**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

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

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