An integrated practice approach to mobility care for older people


Abstract
Mobility is important to older people in nursing homes and residential facilities since it contributes to their health and quality of life. Many residents in such facilities require some form of assistance to move and accomplish activities of daily living. Therefore, nurses and healthcare assistants should have the knowledge and skills to provide effective mobility care. This article discusses three important aspects of mobility care: safety, mobility optimisation and person-centred approaches to care. Safety is important as residents and staff are at risk of injury during mobility care. Mobility optimisation is essential to ensure residents maintain their independence. Person-centred approaches to care are central to providing an integrated approach to mobility care.

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Introduction
Mobility is associated with movement. In the literature on care of older people, the term ‘mobility’ is used primarily when assessing the ability of older people to move in their environment (Rush and Ouellet 1993). While there was an assumed understanding of the meaning of mobility care, this term did not appear in the literature until it was introduced by Taylor et al (2012). Mobility care is a useful descriptor of what occurs when nurses assist older people to move.

Aims and intended learning outcomes
This article aims to help nurses to enhance their mobility care practices for older people in nursing homes and residential facilities. It emphasises important aspects of mobility care and discusses how nurses can best assist older people with their mobility needs. The article may be of value to nurses who assist older people in other healthcare settings. After reading this article and completing the time out activities you should be able to:
- Describe the benefits of mobility care for older people and nursing staff.
- Discuss the three important aspects of mobility care.
- Reflect on the way you make decisions related to mobility care.
- Identify how to improve your mobility care practices.

Benefits of mobility
Older people’s mobility contributes to their health, quality of life and independence. Residents’ efforts to remain mobile can assist with maintaining their physical function and activities of daily living (Forster et al 2009, Weening-Dijkstra et al 2011). By remaining mobile, residents can maintain their independence and have increased
decisional and executional autonomy (Taylor et al 2014a). Maintaining mobility may also mean that residents are less likely to experience depression (Eisses et al 2004, Atkins et al 2013). It is important to recognise that mobility contributes to the prevention of pressure ulcers (National Pressure Ulcer Advisory Panel et al 2014). Regular movement reduces the risk of sustained pressure on individuals’ bony prominences, and a resident who can walk to the toilet is less likely to experience incontinence or remain sitting on wet incontinence pads.

**Complete time out activity**

**Principles of mobility care**

It is important that nurses consider three essential interrelated aspects of mobility care: safety, mobility optimisation and person-centred approaches to care. Safety and mobility optimisation may be considered as integral to person-centredness. However, for the purposes of clarity these aspects are discussed separately.

**Safety**

Both residents and staff have safety needs during mobility care. There have been concerns about nurses sustaining injuries related to moving and handling in the UK and Australia since the 1990s (Green 1996, Fletcher 1997, Health and Safety Executive 2004, Pocock and Bonner 2004). Strategies have been implemented to reduce staff moving and handling injuries in the United States (US) and Europe (Nelson et al 2005, Hignett et al 2007, Koppelaar et al 2009, 2013). Assistive technologies, for example lifting equipment, are increasingly available in developed countries as part of efforts to prevent such injuries. There is increased uptake of assistive devices in nursing homes compared to other settings (Koppelaar et al 2011). However, additional individual and organisational factors should be addressed to improve moving and handling safety for residents and staff (Yassi and Lockhart 2013, Kay et al 2014a).

Episodes where residents being assisted by staff become non-cooperative or aggressive represent a potential risk for staff injury (Galik et al 2009, Taylor et al 2015a). The number of residents with dementia is increasing and some of these individuals may exhibit resistive behaviour. A person-centred approach to care that engages with the person and their view of what is happening (their reality) can successfully reduce episodes of agitation and aggression (Sloane et al 2004, Chenoweth et al 2009). Specialised approaches, which are discussed in this article, are also required when staff assist people with dementia to move (Wångblad et al 2009).

There is a lack of focus in the contemporary literature on the injuries residents may experience as a result of inappropriate moving and handling practices (Elnitsky et al 2014). Inappropriate moving and handling practices may result in falls, skin injuries such as bruising and skin tears (Elnitsky et al 2014, Taylor et al 2015a), pain, loss of dignity and/or loss of control (Taylor et al 2014a). Loss of dignity or control may be described as emotional trauma; a less visible form of injury that may be overlooked by staff in a busy environment. If care is to be holistic, a resident’s dignity and sense of control should be considered as important as their physical safety. However, the tensions that arise when considering staff and resident safety, and issues of autonomy and empowerment, are not always easily resolved (Kay et al 2014b).

