

M — Movement and self-care

19 statements · Recommended tool: CP-MOVE Movement & Self-Care Score · Validated scales: Barthel Index, Katz ADL

M1 Limited ability to move

Group: Movement and self-care | Type: Actual problem

Definition: Pain, weakness, or restrictions reduce the ability to move the body or parts of it.

Possible causes: Pain; weakness; surgery; fear; restrictions

Signs and symptoms: Moves slowly; avoids movement; needs help; stiff

Scenario. After hip replacement, a woman will not move her leg for fear of pain.

S: "I'm afraid to move my leg."

O: Day 1 after hip replacement; will not move the leg; pain 7/10; muscle tight.

Tools: CP-MOVE, CP-PAIN · Barthel Index, Katz ADL, NRS 0–10, FLACC, PAINAD ****CarePath diagnosis:****

Limited ability to move related to pain, as evidenced by moves slowly and avoids movement.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Give pain relief before activity. | Pain relief given before activity lets her move with less pain, which lowers her fear and makes movement more likely and more comfortable. | | Assist with exercises. | Guided exercises keep the joint and muscles working safely and help prevent stiffness and weakness after the surgery. | | Encourage safe movement. | Safe, gradual movement rebuilds strength and circulation and lowers the risk of clots and other complications of staying still. | | Praise progress. | Praise builds confidence and motivation, which helps a frightened patient keep trying and accept each small step forward. | | Follow the therapy plan. | The therapy plan protects the new hip by setting safe movements and limits, so progress does not harm the repair. | ****Expected outcomes**** - Sits at the bedside within 24 hours and walks a short distance with a frame by day 2. - Pain 4/10 or lower with activity. ****Linking the data to the diagnosis**** A woman on day 1 after hip replacement says, "I'm afraid to move my leg." She will not move the leg, her pain is 7/10 and the muscle is tight, so she moves slowly and avoids movement. This is an actual problem that has already happened, not a risk, and pain is the main cause. The plan aims to reduce pain with medicine before activity and to encourage safe movement. The expected outcomes are sitting at the bedside within 24 hours, walking a short distance with a frame by day 2 and pain of 4/10 or lower during activity.

CarePath diagnosis: Limited ability to move related to pain, as evidenced by moves slowly and avoids movement.

Intervention	Rationale
Give pain relief before activity.	Pain relief given before activity lets her move with less pain, which lowers her fear and makes movement more likely and more comfortable.
Assist with exercises.	Guided exercises keep the joint and muscles working safely and help prevent stiffness and weakness after the surgery.
Encourage safe movement.	Safe, gradual movement rebuilds strength and circulation and lowers the risk of clots and other complications of staying still.
Praise progress.	Praise builds confidence and motivation, which helps a frightened patient keep trying and accept each small step forward.
Follow the therapy plan.	The therapy plan protects the new hip by setting safe movements and limits, so progress does not harm the repair.

Expected outcomes: Sits at the bedside within 24 hours and walks a short distance with a frame by day 2. · Pain 4/10 or lower with activity.

Linking the data: A woman on day 1 after hip replacement says, "I'm afraid to move my leg." She will not move the leg, her pain is 7/10 and the muscle is tight, so she moves slowly and avoids movement. This is an actual problem that has already happened, not a risk, and pain is the main cause. The plan aims to reduce pain with medicine before activity and to encourage safe movement. The expected outcomes are sitting at the bedside within 24 hours, walking a short distance with a frame by day 2 and pain of 4/10 or lower during activity.

M2 Tires quickly during activity

Group: Movement and self-care | Type: Actual problem

Definition: Ordinary activity causes breathlessness, fast heart rate, or exhaustion.

Possible causes: Heart or lung disease; anemia; deconditioning; poor sleep

Signs and symptoms: Breathless on small effort; fast pulse; tired after walking; needs rests

Scenario. A patient with heart failure must rest after walking five steps.

S: "I get tired after just a few steps."

O: Short of breath after 5 steps; heart rate rises from 78 to 112; heart failure; needs rest every 10 meters.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Tires quickly during activity related to heart or lung disease, as evidenced by breathless on small effort and fast pulse. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Pace activity. | Spreading activity over time with rests keeps demand on the weak heart lower, so breathlessness, fast pulse and fatigue are less likely to occur. | | Allow rest. | Rest lets the heart rate and breathing settle and restores energy before the next effort. | | Check pulse and breathing. | Pulse and breathing show how hard the heart is working and help the nurse decide when to stop or slow down. | | Increase gradually. | Gradual increases in activity build tolerance step by step, without suddenly overloading a heart that is already weak from heart failure. | | Teach energy saving. | Energy-saving methods, such as sitting for tasks, let him do what he needs with less effort. | | Report chest pain. | Chest pain can signal the heart is not getting enough oxygen and needs prompt medical review. | ****Expected outcomes**** - By day 3: walks 20 meters with one rest, heart rate returns to baseline within 3 minutes, no chest pain. ****Linking the data to the diagnosis**** A patient with heart failure says, "I get tired after just a few steps." He becomes short of breath after 5 steps, his heart rate rises from 78 to 112, and he needs rest every 10 meters. These findings show the problem is already present, so an actual statement fits and a risk statement does not. The plan aims to raise his activity tolerance safely. By day 3 the expected outcomes are walking 20 meters with one rest, a heart rate that returns to baseline within 3 minutes and no chest pain.

CarePath diagnosis: Tires quickly during activity related to heart or lung disease, as evidenced by breathless on small effort and fast pulse.

Intervention	Rationale
Pace activity.	Spreading activity over time with rests keeps demand on the weak heart lower, so breathlessness, fast pulse and fatigue are less likely to occur.
Allow rest.	Rest lets the heart rate and breathing settle and restores energy before the next effort.
Check pulse and breathing.	Pulse and breathing show how hard the heart is working and help the nurse decide when to stop or slow down.
Increase gradually.	Gradual increases in activity build tolerance step by step, without suddenly overloading a heart that is already weak from heart failure.
Teach energy saving.	Energy-saving methods, such as sitting for tasks, let him do what he needs with less effort.
Report chest pain.	Chest pain can signal the heart is not getting enough oxygen and needs prompt medical review.

Expected outcomes: By day 3: walks 20 meters with one rest, heart rate returns to baseline within 3 minutes, no chest pain.

Linking the data: A patient with heart failure says, "I get tired after just a few steps." He becomes short of breath after 5 steps, his heart rate rises from 78 to 112, and he needs rest every 10 meters. These findings show the problem is already present, so an actual statement fits and a risk statement does not. The plan aims to raise his activity tolerance safely. By day 3 the expected outcomes are walking 20 meters with one rest, a heart rate that returns to baseline within 3 minutes and no chest pain.

M3 Cannot turn or change position in bed

Group: Movement and self-care | Type: Actual problem

Definition: The person cannot reposition without help.

Possible causes: Weakness; pain; sedation; paralysis; heavy casts

Signs and symptoms: Cannot roll; slides down the bed; needs help to sit up

Scenario. A man in traction cannot turn without two nurses.

S: "I can't turn myself."

