

Nursing Care Plan for Impaired Physical Mobility

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Introduction

Impaired physical mobility is a standardized nursing diagnosis describing a limitation in independent, purposeful movement of the body or one or more extremities. A useful care plan must connect the diagnosis to the patient's actual findings rather than attach generic exercise advice to every person who reports weakness. In this case, the patient has reduced lower-extremity range of motion, difficulty rising from a chair, dependence with dressing and walking, frustration about lost independence, a sedentary history, and a previous knee injury. Nursing priorities are to identify reversible causes, protect the patient from falls, preserve function, coordinate rehabilitation, manage symptoms, and measure progress through specific activities. The plan below is educational and would require adaptation to the patient's medical condition, orders, preferences, and local clinical policy. (NANDA International, 2024)

Assessment and Diagnostic Reasoning

The nurse should begin with a focused mobility assessment that documents baseline function and identifies factors contributing to the limitation. Subjective information includes the patient's description of weakness, pain, dizziness, fatigue, fear of falling, difficulty completing activities of daily living, and personal mobility goals. Objective assessment includes gait, balance, transfer ability, joint range of motion, muscle strength, sensation, cognition, cardiopulmonary tolerance, skin condition, footwear, and the assistance or device needed for safe movement. Medication effects, recent illness, neurologic changes, anemia, orthostatic hypotension, and environmental barriers should also be considered. The diagnosis of impaired physical mobility is supported when movement is limited, but the plan must also identify related problems such as fall risk, activity intolerance, pain, or self-care deficit. (NANDA International, 2024; Potter et al., 2023)

Subjective, Objective, and Historical Data

The patient reports feeling weak and needing help with walking and dressing, and expresses frustration because reduced mobility has limited freedom. Examination shows restricted motion of the knee and hip, difficulty moving from sitting to standing, and a need for physical assistance. Historical information includes irregular exercise, a largely inactive routine, and a previous knee injury that may have reduced strength and confidence. These data should be recorded in measurable terms: distance

walked, level of assistance, pain score, degrees of motion, time required for transfer, and the exact device used. General statements such as “mobility improved” are insufficient for evaluating change. The nurse should also clarify the home environment, support system, previous level of independence, and whether the patient has fallen recently. (Potter et al., 2023)

Priority Nursing Outcomes

The outcomes should be functional, realistic, time limited, and meaningful to the patient. Within forty-eight hours, the patient will demonstrate the agreed method for requesting assistance and will transfer from bed to chair using the prescribed device with no fall or injury. Within one week, the patient will participate in scheduled mobility activities at the safest tolerated level and will explain two strategies for conserving energy and preventing falls. Within four weeks, the patient will improve a selected measure, such as walking a specified distance, completing a sit-to-stand transfer with less assistance, or dressing the lower body using adaptive techniques. Blood-pressure reduction is not an appropriate primary outcome unless hypertension is an established diagnosis with a separate plan. Mobility goals should be revised when illness, pain, or rehabilitation potential changes. (NANDA International, 2024; Potter et al., 2023)

Fall Prevention and Safe Environment

Fall prevention must be individualized instead of relying on restriction. The nurse should assess patient-specific risks, create a tailored plan with the patient and family, and communicate that plan consistently at the bedside and during handoffs. The call light, mobility aid, water, and personal items should remain within reach; the walking path should be clear; lighting and footwear should be appropriate; and the bed and chair should be positioned safely. Toileting needs should be anticipated because urgent attempts to reach the bathroom commonly lead to falls. Alarms or close observation may be used when clinically justified, but they do not replace assistance and engagement. Unnecessary bed rest and restraints can worsen weakness, delirium, and dependence, so safety should support appropriate movement rather than prevent all movement. (Agency for Healthcare Research and Quality, n.d.)

Progressive Mobility Intervention

The nurse should help the patient move through a graded sequence based on tolerance and clinical stability: repositioning in bed, sitting at the edge of the bed, standing, transferring, and walking. Vital signs, symptoms, pain, fatigue, and quality of movement should be checked before and during progression. Activity should stop and the patient should be reassessed if there is chest pain, severe shortness of breath, syncope, new neurologic change, or unsafe hemodynamic response. Frequency is often more important than one prolonged session, and brief mobility opportunities can be integrated

into toileting, meals, and self-care. The nurse should document distance, duration, assistance, device, and response so that every team member builds on the same baseline rather than restarting assessment. (Agency for Healthcare Research and Quality, n.d.; Potter et al., 2023)

Range-of-Motion and Strengthening

Active range-of-motion exercises are preferred when the patient can perform them safely because they preserve joint movement while engaging muscle. Active-assisted or passive exercises may be required when strength or control is limited, but they should follow rehabilitation guidance and avoid forcing a painful or unstable joint. Strengthening should target the muscles needed for transfers, standing, and walking, with resistance and repetition increased gradually. The original recommendation for jogging, brisk walking, cycling, or yoga is too broad for a patient who currently struggles to stand. Exercise selection must reflect diagnosis, weight-bearing status, surgical precautions, pain, balance, and cardiovascular tolerance. Demonstration and return demonstration help ensure that the patient understands technique and does not substitute unsafe compensatory movements. (American Physical Therapy Association, n.d.; Potter et al., 2023)