Safety is best promoted by multiple systemic safeguards, rather than by relying on error-free performance by individuals who are intrinsically fallible (Coiera 2004, Reason 2005). The Swiss cheese model (Reason 1990, 2000) provides a useful analogue for understanding safety in mobility care, since latent conditions in residential environments for older people may generate risks that are unidentified or underappreciated (Reason 2005). In this model, accidents and injuries can occur when ‘holes’ in different safeguards align; deficiencies in each level of safeguard can be configured such that these line up and the protection afforded to carers and residents is bypassed (Taylor et al 2014b).

**Complete time out activity**

**Mobility optimisation**

Mobility optimisation is an essential component of mobility care; residents who do not have the capacity for improved mobility should have the opportunity to maintain their current activity levels or minimise their rate of deterioration. Staff involvement is frequently required to enable resident mobility. Alternatively, equipment such as bed poles, ‘monkey bars’ and gait aids may assist residents to move themselves.

The onus on staff to optimise residents’ mobility in the context of a safety culture may result in tensions, as previously discussed (Kneafsey 2007, Taylor et al 2011, 2012). The use of safe moving and handling protocols may achieve a desired endpoint, such as the transfer of a resident from a bed to a chair, while simultaneously disregarding a resident’s
Nursing Standard March 16 :: Vol 30 No 29 :: 2016

53

Identify and list five strategies that you could use in your area of practice to provide safe mobility care. Discuss your ideas with a senior colleague.

Complete time out activity

Person-centred approaches to care

Person-centred approaches to mobility care extend beyond the use of predetermined strategies. The concept of person-centred care in dementia was developed by Kitwood (1997) and has since been developed further in the US and UK (Whitehouse and George 2008, Power 2010, 2014, Sheard 2011). Four defining attributes of person-centred care were identified in a concept analysis by Morgan and Yoder (2012): care that is individualised, holistic, respectful and empowering. The main focuses of person-centred care are acknowledging or meeting the individual, the importance of relationships and residents’ need for meaningful engagement in life (Power 2010).

Person-centredness has become a familiar concept in the care of older people. However, there is inadequate understanding of the concept, of what person-centred care looks like in practice and how it may be evaluated (Morgan and Yoder 2012, Edvardsson et al 2014). One challenge is that person-centredness may be considered an add-on to care; a separate task to be incorporated into a busy schedule.

Person-centred practice should be considered a ‘way of being’ that is evidenced in how staff carry out their care tasks, rather than as an additional task or strategy. The manner in which staff carry out their care tasks is dependent on the quality of the resident-staff relationship. Staff should know the person for whom they are caring so that they can develop authentic interactions and relationships. This should include information on the person’s personal history, life story and experiences that have shaped their life (Brooker 2004). It is essential to acknowledge and value the person as an individual who retains many abilities and has the potential for growth. Staff attitudes towards people with dementia are important.

Being person-centred when providing care requires being fully present for and with the person, without being distracted (Kitwood 1997). It involves being mindful, ready to listen and respond appropriately to the person in the moment. There is no universal approach in the provision of safe, mobility optimising and person-centred mobility care. This is especially true when engaging with people with dementia. Staff should be able to meet the person in the moment and to make decisions accordingly.

Decision making in mobility care

Mobility care should safeguard staff and residents, optimise the resident’s mobility and ensure that they have a positive experience of mobility care. Many nursing home residents experience multi-morbidities that may include major physical health issues as well as cognitive impairments. These may result in additional complexity during mobility care. Staff may make decisions during mobility care in several ways, along a cognitive continuum from analytical to intuitive modes of decision making (Taylor et al 2014c).

Analytical modes of decision making are more useful when mobility care tasks are structured and there is time available to think about the task. In contrast, more intuitive decisions are made when tasks are unstructured, such as when working with residents with unpredictable behaviour patterns, or when rapid decisions are required (Standing 2008). The use of care plans or protocols as systematic aids to decision-making during mobility care can help to balance analytical and intuitive modes of decision making. Staff can use these aids (or time out to reflect) before carrying out the next mobility care task.

