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Long-Term Care Survey Alert

Care Planning: A Bed Mobility Care Plan Can Turn Around Your Quality Indicators/Measures

Consider these resident-specific interventions.

An individualized bed mobility care plan can get your clinical outcomes moving in the right direction.

"Bed mobility is very significant not only to MDS scoring but also for care planning," says **Sheryl Rosenfield, RN,** director of clinical services for **Zimmet Healthcare Group** in Morganville, NJ.

Left unaddressed, a resident's impairment in bed mobility can lead to a long list of problems -- and potential F tags. The resident may develop "pressure ulcers, decline in range of motion, weakness and depression," notes **Cheryl Field, RN, MSN,** a rehabilitation nurse expert with **LTCQ Inc.** in Lexington, MA. Also on the list: incontinence and fecal impaction, adds Rosenfield. Bed mobility is also a key quality-of-life issue, which is a growing focus for the **Centers for Medicare & Medicaid Services** (see "Don't Be Waylaid: Here's What's Coming Down The Survey Pike," on p. 36).

Start With the Bed

Position a resident's bed in a way that enhances his independence and quality of life. For example, make sure the person can "view and reach objects such as pictures or other objects of interest on the bedside table," says Field, as "these can provide emotional support."

For example, one resident may prefer to see people coming and going in the hall while another likes to look out the window.

"If the person prefers to be on her right side -- or can only turn independently to the right side -- then position the bedside table on the right," advises Field. If that resident uses a siderail as a bed mobility aid, put the siderail on this right side, she adds.

Teach These Key Moves

If a resident can help himself get out of bed, the care plan might include an intervention to teach him how to do so properly. Discourage him from moving from supine to sitting by "pulling up with his abdominal muscles," says Field. That's hard to do, "and can increase post-operative abdominal incision pain."

Instead: Say a resident prefers his right side or that's his most functional side. He can roll onto his right shoulder and use his left hand to push up against the bed into a sitting position, suggests Field. That way, he "uses his side abdominal and arm muscles."

Don't encourage dependence: If the caregiver puts her arms around the person to pull him to a sitting position each time, the resident will lose strength -- and confidence -- over time, cautions Field.

Consider Positioning Devices

Field notes that staff often think of a trapeze for residents who have had "bilateral hip or knee surgery or spinal cord injuries." But "lower functioning" residents can benefit from positioning devices, including a trapeze and siderails.

For example, to position herself in the middle of the bed, the person can learn to turn on her side, "reach for the rail and push off that rail to position back in the middle of the bed," says Field. Make sure residents who are dependent in bed mobility have an electronic bed that they can adjust from a lying position, suggests Field. And make sure they have the bed controls within reach.

Be specific: Fields finds that many times bed mobility interventions on the care plan are "so generic that staff don't really follow them.".

Example: Instead of writing "assist resident to turn and reposition as needed," consider a more specific directive, such as "assure right siderail is in the up position to enable resident to reposition himself in bed," suggests Field.

Get Restorative With the Bed Mobility Program

Staff can do a restorative nursing program specifically for bed mobility and code it in MDS Section P3, if it meets the RAI manual requirements. The program would include specific teaching about bed mobility at least 15 minutes total a day. For example, you could teach the resident five minutes three times a day, says Field.

Additional programs that might benefit the focus on bed mobility include "dining, grooming and range of motion," suggests Field.

"For a dining program, you might help reposition the person in bed for meals and focus on dining skills for the first five minutes,"says Field. Then you'd provide assistance once the person gets tired and is less hungry, she adds.