely with the help of equipment that I use independently.  | [ ]  I can move around safely with physical assistance from supporters when I transfer or walk.  | [ ]  I can move around safely with **BOTH** physical assistance from supporters and equipment. | [ ]  I am not able to move around without maximum assistance from supporters and equipment. |
| **These are the problems I have with walking and moving:** | [ ]  I have an unsteady gait (abnormal walking pattern).[ ]  I am unable to walk.[ ]  I am unable to transfer.[ ]  I am unable to reposition myself.[ ]  I have contractures in my arms and hands that affect my ability to reach and grasp. Specify location of upper extremity contractures, or indicate if there are NONE.[ ]  I have contractures in my legs and feet that affect my ability to stand and walk. Specify location of lower extremity contractures, or indicate if there are NONE.[ ]  I have poor body alignment that makes it difficult for me to sit or stand straight.[ ]  I have poor muscle strength and coordination, which makes it more difficult for me to move around.[ ]  Describe any other problems I have with physical mobility, or indicate if there are NONE. |
| **My physical mobility is impaired due to:** | [ ]  I have a condition that impacts my muscle strength and coordination, such as cerebral palsy or multiple sclerosis.[ ]  I have a condition that causes peripheral neuropathy (weakness and/or pain in my hands and feet) such as diabetes.[ ]  I have a condition that causes me to experience pain when I ambulate and/or move my legs and arms.[ ]  I have a condition that affects the alignment of my body, such as scoliosis, kyphosis, or lordosis.[ ]  I have a seizure disorder and have experienced falls and/or injury during seizures.[ ]  Describe other causes of my impaired physical mobility, or indicate if there are NONE. |
| **I use these types of equipment to help me move around safely.** | [ ]  Manual wheelchair [ ]  Motorized wheelchair [ ]  Customized wheelchair seating [ ]  Gait belt [ ]  Cane [ ]  Walker [ ]  Sidelyer [ ]  Standing frame [ ]  Mat [ ]  AFOs [ ]  Splints [ ]  Describe any other equipment I use for physical mobility, or indicate if there are NONE. |
| **This is the type of assistance I need from supporters to help me move around safely:** | [ ]  Watch me when I am walking or transferring, and provide verbal cues for my safety. [ ]  Assist me in using my equipment safely by providing verbal cues. [ ]  Assist me in using my equipment safely by providing physical assistance. [ ]  Stand or walk next to me when I am transferring or walking and provide physical assistance, if needed, to help me remain steady. [ ]  Assist me in transferring into alternative positions throughout the day, with no more than XX minutes/hours spent in a position.[ ]  Assist me in wearing my splints and/or AFOs per my doctor’s instructions. [ ]  Provide me with verbal cues to reposition myself at least every XX minutes/hours.[ ]  Follow staff instructions provided by my physical therapist and/or occupational therapist for transfers and ambulation. [ ]  Follow staff instructions developed by my physical therapist and/or occupational therapist for range of motion. [ ]  If I have a seizure, follow my seizure healthcare plan[ ]  If I fall, follow the instructions in my falls healthcare plan.[ ]  Describe any other strategies to help me maintain or improve my physical mobility, or indicate if there are NONE. |
| **Documentation:**  | Describe the things that supporters should write down and where they should write them down. |
| **Nursing Intervention:** | Describe those things that must be done by the nurse relative to impaired physical mobility, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** [ ] Yes [ ] No

 RN Typed Name and Agency

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