There is a lack of understanding of what person-centred care looks like in practice (Taylor et al 2014c). This may partly be due to the nature of residency, which is often busy and time pressured. As a result, staff may find it difficult to respond appropriately to the person in the moment. Staff should be aware of how they use their body and voice when using mobility-enhancing strategies. Many of these strategies rely on staff’s manner, attitude and ability to communicate, verbally and non-verbally (Kindblom-Rising et al 2002, 2011). Mobility-enhancing strategies and the nature of resident-staff communication should be resident and context specific. Flexibility is required to adapt to the circumstances of each mobility event, for example using a standing machine to assist when a resident is tired (Wångblad et al 2009). Various strategies that staff can use to assist people with dementia to move have been described (Oddy 1987, 2003, 2004). Several mobility-enhancing strategies based on Oddy’s (1987, 2003, 2004) work are described by the Alzheimer’s Society (2016).

Mobility optimisation benefits staff as well as residents. The more mobile residents are, the more they will be able to move without nursing assistance, thus reducing moving and handling requirements and associated injuries. Staff have the potential to be injured during physical contact with residents and when using moving and handling equipment, for example hoists or slide sheets, and a hands-off approach is safer for staff and may be therapeutic for residents.

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making relies more on analytical or cognitive judgements than intuitive decision making. Other forms of decision making occur mid-way along the continuum between highly intuitive and highly analytical modes of decision making. These include collaborative approaches where nurses work with other care staff and residents to optimise care episodes.

Reflection has an important role during decision making (Taylor et al 2015b). Reflection may occur during action (reflection-in-action), whereby it guides staff actions by providing a feedback loop about the quality of care simultaneously with care provision (Johns 2004). There are times when flexibility may be essential during mobility care, for example when caring for those with dementia whose behaviour may be unpredictable. Reflection-in-action is considered a more intuitive mode of decision making that allows increased flexibility compared with care provided by rigorous application of care plans or protocols. However, flexibility may not be enough to ensure effective mobility care. Situation awareness is another essential concept to consider in relation to decision making.

Situation awareness occurs at the beginning of the decision-making process (Mosier and Fischer 2010). It is through situation awareness that nurses perceive what is happening in the environment around them (Endsley 1995). Situation awareness is consistent with a holistic assessment of the demands of a mobility care task and the subsequent appropriate action (Sitterding et al 2012). Situation awareness may be enhanced by improving decision-making skills and interprofessional learning may be central to this process (Stubbings et al 2012). This emphasises the importance of effective communication and collaboration between nurses and physiotherapists regarding mobility care assessment, review and care plan development. Presence and awareness (states of being referred to as mindfulness) are central to situation awareness and are important aspects of person-centred care (Taylor et al 2015b).

In contrast, reflection-on-action is a form of decision making that describes how staff can reflect independently or with other staff after an event (Schön 1983, Ghaye and Lillyman 2010). As a result of actively reflecting on their actions, staff may see how their care could be improved; this may include responding to a resident in a different way in future.

**TIME OUT**

Consider a recent mobility care episode. How did you prepare for the task? Did you provide person-centred care in that instance? Write notes on how you might respond differently if similar circumstances arise in future.

**Achieving person-centred mobility care**

Relationships (taking care of all persons in a relational context) are central to person-centred care. Therefore, person-centred mobility care should start with the principle of relationships being central to care. Other aspects of care follow on from this, including staff attitudes, application of knowledge and skills, responses in the moment, and the ability to independently and collaboratively reflect on practice.

**Philosophy and attitude**

Valuing relationships as having inherent value in themselves is integral to a person-centred approach to care. This is essential to the act of caring and the development of effective interactions with residents and other staff, rather than as a means to accomplish tasks.

**Skills and technical aspects**

Approaches to improve mobility care are often limited to training in safe moving and handling to protect staff from injury, technical solutions such as the introduction of lifting equipment, or restoration of residents’ mobility and function. An integrated approach to improve mobility care is required urgently. This should encompass safety, mobility optimisation and the quality of the resident-staff and staff-staff interactions during mobility care episodes.

Comprehensive discussion of safe moving and handling and mobility optimisation is beyond the scope of this article. Readers are directed to Oddy’s (1987, 2003, 2004) work on strategies for enhancing mobility, particularly for people with dementia, and to Nelson et al (2009), Safe Work Australia (2011), Hignett et al (2013) and Elnitsky et al (2014) for technical information on safe moving and handling.