O: In traction; needs two nurses to turn; slides down in bed.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Cannot turn or change position in bed related to weakness, as evidenced by cannot roll and slides down the bed. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use turning aids. | Slide sheets and other aids reduce friction and force, making turns easier for the patient and safer for staff. | | Assist safely. | Safe assistance, with enough people and the correct technique, protects both the patient and the nurses from injury during turning. | | Reposition regularly. | Regular repositioning relieves pressure on the skin and lowers the chance of pressure injuries in someone who cannot turn alone. | | Check skin. | Skin checks find early redness or damage from pressure, which is a risk when someone cannot move himself. | | Teach use of bed handles. | Using bed handles lets him take part in moving, which builds strength, confidence and independence. | ****Expected outcomes**** - Turned every 2 hours safely. - Skin stays intact. - Patient uses the bed handle to help. - No strain injuries to staff. ****Linking the data to the diagnosis**** A man in traction says, "I can't turn myself." He needs two nurses to turn him and slides down in the bed, so he cannot roll or change position without help. This is an actual problem, not a risk, because the inability to turn is already present. The plan aims to turn him safely every 2 hours with aids so that his skin stays intact and staff are not strained. It also aims to teach him to use the bed handle so that he can help with his own movement.

CarePath diagnosis: Cannot turn or change position in bed related to weakness, as evidenced by cannot roll and slides down the bed.

Intervention	Rationale
Use turning aids.	Slide sheets and other aids reduce friction and force, making turns easier for the patient and safer for staff.
Assist safely.	Safe assistance, with enough people and the correct technique, protects both the patient and the nurses from injury during turning.
Reposition regularly.	Regular repositioning relieves pressure on the skin and lowers the chance of pressure injuries in someone who cannot turn alone.
Check skin.	Skin checks find early redness or damage from pressure, which is a risk when someone cannot move himself.
Teach use of bed handles.	Using bed handles lets him take part in moving, which builds strength, confidence and independence.

Expected outcomes: Turned every 2 hours safely. · Skin stays intact. · Patient uses the bed handle to help. · No strain injuries to staff.

Linking the data: A man in traction says, "I can't turn myself." He needs two nurses to turn him and slides down in the bed, so he cannot roll or change position without help. This is an actual problem, not a risk, because the inability to turn is already present. The plan aims to turn him safely every 2 hours with aids so that his skin stays intact and staff are not strained. It also aims to teach him to use the bed handle so that he can help with his own movement.

M4 Difficulty walking

Group: Movement and self-care | Type: Actual problem

Definition: Walking is slow, unsteady, painful, or not possible without help.

Possible causes: Weak legs; pain; stroke; poor balance; arthritis

Signs and symptoms: Shuffling; limping; needs support; slow pace

Scenario. A patient with arthritis walks very slowly and winces.

S: "My knees hurt and walking is slow."

O: Arthritis; shuffling walk; limping; pain 6/10 on walking; uses a stick.

Tools: CP-MOVE, CP-PAIN · Barthel Index, Katz ADL, NRS 0–10, FLACC, PAINAD ****CarePath diagnosis:**** Difficulty walking related to weak legs, as evidenced by shuffling and limping. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess walking. | Assessing the walk shows what is wrong, such as pain, weakness or poor balance, so the plan can target the real problem. | | Use a walking aid. | A suitable aid takes weight off painful joints and improves balance, which makes walking safer and less painful for him. | | Physiotherapy. | Physiotherapy builds leg strength and teaches better walking patterns, which helps his long-term mobility and independence. | | Give pain relief. | Pain relief lets him move with less pain, so he can walk further and take part in exercises. | | Ensure safe footwear. | Supportive footwear with good grip improves stability and lowers the risk of slipping or falling. | | Assist. | Help close by prevents falls while his walking is slow and unsteady, and it gives him confidence to keep moving. | ****Expected outcomes**** - Within 1 week: walks 30 meters with aid and pain 4/10 or lower. - Safe footwear. - Stable walk. ****Linking the data to the diagnosis**** A patient with arthritis says, "My knees hurt and walking is slow." He has a shuffling, limping walk, pain of 6/10 on walking and uses a stick. The difficulty is already present, so this is an actual diagnosis and not a risk. The plan aims to improve his walking through pain relief, a suitable aid, physiotherapy and safe footwear. Within 1 week the expected outcomes are walking 30 meters with an aid, pain of 4/10 or lower, safe footwear and a stable walk.

CarePath diagnosis: Difficulty walking related to weak legs, as evidenced by shuffling and limping.

Intervention	Rationale
Assess walking.	Assessing the walk shows what is wrong, such as pain, weakness or poor balance, so the plan can target the real problem.
Use a walking aid.	A suitable aid takes weight off painful joints and improves balance, which makes walking safer and less painful for him.
Physiotherapy.	Physiotherapy builds leg strength and teaches better walking patterns, which helps his long-term mobility and independence.
Give pain relief.	Pain relief lets him move with less pain, so he can walk further and take part in exercises.
Ensure safe footwear.	Supportive footwear with good grip improves stability and lowers the risk of slipping or falling.
Assist.	Help close by prevents falls while his walking is slow and unsteady, and it gives him confidence to keep moving.

Expected outcomes: Within 1 week: walks 30 meters with aid and pain 4/10 or lower. · Safe footwear. · Stable walk.

Linking the data: A patient with arthritis says, "My knees hurt and walking is slow." He has a shuffling, limping walk, pain of 6/10 on walking and uses a stick. The difficulty is already present, so this is an actual diagnosis and not a risk. The plan aims to improve his walking through pain relief, a suitable aid, physiotherapy and safe footwear. Within 1 week the expected outcomes are walking 30 meters with an aid, pain of 4/10 or lower, safe footwear and a stable walk.

M5 Needs help to wash

Group: Movement and self-care | Type: Actual problem

Definition: The person cannot bathe or wash alone.

Possible causes: Weakness; pain; paralysis; low energy; confusion

Signs and symptoms: Needs help to reach, wash, and dry; skin not cleaned

Scenario. A stroke patient cannot wash his back or legs.

S: "I can't reach my back."

O: Needs help washing back and legs after stroke; right arm weak; skin clean otherwise.

Tools: CP-MOVE, CP-SKIN · Barthel Index, Katz ADL, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Needs help to wash related to weakness, as evidenced by needs help to reach, wash, and dry and skin not cleaned. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assist as needed. | Helping with the parts he cannot do keeps him clean and comfortable and protects his skin while he recovers from the stroke. | | Let him do what he can. | Doing what he can for himself keeps his abilities, builds confidence and supports recovery after stroke. | | Ensure privacy. | Privacy protects his dignity and lowers embarrassment, which helps him accept help with washing after the stroke. | | Check skin. | Washing is a chance to look at skin for redness, sores or other changes, especially on areas he cannot reach. | | Protect dignity. | Treating him with respect keeps his self-esteem and encourages him to take part in his own care. | ****Expected outcomes**** - Washes face and front independently with set-up. - Completes bathing with minimal help within 1 week. ****Linking the data to the diagnosis**** A stroke patient says, "I can't reach my back." He needs help washing his back and legs, and his right arm is weak, although his skin is otherwise clean. He is already unable to wash alone, so an actual statement fits. The plan aims to give help where needed while he does what he can. The expected outcomes are washing his face and front independently with set-up, then completing bathing with minimal help within 1 week, while his privacy and dignity are protected.

CarePath diagnosis: Needs help to wash related to weakness, as evidenced by needs help to reach, wash, and dry and skin not cleaned.

