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Safe mobility and fall prevention Initial assessment

Nursing Foundation | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

81-year-old woman with dizziness and an unfamiliar walking aid. Care stage: At the first supervised assessment.

Medical history: The patient used a walking aid at home and recently developed postural dizziness. The unfamiliar ward environment has increased fear during transfers. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Fear of falling and difficulty reaching the toilet safely.

Objective findings and required checks: Unsteady transfer and postural symptoms; needs an individualized assistance level.

Physical examination and investigations: Assess gait, vision, cognition, postural symptoms, medicines and prior falls.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Safe mobility and fall prevention: Weakness, medicine effects and environmental hazards can combine to increase fall risk.

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Medical / surgical management

Supervise transfers, check aids and footwear, provide an accessible call bell and review reversible causes.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Medication review	Identify drugs contributing to sedation or hypotension	Changes require an authorized prescriber
prescribed analgesia	Support safe movement	Monitor dizziness and sedation.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Fear of falling and difficulty reaching the toilet safely. Unsteady transfer and postural symptoms; needs an individualized assistance level. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize vulnerability to a fall or accidental injury; movement limited by weakness, discomfort or restriction; emotional distress affecting participation in care; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Supervise transfers, check aids and footwear, provide an accessible call bell and review reversible causes. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

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vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about falls, dizziness, vision and usual walking aids. Assess: Assess gait, medicines, cognition and environmental risks.	Vulnerability to a fall or accidental injury. Possible factors: unsteady mobility, dizziness or environmental hazards. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Transfers and essential activity occur without a fall during the care period. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates safe use of assistance and identifies home hazards.	1. Individualize fall precautions and keep necessary items and the call bell accessible. Rationale: Accessible support reduces unsafe unassisted movement. 2. Supervise transfers according to assessed need and check footwear and aids. Rationale: Correct assistance and equipment improve stability. 3. Review reversible contributors with the team, including postural symptoms and medicines. Rationale: Addressing causes improves safety beyond environmental measures. 4. Supervise transfers, check aids and footwear, provide an accessible call bell and review reversible causes. Rationale: Weakness, medicine effects and environmental hazards can combine to increase fall risk. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about usual mobility, fatigue and help needed with activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Movement limited by weakness, discomfort or restriction. Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Completes a jointly agreed movement task safely with appropriate assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the home exercise or mobility plan before discharge.	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching support to ability prevents injury. 2. Plan graded movement, position changes and rest with physiotherapy where indicated. Rationale: Progressive activity supports function while limiting exhaustion. 3. Monitor tolerance and stop for new concerning symptoms. Rationale: Symptoms may indicate unsafe exertion or deterioration.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: After the first indicated intervention, at the documented review time:	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Demonstrate safe transfers and use of aids; discuss lighting, bathroom access and home hazards. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Demonstrate safe transfers and use of aids; discuss lighting, bathroom access and home hazards.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

New neurological deficit, syncope, head injury or inability to bear weight requires prompt assessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Weakness, medicine effects and environmental hazards can combine to increase fall risk.

- Priority concerns: Vulnerability to a fall or accidental injury; Movement limited by weakness, discomfort or restriction; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- New neurological deficit, syncope, head injury or inability to bear weight requires prompt assessment.

- Demonstrate safe transfers and use of aids; discuss lighting, bathroom access and home hazards.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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