Figure 1 provides a moving and handling algorithm that illustrates the complexity of decision making surrounding the use of equipment during the main mobility tasks in nursing homes. The algorithm may be used to assist in decision making regarding appropriate assistance for residents’ bed mobility, transfers and ambulation.

**Moving and handling algorithm**

The starting point for using the algorithm is the black box in the centre of the schema, ‘Start here’. The first important question is ‘Can the resident weight bear?’ Facts regarding the weight-bearing ability of the resident should be ascertained; physiotherapists should be consulted if a specific assessment is required to clarify the answer. Path 1 in the upper section
FIGURE 1
Moving and handling algorithm

Path 1 – Bed mobility and transfers

Start here

Can the resident move from lying down to sitting and vice versa?

- Yes
  - Use slide sheets to turn or move the resident
  - Path 1
- No
  - Partially
  - Use an electric bed head to raise and prompt resident to push up

Can the resident turn or move up and down the bed?

- Yes
  - Path 1
- No
  - Use a sling hoist to move resident on and off the bed

Can the resident maintain sitting balance on the bed?

- Yes
  - Use a stand hoist to assist the resident from chair to chair
- No
  - Partially
  - Use a stand hoist to assist the resident from chair to chair

Can the resident weight bear?

- Yes
  - Use a stand hoist to assist the resident from chair to chair
- No
  - Partially
  - Use a stand hoist to assist the resident from chair to chair

Path 2 – Transfers and ambulation

Can the resident sit down in a controlled manner?

- Yes
  - Refer to physiotherapist
- No
  - Partially
  - Refer to physiotherapist

Can the resident do a step turn (using a gait aid if necessary)?

- Yes
  - Use a stand hoist to assist the resident from chair to chair
- No
  - Partially
  - Use a stand hoist to assist the resident from chair to chair

Can the resident walk safely?

- Yes
  - Use a stand hoist to assist the resident from chair to chair
- No
  - Partially
  - Use a stand hoist to assist the resident from chair to chair

Can the resident stand from bed or chair doing most of the activity after prompts?

- Yes
  - Use a stand hoist to assist the resident from chair to chair
- No
  - Partially
  - Use a stand hoist to assist the resident from chair to chair

Assist the resident to do step transfers (using a gait aid)

Walk with the resident ensuring use of the correct gait aid
of the algorithm may be followed to determine what equipment, if any, should be used to assist on-bed mobility and bed-to-chair transfers for less mobile residents. Path 2, in the lower section of the algorithm, provides information for the assessment of transfers and ambulation by residents with a greater capacity for mobility. Path 2 is redundant for residents who require the use of a sling hoist in Path 1.

It is important to differentiate between residents who can weight bear and those who can ambulate; the former does not guarantee the latter. Some residents who can weight bear may not be able to ambulate (the last question on Path 2), nor be able to safely effect a step turn – steps taken to turn during transfers to avoid risks associated with swivelling on stationary feet (the second question on Path 2). In such cases, a stand hoist should be used.

The first consideration for mobility care is to allow residents to do as much of an activity as they can themselves (Australian Nursing and Midwifery Federation 2015). This requires knowledge of mobility-enhancing strategies that focus on residents doing as much as they are able to with minimal physical assistance, thereby embracing a therapeutic approach to mobility care. Mobility-enhancing strategies frequently incorporate clear and supportive communication and the use of gestures, such as waving hands with palms turned upwards to indicate stand up or with palms facing down to indicate sit down, which may be helpful in the appropriate context. Complete time out activity (6)

Responses in the moment
In the context of care, unpredictable events and behaviours may arise requiring nurses to practise at the intuitive end of the decision-making spectrum. This requires presence and situation awareness. Kitwood (1997) discussed being present ‘with and for’ the resident ‘without distraction’. This form of mindfulness is important to enhance mobility care, especially when there are competing demands on nursing staff’s attention. Mindfulness is an approach that requires time to develop and should be attended to regularly, given the multitude of internal and external stimuli that may distract staff.

Qualities that allow nurses to be fully present in the moment include:
- The intention of being ‘with and for’ the resident.
- Being aware of yourself and the resident to gain deeper insight into the interaction taking place.
- Focusing on the person and paying attention to the quality of your relationships.
- Paying attention to what is happening in the moment.

Boxes 1 and 2 include reflections that may help nurses to develop self-awareness and attention, as well as relationship skills.

