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Movement limited by weakness, discomfort or restriction Safe mobility and fall prevention

Nursing Foundation | Focused diagnosis-based template

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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.

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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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Focused nursing-problem template

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 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: At the next patient-specific reassessment: 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. 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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: Movement limited by weakness, discomfort or restriction.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

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B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council

https://www.indiannursingcouncil.org/gazette-notification

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