Intervention	Rationale
Assist as needed.	Helping with the parts he cannot do keeps him clean and comfortable and protects his skin while he recovers from the stroke.
Let him do what he can.	Doing what he can for himself keeps his abilities, builds confidence and supports recovery after stroke.
Ensure privacy.	Privacy protects his dignity and lowers embarrassment, which helps him accept help with washing after the stroke.
Check skin.	Washing is a chance to look at skin for redness, sores or other changes, especially on areas he cannot reach.
Protect dignity.	Treating him with respect keeps his self-esteem and encourages him to take part in his own care.

Expected outcomes: Washes face and front independently with set-up. · Completes bathing with minimal help within 1 week.

Linking the data: A stroke patient says, "I can't reach my back." He needs help washing his back and legs, and his right arm is weak, although his skin is otherwise clean. He is already unable to wash alone, so an actual statement fits. The plan aims to give help where needed while he does what he can. The expected outcomes are washing his face and front independently with set-up, then completing bathing with minimal help within 1 week, while his privacy and dignity are protected.

M6 Needs help to dress

Group: Movement and self-care | Type: Actual problem

Definition: The person cannot choose, put on, or remove clothing alone.

Possible causes: Arm weakness; arthritis; pain; confusion

Signs and symptoms: Struggles with buttons; cannot lift arms; needs help

Scenario. A woman with a shoulder injury cannot put on a shirt.

S: "I can't lift my arm to get my shirt on."

O: Shoulder injury; cannot raise the right arm; fastens buttons slowly.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Needs help to dress related to arm weakness, as evidenced by struggles with buttons and cannot lift arms. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Offer easy-fit clothing. | Loose, stretchy or front-opening clothes need less arm movement, so dressing is easier and less painful. | | Dress the affected side first. | Dressing the injured arm first means it goes through the sleeve while it has the most room, which avoids pulling it. | | Allow time. | Rushing causes pain and frustration, whereas extra time lets her work at her own pace and succeed. | | Encourage independence. | Doing tasks herself builds confidence and keeps her skills, which supports recovery and a sense of control. | ****Expected outcomes**** - Within 1 week: dresses upper body with adaptive clothing in about 10 minutes. - Patient states the technique. ****Linking the data to the diagnosis**** A woman with a shoulder injury says, "I can't lift my arm to get my shirt on." She cannot raise her right arm and fastens buttons slowly, so she already struggles to dress. This is an actual problem, not a risk. The plan aims to make dressing possible and safe using easy-fit clothing and a good technique, giving her time and encouraging independence. Within 1 week the expected outcomes are dressing the upper body with adaptive clothing in about 10 minutes and the patient stating the technique herself.

CarePath diagnosis: Needs help to dress related to arm weakness, as evidenced by struggles with buttons and cannot lift arms.

Intervention	Rationale
Offer easy-fit clothing.	Loose, stretchy or front-opening clothes need less arm movement, so dressing is easier and less painful.
Dress the affected side first.	Dressing the injured arm first means it goes through the sleeve while it has the most room, which avoids pulling it.
Allow time.	Rushing causes pain and frustration, whereas extra time lets her work at her own pace and succeed.
Encourage independence.	Doing tasks herself builds confidence and keeps her skills, which supports recovery and a sense of control.

Expected outcomes: Within 1 week: dresses upper body with adaptive clothing in about 10 minutes. · Patient states the technique.

Linking the data: A woman with a shoulder injury says, "I can't lift my arm to get my shirt on." She cannot raise her right arm and fastens buttons slowly, so she already struggles to dress. This is an actual problem, not a risk. The plan aims to make dressing possible and safe using easy-fit clothing and a good technique, giving her time and encouraging independence. Within 1 week the expected outcomes are dressing the upper body with adaptive clothing in about 10 minutes and the patient stating the technique herself.

M7 Needs help to eat

Group: Movement and self-care | Type: Actual problem

Definition: The person cannot bring food to the mouth or manage meals alone.

Possible causes: Tremor; weak hands; poor vision; confusion; fatigue

Signs and symptoms: Spills food; cannot cut meat; stops eating early

Scenario. A man with Parkinson's disease shakes and spills his soup.

S: "My hands shake and I drop things."

O: Parkinson's disease; spills soup; takes 45 minutes to eat; eats only half.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Needs help to eat related to tremor, as evidenced by spills food and cannot cut meat. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Set up the meal. | Setting out the meal, opening packages and cutting food lets him start eating without wasting energy on tasks he cannot manage. | | Use adaptive cutlery. | Weighted or built-up cutlery steadies the hand and cuts spilling, so he can feed himself. | | Give time. | Eating slowly with a tremor takes longer, and time lets him finish without rushing or becoming tired and frustrated. | | Assist if needed. | Help prevents him going hungry or giving up when the tremor is too strong, while still leaving him to do what he can. | | Check intake. | Checking how much he eats shows whether he is getting enough nourishment and whether the plan is working. | ****Expected outcomes**** - Within 1 week: eats at least 75% of meals, uses adaptive cutlery, finishes meals in under 30 minutes. ****Linking the data to the diagnosis**** A man with Parkinson's disease says, "My hands shake and I drop things." He spills his soup, takes 45 minutes to eat and eats only half. The difficulty is already affecting his food intake, so this is an actual problem and not a risk. The plan aims to help him eat well and keep his independence through set-up, adaptive cutlery and time. Within 1 week the expected outcomes are eating at least 75% of meals, using adaptive cutlery and finishing meals in under 30 minutes.

CarePath diagnosis: Needs help to eat related to tremor, as evidenced by spills food and cannot cut meat.

Intervention	Rationale
Set up the meal.	Setting out the meal, opening packages and cutting food lets him start eating without wasting energy on tasks he cannot manage.
Use adaptive cutlery.	Weighted or built-up cutlery steadies the hand and cuts spilling, so he can feed himself.
Give time.	Eating slowly with a tremor takes longer, and time lets him finish without rushing or becoming tired and frustrated.
Assist if needed.	Help prevents him going hungry or giving up when the tremor is too strong, while still leaving him to do what he can.
Check intake.	Checking how much he eats shows whether he is getting enough nourishment and whether the plan is working.

Expected outcomes: Within 1 week: eats at least 75% of meals, uses adaptive cutlery, finishes meals in under 30 minutes.

Linking the data: A man with Parkinson's disease says, "My hands shake and I drop things." He spills his soup, takes 45 minutes to eat and eats only half. The difficulty is already affecting his food intake, so this is an actual problem and not a risk. The plan aims to help him eat well and keep his independence through set-up, adaptive cutlery and time. Within 1 week the expected outcomes are eating at least 75% of meals, using adaptive cutlery and finishing meals in under 30 minutes.

M8 Needs help to use the toilet

Group: Movement and self-care | Type: Actual problem

Definition: The person cannot get to, use, or clean up after the toilet alone.

Possible causes: Weak legs; pain; confusion; frailty

Signs and symptoms: Cannot transfer to the toilet; needs help to clean

Scenario. A frail woman cannot lift herself from the toilet.

S: "I can't get up from the toilet."