Reflection
After an interaction, nurses should take a few moments to reflect on what has happened, individually or with others. The following reflections may help:
- Is the resident now comfortable, happy or content, settled and ready to be left?
- Have I reassured the resident if they are still anxious?
- Have I taken my leave in a way which leaves the resident in a good state?
- Was there a flow to the interaction, a sense of harmony?
- Was there something I could have done differently to improve any aspect of the interaction, in the relationship or moving and handling techniques?
- Is there something I should follow up?
- What can I learn from this interaction?

Nurses could also reflect on their own state of being, including:
- Are there areas of pain or strain in my body? If so, where and why?
- Am I cross, angry or sad? If so, why?

Such reflections enable nurses to gain an understanding of the quality of their mobility care practice and how to improve it, especially if they pay attention to the responses of other people.

TIME OUT
6) Apply the transfer algorithm in Figure 1 to one of your residents and discuss your findings with the physiotherapist in your facility.

BOX 1
Reflective questions that may help nurses develop self-awareness and attention
- Am I paying attention to the now?
- How do I feel in my body in this moment? Do I feel tight or tense or loose and relaxed?
- If I feel tight or tense, where exactly?
- Am I feeling stressed, rushed, upset or calm?
- Can I set aside competing thoughts to focus on what’s happening now?
- How aware am I of my immediate environment (people, objects, equipment)?

BOX 2
Reflective questions that may help nurses develop their relationship skills
- How am I approaching the person (residents or staff)? Am I respecting their personal space? Am I rushing them or being abrupt?
- How is my touch? Is it gentle, light and respectful? Is it appropriate to the person?
- Am I engaging with the person, acknowledging their personhood?
- Am I engaging co-operatively with the resident or just doing something to them?
Intuitively they may realise what changes they can make in their behaviour, focusing on small changes that they can reflect on.

**Collaborative reflection on practice**

Reflection on one’s practice is part of ongoing professional learning and development. Therefore, time for extended reflection is important. If nurses are unsure how to proceed, collaborating with a trusted colleague at work or through other networks may help in the reflection-on-action process. It may be necessary to establish one’s support network. A trusted colleague may be able to help identify blind spots, such as an habitual tendency to help residents who can stand up unassisted. Individuals should accept constructive criticism and find ways to impart their knowledge, skills and attitude to others who may benefit from advice, remembering to impart this in a respectful and helpful way. People accept advice more freely if the nurse has developed a positive relationship with them. However, relationships take time to develop and are based on trust. Nurses, by starting their own process of respectful, mindful and reflective behaviour change, can become effective leaders.

**PERSAMO – an integrated model of mobility care**

Integrated mobility care is challenging. However, challenges may enable individuals to go beyond frustration and routine. Relationship skills are essential in the provision of mobility care. The authors have developed an integrated model of PERson-centred and SAfe MObility care, PERSAMO, where relationships are central to care. The PERSAMO model is first described in this article. Figure 2 identifies the three separate but integrated aspects of the PERSAMO model, whereby person-centredness (relationship), safety and mobility optimisation are connected and mutually supporting.

Although this article has discussed the three essential elements of mobility care separately; all three are integral to effective mobility care. Strategies around safety and mobility optimisation are insufficient if attention is not paid to the individual and the relationships involved. The aims of person-centred care are consistent with the aims of safety and mobility optimisation, whereby the focus is on the wellbeing and empowerment of all persons in the relationship, in addition to an enabling, rather than disabling, approach to care. This approach often requires negotiation of power or control, especially when embedded modes of practice (routines or habits) are based on staff taking control. Person-centredness requires respectful communication and that every effort is made to consider different perspectives. To achieve optimal outcomes, the needs of all parties must be recognised.

The PERSAMO model emphasises the importance of relationships to ensure

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**FIGURE 2**

**PERSAMO (PERson-centred and SAfe MObility care) model**

- **Person-centred relationship**
  - Attitude to person – still has strengths, remains a person.
  - Recognition of the relationship, working cooperatively.
  - Knowledge of the person.
  - Relational skills – presence, awareness, sensitivity to non-verbal aspects of the relationship.
  - Self-awareness, insight.
  - Ability to respond to what is happening in the moment (decision making, improvisation).

- **Safety**
  - Knowledge of safe moving and handling.
  - Skills acquisition and application.
  - Situation and other awareness.