Physical and Occupational Therapy Collaboration

Physical therapy can evaluate gait, balance, strength, joint motion, device selection, and the progression of therapeutic exercise. Occupational therapy can address dressing, bathing, toileting, energy conservation, adaptive equipment, and modification of tasks or the home. Nursing care continues between therapy sessions by reinforcing the prescribed techniques and helping the patient practice safely during ordinary activities. The nurse should communicate changes in pain, cognition, endurance, skin condition, or transfer ability that affect the therapy plan. Collaboration is not a referral followed by withdrawal of nursing responsibility. The shared objective is consistent practice across disciplines, with the patient participating in goal selection. If progress stalls, the team should reconsider diagnosis, treatment burden, motivation, equipment fit, and medical barriers rather than simply telling the patient to try harder. (American Physical Therapy Association, n.d.; Potter et al., 2023)

Pain, Fatigue, and Symptom Management

Pain and fatigue can make mobility appear worse and can cause the patient to avoid activity. The nurse should assess location, intensity, timing, aggravating factors, and the effect of symptoms on function. Analgesia may be timed before activity when ordered, while nonpharmacologic measures such as positioning, heat or cold where appropriate, relaxation, pacing, and rest periods may improve participation. Sedating medicines, antihypertensives, and other treatments can increase dizziness or fall risk, so medication review may be necessary. Anxiety and fear of falling should be acknowledged

without allowing fear to produce permanent inactivity. The patient benefits from predictable sessions, achievable steps, and evidence of improvement. Symptoms are information for adjusting the plan, not proof that all movement is unsafe or that discomfort must be ignored. (Potter et al., 2023)

Skin Integrity and Complication Prevention

Reduced movement increases the risk of pressure injury, venous stasis, constipation, respiratory complications, contracture, and deconditioning. The nurse should assess skin, reposition according to risk and tolerance, use pressure-redistributing surfaces when indicated, and protect heels and other vulnerable areas. Hydration, nutrition, bowel routines, and prescribed thrombosis prevention should be integrated into the plan. The patient should be encouraged to shift weight and participate in repositioning to the greatest safe extent. Immobility complications can develop even while the primary injury appears stable, so prevention must begin early. Documentation should distinguish inability from lack of opportunity: a patient cannot maintain function when staff complete every task automatically or leave necessary equipment out of reach. (National Pressure Injury Advisory Panel, n.d.; Potter et al., 2023)

Education and Self-Management

Education should explain why movement matters, how to use assistance, and which warning signs require help. The nurse can teach the patient to rise slowly, position the mobility device correctly, wear secure footwear, follow weight-bearing instructions, and avoid walking alone when the plan requires assistance. Written instructions should use clear language and match vision, cognition, literacy, and preferred language. Family members should learn safe support techniques without lifting in ways that injure themselves or the patient. A home exercise or activity plan should come from the relevant clinician and include frequency, progression, and stopping rules. Mindfulness may help anxiety, but it is not a direct treatment for impaired physical mobility and should not displace exercise, symptom management, or rehabilitation. (American Physical Therapy Association, n.d.; Potter et al., 2023)

Evaluation of Progress

Evaluation compares actual performance with the defined outcomes. A partially met result should specify what changed: the patient now transfers with one-person assistance instead of two, walks a measured distance with a walker, dresses the upper body independently, or demonstrates improved knee motion. It should also identify what remains limited and why. If the patient has improved strength but still requires help because of pain or balance, the next plan should target those barriers. Reassessment should include patient perception, because a small functional improvement may be highly meaningful or may fail to address the activity the patient values most. Goals should be

continued, advanced, modified, or discontinued based on evidence rather than copied unchanged into each note. (NANDA International, 2024; Potter et al., 2023)

Discharge and Continuation Plan

Discharge planning should begin early and address the environment in which the patient will actually function. The team should confirm equipment availability, safe entry and bathroom access, transportation, medication management, follow-up appointments, and the capacity of caregivers. The patient should know whom to contact if mobility suddenly worsens, a fall occurs, or new pain, weakness, swelling, breathlessness, or neurologic symptoms develop. Home health, outpatient therapy, community exercise, or rehabilitation placement may be appropriate depending on function and support. The continuation plan should preserve the same measurable goals used in the facility so progress can be followed across settings. A safe discharge is not defined only by medical stability; it requires a realistic method for daily movement and self-care. (Potter et al., 2023; American Physical Therapy Association, n.d.)

Conclusion

A strong nursing care plan for impaired physical mobility begins with detailed assessment and proceeds through individualized outcomes, progressive movement, fall prevention, symptom control, interdisciplinary rehabilitation, education, and measurable evaluation. The original plan correctly recognized range-of-motion exercise and physical-therapy collaboration, but it included activities and blood-pressure goals that were not clearly connected to the patient's current mobility problem. Nursing care should avoid both unsafe overexertion and unnecessary restriction. The patient's ability to transfer, walk, perform self-care, and participate in preferred roles provides the most meaningful evidence of improvement. By documenting assistance, distance, device, symptoms, and response, the nurse can adjust care rationally and help the patient regain the greatest safe level of independence. (NANDA International, 2024; Potter et al., 2023)

References

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6. National Pressure Injury Advisory Panel. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline.*