O: Frail; needs two people to stand; transfer unsafe; toilet seat low.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Needs help to use the toilet related to weak legs, as evidenced by cannot transfer to the toilet and needs help to clean. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Provide a raised seat and rails. | A raised seat and rails shorten the distance to stand and give something firm to push on, making standing safer and easier. | | Assist and give privacy. | Help lowers the risk of falls during transfer, and privacy protects her dignity while she is vulnerable. | | Schedule toileting. | Regular offers to toilet prevent urgent rushes and accidents, and the time can be planned when help is ready. | | Protect dignity. | Treating her with respect keeps her self-esteem and her willingness to ask for help when she needs it. | ****Expected outcomes**** - Within 1 week: transfers safely with one person and a raised seat. - No falls. - Dignity kept. ****Linking the data to the diagnosis**** A frail woman says, "I can't get up from the toilet." She needs two people to stand, the transfer is unsafe and the toilet seat is low, so she cannot use the toilet without help. This is already happening, which makes the statement actual and not a risk. The plan aims to make toileting safe with a raised seat and rails, planned toileting and respectful help. Within 1 week the expected outcomes are safe transfers with one person and a raised seat, no falls and her dignity kept.

CarePath diagnosis: Needs help to use the toilet related to weak legs, as evidenced by cannot transfer to the toilet and needs help to clean.

Intervention	Rationale
Provide a raised seat and rails.	A raised seat and rails shorten the distance to stand and give something firm to push on, making standing safer and easier.
Assist and give privacy.	Help lowers the risk of falls during transfer, and privacy protects her dignity while she is vulnerable.
Schedule toileting.	Regular offers to toilet prevent urgent rushes and accidents, and the time can be planned when help is ready.
Protect dignity.	Treating her with respect keeps her self-esteem and her willingness to ask for help when she needs it.

Expected outcomes: Within 1 week: transfers safely with one person and a raised seat. · No falls. · Dignity kept.

Linking the data: A frail woman says, "I can't get up from the toilet." She needs two people to stand, the transfer is unsafe and the toilet seat is low, so she cannot use the toilet without help. This is already happening, which makes the statement actual and not a risk. The plan aims to make toileting safe with a raised seat and rails, planned toileting and respectful help. Within 1 week the expected outcomes are safe transfers with one person and a raised seat, no falls and her dignity kept.

M9 Too little physical activity

Group: Movement and self-care | Type: Actual problem

Definition: Daily movement is below what is needed for good health.

Possible causes: Sedentary job; fear; pain; obesity; low motivation

Signs and symptoms: Little movement; weight gain; weak muscles; breathlessness

Scenario. An office worker sits ten hours a day and does no exercise.

S: "I sit at work all day and don't exercise."

O: Sedentary job; BMI 31; blood pressure 142/90; no regular activity.

Tools: CP-MOVE, CP-SKIN, CP-BREATH · Barthel Index, Katz ADL, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG **CarePath diagnosis:** Too little physical activity related to sedentary job, as evidenced by little movement and weight gain. **Interventions and rationale** | Intervention | Rationale |
|---|---| | Set small goals. | Small goals feel achievable, so he is more likely to start and succeed, which builds motivation to continue. | | Teach benefits. | Understanding how activity helps weight, blood pressure and heart health gives him a personal reason to change. | | Start gently. | Starting gently lowers the risk of injury and discouragement in someone who has not been active. | | Plan a walking routine. | A regular walking routine turns intentions into habit, and walking is easy to do at no cost. | | Review progress. | Reviewing progress shows what is working, allows goals to be adjusted and keeps him motivated. | **Expected outcomes** - Within 4 weeks: walks 20 minutes 5 times weekly. - Patient states 3 benefits and a personal activity goal. **Linking the data to the diagnosis** An office worker says, "I sit at work all day and don't exercise." He has a sedentary job, a BMI of 31, blood pressure of 142/90 and no regular activity. Because the low activity and its effects are already present, an actual statement fits. The plan aims to raise his activity step by step with small goals, teaching and a walking routine. Within 4 weeks the expected outcomes are walking 20 minutes 5 times weekly and stating 3 benefits of activity and a personal activity goal.

CarePath diagnosis: Too little physical activity related to sedentary job, as evidenced by little movement and weight gain.

Intervention	Rationale
Set small goals.	Small goals feel achievable, so he is more likely to start and succeed, which builds motivation to continue.
Teach benefits.	Understanding how activity helps weight, blood pressure and heart health gives him a personal reason to change.
Start gently.	Starting gently lowers the risk of injury and discouragement in someone who has not been active.
Plan a walking routine.	A regular walking routine turns intentions into habit, and walking is easy to do at no cost.
Review progress.	Reviewing progress shows what is working, allows goals to be adjusted and keeps him motivated.

Expected outcomes: Within 4 weeks: walks 20 minutes 5 times weekly. · Patient states 3 benefits and a personal activity goal.

Linking the data: An office worker says, "I sit at work all day and don't exercise." He has a sedentary job, a BMI of 31, blood pressure of 142/90 and no regular activity. Because the low activity and its effects are already present, an actual statement fits. The plan aims to raise his activity step by step with small goals, teaching and a walking routine. Within 4 weeks the expected outcomes are walking 20 minutes 5 times weekly and stating 3 benefits of activity and a personal activity goal.

M10 Difficulty using a walking aid

Group: Movement and self-care | Type: Actual problem

Definition: The person struggles with a frame, crutches, stick, or wheelchair.

Possible causes: New equipment; weakness; poor technique; pain

Signs and symptoms: Wrong height; leaning; tripping; avoids using the aid

Scenario. A patient uses crutches that are too long and nearly falls.

S: "The crutches feel too long."

O: Crutches too tall; leans forward; trips; unsteady on stairs.

Tools: CP-MOVE, CP-SAFE · Barthel Index, Katz ADL, Morse Fall Scale ****CarePath diagnosis:**** Difficulty using a walking aid related to new equipment, as evidenced by wrong height and leaning.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check the fit. | Crutches of the wrong height cause leaning, poor balance and strain on the shoulders, so correct fit must come first. | | Teach technique. | Correct technique, such as the right gait pattern, keeps weight where it should be and lowers the chance of a fall. | | Practice with supervision. | Supervised practice lets the nurse correct mistakes at once, so he learns before he tries alone. | | Watch for tiredness. | Tiredness makes technique worse and raises the risk of falls, so he should rest when needed. | | Reinforce safe use. | Reinforcing safe habits builds confidence and keeps him using the aid properly, including after discharge when no one is watching. | ****Expected outcomes**** - Within 24 hours: uses crutches safely with correct fit and technique. - No falls. - Completes stair practice with the therapist. ****Linking the data to the diagnosis**** A patient says, "The crutches feel too long." The crutches are too tall, he leans forward, trips and is unsteady on stairs, and he nearly fell. These problems are already present, so an actual statement fits and a risk statement does not. The wrong fit and new equipment are the cause. The plan aims to correct the fit and teach safe technique with supervised practice. Within 24 hours the expected outcomes are using the crutches safely with correct fit and technique, no falls and stair practice completed with the therapist.

CarePath diagnosis: Difficulty using a walking aid related to new equipment, as evidenced by wrong height and leaning.

Intervention	Rationale
Check the fit.	Crutches of the wrong height cause leaning, poor balance and strain on the shoulders, so correct fit must come first.
Teach technique.	Correct technique, such as the right gait pattern, keeps weight where it should be and lowers the chance of a fall.
Practice with supervision.	Supervised practice lets the nurse correct mistakes at once, so he learns before he tries alone.
Watch for tiredness.	Tiredness makes technique worse and raises the risk of falls, so he should rest when needed.
Reinforce safe use.	Reinforcing safe habits builds confidence and keeps him using the aid properly, including after discharge when no one is watching.

Expected outcomes: Within 24 hours: uses crutches safely with correct fit and technique. · No falls. · Completes stair practice with the therapist.

Linking the data: A patient says, "The crutches feel too long." The crutches are too tall, he leans forward, trips and is unsteady on stairs, and he nearly fell. These problems are already present, so an actual statement fits and a risk statement does not. The wrong fit and new equipment are the cause. The plan aims to correct the fit and teach safe technique with supervised practice. Within 24 hours the expected outcomes are using the crutches safely with correct fit and technique, no falls and stair practice completed with the therapist.

M11 Muscle weakness

Group: Movement and self-care | Type: Actual problem

Definition: Muscles lack the strength needed for normal tasks.

Possible causes: Illness; inactivity; poor nutrition; nerve disease; aging

Signs and symptoms: Cannot lift; tires quickly; trembling

Scenario. After a long ICU stay, a patient cannot lift his arms.

S: "My arms feel weak."

O: After 3 weeks in ICU; cannot lift arms above the shoulder; grip 3/5.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Muscle weakness related to illness, as evidenced by cannot lift and tires quickly. ****Interventions and rationale**** | Intervention | Rationale |
|---|---| | Encourage exercise. | Regular exercise rebuilds muscle that has wasted from illness and bed rest, and it must increase gradually so he is not overtired. | | Physiotherapy. | Physiotherapists design safe, targeted programs that restore strength and function, which is needed after a long illness such as his ICU stay. | | Give protein-rich nutrition. | Muscles need protein to repair and grow, and illness raises protein needs, so a protein-rich diet supports rebuilding his strength. | | Assist safely. | Safe help prevents falls and strain while his arms and body are weak, and it still lets him do as much as he can. | | Monitor strength. | Measuring strength regularly shows whether he is improving and lets the plan be changed if he is not. | ****Expected outcomes**** - Within 2 weeks: strength improves one grade. - Sits unsupported 10 minutes. - Completes daily exercises. ****Linking the data to the diagnosis**** After 3 weeks in ICU, a patient says, "My arms feel weak." He cannot lift his arms above the shoulder and his grip is 3/5, so the weakness is measurable and already present. That makes this an actual diagnosis, not a risk. Illness is the cause. The plan aims to rebuild strength through exercise, physiotherapy and good nutrition while helping him safely. Within 2 weeks the expected outcomes are strength improving by one grade, sitting unsupported for 10 minutes and completing his daily exercises.

CarePath diagnosis: Muscle weakness related to illness, as evidenced by cannot lift and tires quickly.

Intervention	Rationale
Encourage exercise.	Regular exercise rebuilds muscle that has wasted from illness and bed rest, and it must increase gradually so he is not overtired.
Physiotherapy.	Physiotherapists design safe, targeted programs that restore strength and function, which is needed after a long illness such as his ICU stay.
Give protein-rich nutrition.	Muscles need protein to repair and grow, and illness raises protein needs, so a protein-rich diet supports rebuilding his strength.
Assist safely.	Safe help prevents falls and strain while his arms and body are weak, and it still lets him do as much as he can.
Monitor strength.	Measuring strength regularly shows whether he is improving and lets the plan be changed if he is not.

Expected outcomes: Within 2 weeks: strength improves one grade. · Sits unsupported 10 minutes. · Completes daily exercises.

Linking the data: After 3 weeks in ICU, a patient says, "My arms feel weak." He cannot lift his arms above the shoulder and his grip is 3/5, so the weakness is measurable and already present. That makes this an actual diagnosis, not a risk. Illness is the cause. The plan aims to rebuild strength through exercise, physiotherapy and good nutrition while helping him safely. Within 2 weeks the expected outcomes are strength improving by one grade, sitting unsupported for 10 minutes and completing his daily exercises.

M12 Stiff joints or shortened muscles

Group: Movement and self-care | Type: Actual problem

Definition: Joints move poorly or muscles tighten, limiting range of motion.

Possible causes: Long immobility; arthritis; nerve damage; burns; stroke

Signs and symptoms: Reduced movement; pain on stretching; fixed positions

Scenario. A patient lying in bed for weeks has a bent, stiff knee.

S: "My knee won't straighten."

O: Knee fixed bent after weeks in bed; pain on stretching; range of movement 40 degrees short.

Tools: CP-MOVE, CP-PAIN · Barthel Index, Katz ADL, NRS 0-10, FLACC, PAINAD ****CarePath diagnosis:**** Stiff joints or shortened muscles related to long immobility, as evidenced by reduced movement and pain on stretching. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Do range-of-motion exercises. | Moving each joint through its full range regularly keeps muscles and joint tissues from tightening and shortening further. | | Position correctly. | Good positioning keeps joints in a position that prevents the knee staying bent and the muscles tightening even more. | | Use splints as ordered. | Splints hold the joint in a good position and gently stretch tight tissue, but only as ordered so they do no harm. | | Encourage early movement. | Early movement keeps joints and muscles flexible and prevents further shortening and stiffness that come from lying still. | | Stretch gently. | Gentle, slow stretching gradually lengthens tight tissue without tearing it or causing extra pain, which would make him resist movement. | ****Expected outcomes**** - Within 1 week: range of movement improves by 10 degrees, no new contractures. - Splint used as ordered. ****Linking the data to the diagnosis**** A patient who has lain in bed for weeks says, "My knee won't straighten." The knee is fixed bent, it hurts on stretching and the range of movement is 40 degrees short. Stiffness and shortening are already present, so this is an actual diagnosis resulting from long immobility. The plan aims to stop it getting worse and begin to reverse it with exercises, positioning, splints as ordered and gentle stretching. Within 1 week the expected outcomes are improvement of 10 degrees in range of movement, no new contractures and splint use as ordered.

CarePath diagnosis: Stiff joints or shortened muscles related to long immobility, as evidenced by reduced movement and pain on stretching.

Intervention	Rationale
Do range-of-motion exercises.	Moving each joint through its full range regularly keeps muscles and joint tissues from tightening and shortening further.
Position correctly.	Good positioning keeps joints in a position that prevents the knee staying bent and the muscles tightening even more.
Use splints as ordered.	Splints hold the joint in a good position and gently stretch tight tissue, but only as ordered so they do no harm.
Encourage early movement.	Early movement keeps joints and muscles flexible and prevents further shortening and stiffness that come from lying still.
Stretch gently.	Gentle, slow stretching gradually lengthens tight tissue without tearing it or causing extra pain, which would make him resist movement.

Expected outcomes: Within 1 week: range of movement improves by 10 degrees, no new contractures. · Splint used as ordered.

Linking the data: A patient who has lain in bed for weeks says, "My knee won't straighten." The knee is fixed bent, it hurts on stretching and the range of movement is 40 degrees short. Stiffness and shortening are already present, so this is an actual diagnosis resulting from long immobility. The plan aims to stop it getting worse and begin to reverse it with exercises, positioning, splints as ordered and gentle stretching. Within 1 week the expected outcomes are improvement of 10 degrees in range of movement, no new contractures and splint use as ordered.

M13 Cannot groom or care for appearance

Group: Movement and self-care | Type: Actual problem

Definition: The person cannot manage hair, teeth, nails, shaving, or similar personal care.

Possible causes: Weakness; fatigue; low mood; paralysis

Signs and symptoms: Unwashed hair; unkempt look; teeth not brushed

Scenario. A depressed patient stops brushing his hair and teeth.

S: "I just don't care how I look anymore."

O: Unwashed hair; unshaven; teeth not brushed for 3 days; low mood noted.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Cannot groom or care for appearance related to low mood, as evidenced by unwashed hair, being unshaven, and teeth not brushed for 3 days.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assist with grooming. | Help with the parts he is not managing keeps him clean and comfortable and protects his mouth and skin health. | | Encourage independence. | Doing tasks himself keeps his skills and builds a sense of control, which supports recovery of mood. | | Offer choices. | Choices, such as what to wear or when to groom, give him back some control, which helps when mood is low. | | Support dignity. | Care that respects dignity improves self-worth and encourages him to take an interest in himself again. | ****Expected outcomes**** - Within 1 week: grooms daily with prompting and says he feels more like himself. - Hygiene checks completed. ****Linking the data to the diagnosis**** A depressed patient says, "I just don't care how I look anymore." His hair is unwashed, he is unshaven and he has not brushed his teeth for 3 days, with low mood noted. He is not caring for his appearance now, so an actual statement fits and a risk statement does not. The plan aims to restore grooming with help, choices and respect. Within 1 week the expected outcomes are grooming daily with prompting, saying he feels more like himself and completed hygiene checks.

CarePath diagnosis: Cannot groom or care for appearance related to low mood, as evidenced by unwashed hair, being unshaven, and teeth not brushed for 3 days.

Intervention	Rationale
Assist with grooming.	Help with the parts he is not managing keeps him clean and comfortable and protects his mouth and skin health.
Encourage independence.	Doing tasks himself keeps his skills and builds a sense of control, which supports recovery of mood.
Offer choices.	Choices, such as what to wear or when to groom, give him back some control, which helps when mood is low.
Support dignity.	Care that respects dignity improves self-worth and encourages him to take an interest in himself again.

Expected outcomes: Within 1 week: grooms daily with prompting and says he feels more like himself.
· Hygiene checks completed.

Linking the data: A depressed patient says, "I just don't care how I look anymore." His hair is unwashed, he is unshaven and he has not brushed his teeth for 3 days, with low mood noted. He is not caring for his appearance now, so an actual statement fits and a risk statement does not. The plan aims to restore grooming with help, choices and respect. Within 1 week the expected outcomes are grooming daily with prompting, saying he feels more like himself and completed hygiene checks.

M14 Unsafe wheelchair or transfer

Group: Movement and self-care | Type: Actual problem

Definition: Moving between bed, chair, and toilet is unsafe for the person or the helper.

Possible causes: Weak legs; heavy patient; poor technique; no equipment

Signs and symptoms: Near falls during transfer; pain in the helper's back

Scenario. A nurse transfers a heavy patient alone and strains her back.

S: "I'm afraid I'll fall when you move me."

O: Heavy patient; nurse transferred alone and strained her back; patient grips tightly; near fall.

Tools: CP-MOVE, CP-SAFE · Barthel Index, Katz ADL, Morse Fall Scale ****CarePath diagnosis:**** Unsafe wheelchair or transfer related to weak legs, as evidenced by near falls during transfer and pain in the helper's back. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use hoists or slide sheets. | Hoists and slide sheets take the load off the nurse and move the patient smoothly, which lowers the risk of back injury and dropping her. | | Use two staff when needed. | A heavy patient is too much for one person, and a second staff member shares the load and helps keep her stable. | | Lock wheels. | Locked wheels stop the chair rolling away during transfer, which is a common cause of falls. | | Teach safe transfer. | Correct technique protects the nurse's back and keeps the patient steady, so she feels safe and cooperates. | | Assess ability first. | Assessment shows how much she can do herself and which equipment and how many staff are needed, so the right method is chosen. ****Expected outcomes**** - All transfers done with equipment and two staff. - No falls or injuries. - Patient says she feels safe. ****Linking the data to the diagnosis**** A patient says, "I'm afraid I'll fall when you move me." She is heavy, the nurse transferred her alone and strained her back, the patient gripped tightly and there was a near fall. The unsafe transfer has already happened and injured a helper, so an actual statement fits. The plan aims to make every transfer safe by using equipment and two staff, locking wheels and assessing first. The expected outcomes are all transfers with equipment and two staff, no falls or injuries and the patient saying she feels safe.

CarePath diagnosis: Unsafe wheelchair or transfer related to weak legs, as evidenced by near falls during transfer and pain in the helper's back.

Intervention	Rationale
Use hoists or slide sheets.	Hoists and slide sheets take the load off the nurse and move the patient smoothly, which lowers the risk of back injury and dropping her.
Use two staff when needed.	A heavy patient is too much for one person, and a second staff member shares the load and helps keep her stable.
Lock wheels.	Locked wheels stop the chair rolling away during transfer, which is a common cause of falls.
Teach safe transfer.	Correct technique protects the nurse's back and keeps the patient steady, so she feels safe and cooperates.
Assess ability first.	Assessment shows how much she can do herself and which equipment and how many staff are needed, so the right method is chosen.

Expected outcomes: All transfers done with equipment and two staff. · No falls or injuries. · Patient says she feels safe.

Linking the data: A patient says, "I'm afraid I'll fall when you move me." She is heavy, the nurse transferred her alone and strained her back, the patient gripped tightly and there was a near fall. The unsafe transfer has already happened and injured a helper, so an actual statement fits. The plan aims to make every transfer safe by using equipment and two staff, locking wheels and assessing first. The expected outcomes are all transfers with equipment and two staff, no falls or injuries and the patient saying she feels safe.

M15 Cannot do household tasks

Group: Movement and self-care | Type: Actual problem

Definition: Cooking, cleaning, shopping, or laundry are beyond the person's current ability.

Possible causes: Weakness; poor memory; poor vision; pain

Signs and symptoms: Dirty home; no meals; unpaid bills; unsafe kitchen

Scenario. An older widow cannot clean or cook after a fracture.

S: "I can't cook or clean since my fracture."

O: Lives alone; unwashed dishes; no fresh food; uses a walker.

Tools: CP-MOVE · Barthel Index, Katz ADL **CarePath diagnosis:** Cannot do household tasks related to weakness, as evidenced by dirty home and no meals. **Interventions and rationale** | Intervention | Rationale | |---|---| | Assess abilities. | Assessing what she can still do shows where help is really needed, so support fits her needs and does not remove her skills. | | Arrange home help. | Home help covers tasks she cannot manage, such as cooking and cleaning, so she has meals and a safe home while she recovers. | | Teach safe methods. | Safe methods, such as sitting to prepare food, let her do tasks with less pain and a lower risk of falling. | | Refer to community support. | Community services give ongoing support after discharge, which matters because she lives alone and has no one else to help daily. | **Expected outcomes** - Within 1 week: home help arranged, regular meals, house safe. - Patient names community help available. **Linking the data to the diagnosis** An older widow says, "I can't cook or clean since my fracture." She lives alone, has unwashed dishes and no fresh food, and uses a walker. The household tasks are already not being done, so an actual statement fits and a risk statement does not. The plan aims to make sure she is fed and her home is safe by assessing her abilities, arranging home help and linking her with community support. Within 1 week the expected outcomes are home help arranged, regular meals, a safe house and her naming the community help available.

CarePath diagnosis: Cannot do household tasks related to weakness, as evidenced by dirty home and no meals.

Intervention	Rationale
Assess abilities.	Assessing what she can still do shows where help is really needed, so support fits her needs and does not remove her skills.
Arrange home help.	Home help covers tasks she cannot manage, such as cooking and cleaning, so she has meals and a safe home while she recovers.
Teach safe methods.	Safe methods, such as sitting to prepare food, let her do tasks with less pain and a lower risk of falling.
Refer to community support.	Community services give ongoing support after discharge, which matters because she lives alone and has no one else to help daily.

Expected outcomes: Within 1 week: home help arranged, regular meals, house safe. · Patient names community help available.

Linking the data: An older widow says, "I can't cook or clean since my fracture." She lives alone, has unwashed dishes and no fresh food, and uses a walker. The household tasks are already not being done, so an actual statement fits and a risk statement does not. The plan aims to make sure she is fed and her home is safe by assessing her abilities, arranging home help and linking her with community support. Within 1 week the expected outcomes are home help arranged, regular meals, a safe house and her naming the community help available.

M16 Poor balance

Group: Movement and self-care | Type: Actual problem

Definition: Unsteady standing or walking raises the chance of falling.

Possible causes: Weak legs; dizziness; nerve disease; inner ear problems

Signs and symptoms: Sways; holds furniture; wide steps; falls

Scenario. An older man sways when standing and holds the wall.

S: "I feel like I'm swaying."

O: Sways when standing; holds the wall; wide steps; positive balance test.

Tools: CP-MOVE · Barthel Index, Katz ADL **CarePath diagnosis:** Poor balance related to weak legs and dizziness, as evidenced by swaying when standing, holding the wall, wide steps, and a positive balance test. **Interventions and rationale** | Intervention | Rationale | |---|---| | Assess balance. | Assessing balance shows how severe the problem is and which causes, such as weak legs or dizziness, need treatment. | | Use an aid. | A suitable aid widens his base of support and gives him something steady to hold, which lowers the risk of falls. | | Non-slip shoes. | Non-slip shoes grip the floor and give a stable base, lowering the risk of slipping. | | Remove hazards. | Clutter, wet floors and loose rugs can trip someone who is unsteady, so removing them cuts the chance of a fall. | | Teach balance exercises. | Balance exercises strengthen the muscles and reflexes that keep a person upright, improving stability over time. | | Assist. | Help close by can catch him if he sways, which prevents a fall while his balance is poor. | **Expected outcomes** - No falls. - Balance score improves in 2-4 weeks. - Walks with the correct aid. - Patient does balance exercises. **Linking the data to the diagnosis** The patient sways when he stands, holds the wall, takes wide steps, and has a positive balance test. These findings are present now, so the correct choice is the actual statement Poor balance (M16) and not a risk statement. It is also different from Likely to fall (S1), which describes the chance of a fall. The plan therefore aims to improve balance and to prevent the fall that his weak legs and dizziness make likely, by using an aid, non-slip shoes, and balance exercises.

CarePath diagnosis: Poor balance related to weak legs and dizziness, as evidenced by swaying when standing, holding the wall, wide steps, and a positive balance test.

Intervention	Rationale
Assess balance.	Assessing balance shows how severe the problem is and which causes, such as weak legs or dizziness, need treatment.
Use an aid.	A suitable aid widens his base of support and gives him something steady to hold, which lowers the risk of falls.
Non-slip shoes.	Non-slip shoes grip the floor and give a stable base, lowering the risk of slipping.
Remove hazards.	Clutter, wet floors and loose rugs can trip someone who is unsteady, so removing them cuts the chance of a fall.
Teach balance exercises.	Balance exercises strengthen the muscles and reflexes that keep a person upright, improving stability over time.
Assist.	Help close by can catch him if he sways, which prevents a fall while his balance is poor.

Expected outcomes: No falls. · Balance score improves in 2-4 weeks. · Walks with the correct aid. · Patient does balance exercises.

Linking the data: The patient sways when he stands, holds the wall, takes wide steps, and has a positive balance test. These findings are present now, so the correct choice is the actual statement Poor balance (M16) and not a risk statement. It is also different from Likely to fall (S1), which describes the chance of a fall. The plan therefore aims to improve balance and to prevent the fall that his weak legs and dizziness make likely, by using an aid, non-slip shoes, and balance exercises.

M17 Loss of limb movement

Group: Movement and self-care | Type: Actual problem

Definition: One or more limbs cannot move or move only weakly.

Possible causes: Stroke; spinal injury; nerve injury; muscle disease

Signs and symptoms: Cannot move an arm or leg; weak grip; one-sided weakness

Scenario. A stroke patient cannot lift his right arm.

S: "I can't lift my right arm."

O: Stroke; right arm and leg weak (2/5); cannot raise arm against gravity.

Tools: CP-MOVE · Barthel Index, Katz ADL ****CarePath diagnosis:**** Loss of limb movement related to stroke, as evidenced by cannot move an arm or leg and weak grip. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Position correctly. | Correct positioning keeps the weak joints aligned and supported, which prevents shoulder strain, swelling and stiffness while the arm cannot hold itself against gravity. | | Do passive exercises. | Moving the joints gently through their full range for the patient keeps them flexible and maintains circulation, which helps prevent contractures while his own muscle control is limited. | | Protect from injury. | A weak limb is easily bumped, pulled or trapped, and the patient may not react in time, so protecting it prevents bruising, joint damage and other avoidable injury. | | Encourage use of the affected limb. | Safe, supported use of the affected limb helps the brain relearn movement pathways and builds confidence, which supports recovery of strength after a stroke. | | Refer to therapy. | Physiotherapists and occupational therapists have specialist skills to set graded exercises, splints and aids, which gives the patient the best chance of regaining function. | ****Expected outcomes**** - Maintains joint movement with no contracture. - Improves by one power grade in 2 weeks. - Supports the affected arm correctly. ****Linking the data to the diagnosis**** The patient has had a stroke and says, "I can't lift my right arm." The nurse finds the right arm and leg weak at 2/5, and he cannot raise the arm against gravity, so movement is already lost. This is an actual problem, not a risk, because the weakness is present now. The plan aims to keep the joints moving with no contracture, protect the arm, and support it correctly. The expected outcome is improvement by one power grade in 2 weeks, with therapy guiding recovery.

CarePath diagnosis: Loss of limb movement related to stroke, as evidenced by cannot move an arm or leg and weak grip.

Intervention	Rationale
Position correctly.	Correct positioning keeps the weak joints aligned and supported, which prevents shoulder strain, swelling and stiffness while the arm cannot hold itself against gravity.
Do passive exercises.	Moving the joints gently through their full range for the patient keeps them flexible and maintains circulation, which helps prevent contractures while his own muscle control is limited.
Protect from injury.	A weak limb is easily bumped, pulled or trapped, and the patient may not react in time, so protecting it prevents bruising, joint damage and other avoidable injury.
Encourage use of the affected limb.	Safe, supported use of the affected limb helps the brain relearn movement pathways and builds confidence, which supports recovery of strength after a stroke.
Refer to therapy.	Physiotherapists and occupational therapists have specialist skills to set graded exercises, splints and aids, which gives the patient the best chance of regaining function.

Expected outcomes: Maintains joint movement with no contracture. · Improves by one power grade in 2 weeks. · Supports the affected arm correctly.

Linking the data: The patient has had a stroke and says, "I can't lift my right arm." The nurse finds the right arm and leg weak at 2/5, and he cannot raise the arm against gravity, so movement is already lost. This is an actual problem, not a risk, because the weakness is present now. The plan aims to keep the joints moving with no contracture, protect the arm, and support it correctly. The expected outcome is improvement by one power grade in 2 weeks, with therapy guiding recovery.

M18 Muscle wasting from bed rest

Group: Movement and self-care | Type: Risk problem

Definition: Long inactivity may cause weakness, stiffness, and loss of muscle.

Risk factors: Long bed rest; paralysis; severe illness; no exercise

Warning signs: Weak muscles; thin limbs; stiff joints; pressure sores

Scenario. A patient has been on bed rest in ICU for five days with severe illness.

S: "I am too weak to move."

O: Day 5 in ICU; lightly sedated; no exercise yet; muscle bulk normal; joints move freely; skin intact.

Tools: CP-MOVE, CP-SKIN · Barthel Index, Katz ADL, Braden Scale, TIME wound chart **CarePath** diagnosis: Muscle wasting from bed rest related to long bed rest and severe illness (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | |---|---| | Mobilize early. | Getting the patient moving early, as soon as it is safe, keeps muscles working and circulation active, which slows the weakness and stiffness that long inactivity causes. | | Exercise. | Regular active or assisted exercise loads the muscles and joints, which helps preserve muscle bulk and joint range even while the patient is critically ill. | | Give protein nutrition. | Muscle needs enough protein to repair and maintain itself during severe illness, and inactivity speeds muscle loss, so adequate protein supports strength and healing. | | Turn often. | Changing position often relieves pressure on bony areas and keeps blood flowing to the skin, which helps prevent pressure injury in a patient who cannot easily move. | | Physiotherapy. | Physiotherapists can design safe, graded movement and strengthening for a lightly sedated ICU patient, which reduces the chance of lasting weakness. | **Expected outcomes** - Sits out of bed daily. - Muscle strength improves. - No new pressure injury. - Protein targets met. **Linking the data to the diagnosis** The patient has been on bed rest in ICU for five days with severe illness and says, "I am too weak to move." This is a risk diagnosis because the problem has not happened yet: muscle bulk is normal, joints move freely and skin is intact. The diagnosis rests on risk factors, namely day 5 in ICU, light sedation and no exercise so far. The plan aims to prevent wasting by sitting out of bed daily, improving strength, meeting protein targets and avoiding any new pressure injury.

CarePath diagnosis: Muscle wasting from bed rest related to long bed rest and severe illness (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Mobilize early.	Getting the patient moving early, as soon as it is safe, keeps muscles working and circulation active, which slows the weakness and stiffness that long inactivity causes.
Exercise.	Regular active or assisted exercise loads the muscles and joints, which helps preserve muscle bulk and joint range even while the patient is critically ill.
Give protein nutrition.	Muscle needs enough protein to repair and maintain itself during severe illness, and inactivity speeds muscle loss, so adequate protein supports strength and healing.
Turn often.	Changing position often relieves pressure on bony areas and keeps blood flowing to the skin, which helps prevent pressure injury in a patient who cannot easily move.
Physiotherapy.	Physiotherapists can design safe, graded movement and strengthening for a lightly sedated ICU patient, which reduces the chance of lasting weakness.

Expected outcomes: Sits out of bed daily. · Muscle strength improves. · No new pressure injury. · Protein targets met.

Linking the data: The patient has been on bed rest in ICU for five days with severe illness and says, "I am too weak to move." This is a risk diagnosis because the problem has not happened yet: muscle bulk is normal, joints move freely and skin is intact. The diagnosis rests on risk factors, namely day 5 in ICU, light sedation and no exercise so far. The plan aims to prevent wasting by sitting out of bed daily, improving strength, meeting protein targets and avoiding any new pressure injury.

M19 Poor body positioning

Group: Movement and self-care | Type: Actual problem

Definition: The body is held in a position that is uncomfortable or harmful.

Possible causes: Weakness; pain; devices; staff unaware of correct positions

Signs and symptoms: Slumped; twisted spine; hanging limbs; pressure on one area

Scenario. A patient slides down the chair with his neck bent.

S: "My neck hurts when I sit."

O: Slumps in the chair; neck bent; sliding down; pressure on the sacrum.

Tools: CP-MOVE, CP-PAIN, CP-SKIN · Barthel Index, Katz ADL, NRS 0–10, FLACC, PAINAD, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Poor body positioning related to weakness, as evidenced by slumped and twisted spine. ****Interventions and rationale**** | Intervention | Rationale | |---| | Align the body. | Aligning the head, neck, spine and limbs spreads body weight evenly, which reduces strain on muscles and joints and relieves neck pain. | | Support with pillows. | Pillows fill gaps and hold the body in a good position, which reduces effort for a weak patient and eases pressure on sore or stressed areas. | | Reposition often. | Changing position regularly stops prolonged pressure on one area such as the sacrum, which protects the skin and tissue underneath and prevents stiffness. | | Use chair cushions. | A suitable cushion spreads pressure and helps hold the hips back in the chair, which reduces sliding down and protects the skin over the sacrum. | | Teach staff. | Staff who know correct positions can keep the patient well placed at every shift and check, so the improvement does not depend on one nurse. | ****Expected outcomes**** - Position corrected every 2 hours. - No pain or pressure damage. - Patient sits upright with support. ****Linking the data to the diagnosis**** The patient slides down the chair with his neck bent and says, "My neck hurts when I sit." The nurse sees him slumped, the neck bent and pressure on the sacrum, so poor positioning is already causing discomfort and risk to the skin. It is an actual problem, not a risk. The plan aims to correct his position every 2 hours, prevent pain or pressure damage, and help him sit upright with support, so the neck pain settles and the sacrum is protected.

CarePath diagnosis: Poor body positioning related to weakness, as evidenced by slumped and twisted spine.

Intervention	Rationale
Align the body.	Aligning the head, neck, spine and limbs spreads body weight evenly, which reduces strain on muscles and joints and relieves neck pain.
Support with pillows.	Pillows fill gaps and hold the body in a good position, which reduces effort for a weak patient and eases pressure on sore or stressed areas.
Reposition often.	Changing position regularly stops prolonged pressure on one area such as the sacrum, which protects the skin and tissue underneath and prevents stiffness.
Use chair cushions.	A suitable cushion spreads pressure and helps hold the hips back in the chair, which reduces sliding down and protects the skin over the sacrum.
Teach staff.	Staff who know correct positions can keep the patient well placed at every shift and check, so the improvement does not depend on one nurse.

Expected outcomes: Position corrected every 2 hours. · No pain or pressure damage. · Patient sits upright with support.

Linking the data: The patient slides down the chair with his neck bent and says, "My neck hurts when I sit." The nurse sees him slumped, the neck bent and pressure on the sacrum, so poor positioning is already causing discomfort and risk to the skin. It is an actual problem, not a risk. The plan aims to correct his position every 2 hours, prevent pain or pressure damage, and help him sit upright with support, so the neck pain settles and the sacrum is protected.