- **Mobility optimisation (empowerment)**
  - Commitment to empowerment of the person.
  - Knowledge of the person’s mobility needs.
  - Knowledge of mobility optimisation.
  - Skills acquisition and application.
optimal mobility care. Specific skills and knowledge are required to carry out the aims of the model.

The model embraces a reflective stance that:
- Enables staff to be present and able to respond in the moment (reflection-in-action).
- Encourages ongoing practice development through individual and collaborative reflection-on-action.

Training that extends beyond the limitations of didactic modes, for example by the use of experiential methods, modelling, collaborative learning and reflective practice demonstrated increased success in achieving desired practice improvements (Rahman et al 2011, McCormack et al 2013). Optimal learning and sustainable practice change may require leaders to work closely with other staff to model person-centred mobility care and provide a supportive environment for implementation of this approach (Taylor et al 2015a). Collaboration, leadership and teamwork, aspects of person and relationship-centred care, are effective starting points for the development of positive organisational cultures (Brown Wilson 2009, Tyler and Parker 2011). The connection between organisational culture and person-centred care requires further exploration. However, changing behaviour at a personal level is an essential component of organisational change at all levels of an organisation.

Conclusion

Practice improvement with the aim of enabling person-centred mobility care should aim to increase knowledge and improve skills, and to inspire person and relationship-centred approaches to care. Without these attributes, the value of knowledge and technical skills in mobility care is limited. This article includes information and prompts, such as reflective and reflexive activities, that may be used by nurses to enhance their mobility care practices. By adopting person-centredness in the challenging context of mobility care, nurses can embody and sustain the wisdom and compassion necessary for caring relationships.

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Mobility care for older people

TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 835

1. Which is not an important aspect of mobility care?
   a) Person-centredness
   b) Mobility optimisation
   c) Dependency
   d) Safety

2. Remaining mobile enables residents to:
   a) Maintain their physical function
   b) Have increased decisional and executional autonomy
   c) Reduce their risk of developing pressure ulcers
   d) All of the above

3. An emotional trauma experienced by older people during inappropriate moving and handling is:
   a) A fall
   b) Bruising
   c) Loss of control
   d) A skin tear

4. Safety is best promoted by:
   a) Relying on error-free performance by individuals
   b) Multiple systemic safeguards
   c) Multiple risk assessments
   d) Ensuring residents are only mobile when staff are available to assist them

5. Mobility optimisation does not:
   a) Enable residents to move without nursing assistance, where possible
   b) Reduce reliance on moving and handling equipment
   c) Increase the potential for injury associated with physical contact with residents
   d) Reduce the potential for injury associated with moving and handling equipment

6. Which statement is true?
   a) All residents who can weight bear can ambulate
   b) All residents who can weight bear can effect a step turn safely
   c) A stand hoist should be used for residents who cannot effect a step turn safely
   d) All residents who cannot weight bear require assistance with ambulation

7. Mobility-enhancing strategies:
   a) Should be resident specific only
   b) Should be context specific only
   c) Should be resident and context specific
   d) Contribute to deconditioning and imposed dependency

8. Person-centred care should not:
   a) Be considered an optional add-on to care
   b) Acknowledge the individual
   c) Involve developing an authentic relationship with the resident
   d) Involve responding appropriately to the resident

9. Flexible, intuitive decision making is not enabled by:
   a) Reflection-in-action
   b) Care plans and protocols
   c) Situation awareness
   d) Mindfulness

10. The safety aspect of the PERSAMO (PERSON-centred and SAFE MOBILITY care) model includes:
    a) Commitment to empowerment of the person
    b) Knowledge of the person
    c) Situation and other awareness
    d) Recognition of the relationship

   This self-assessment questionnaire was compiled by Beth Knight

   The answers to this questionnaire will be published on March 30

   The answers to SAQ 833 on lymphoedema, which appeared in the March 2 issue, are:

How to use this assessment

This self-assessment questionnaire (SAQ) will help you to test your knowledge. Each week you will find ten multiple-choice questions that are broadly linked to the CPD article. Note: there is only one correct answer for each question.

- You could test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article to update yourself before attempting the questions.

When you have completed your self-assessment, add it to your professional portfolio. You can record the amount of time it has taken, Space has been provided for comments.

You might like to consider writing a reflective account, see page 62.

Report back

This activity has taken me ______ hours to complete.
Other comments:

Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent
Good
Satisfactory
Unsatisfactory
Poor

As a result of this I intend to: