

FIT Mobility Assessment for Frail Nursing Home Residents

Resident Name: _____

Date ____/____/____

STAFF ASSESSOR: _____

Trial 1

Trial 2

1) Time of Day

Apical Pulse

Blood Pressure

Note: Apical Pulse and Blood Pressure are optional.

2) Sit To Stand:

1: _____

Note: For trial 1: record how long it takes to do one sit to stand.

For trial 2: Record how many sit to stands resident can do in 30 seconds.

Sit to Stand level of Assist: ___Level 1 ___level 2 ___level 3 ___level 4 ___unable to stand

3) Walking/Wheeling ability

Time @ 6meters:

Distance @ 5 Minutes

Walking/Wheeling level of Assist: ___Level 1 ___level 2 ___level 3 ___level 4 ___unable to walk

ASSISTIVE DEVICE(s) NEEDED (E.G., walker, gait belt): _____

Why Stopped? (circle)

Physical Fatigue

Physical Fatigue

Verbal Fatigue

Verbal Fatigue

Instability

Instability

Lack/Motivation

Lack/Motivation

Other _____

Other _____

LEVELS OF ASSISTANCE – DEFINITIONS:

LEVEL 1: INDEPENDENT – RESIDENT ABLE TO PERFORM ACTIVITY ON COMMAND (e.g., “please stand up).

LEVEL 2: VERBAL INSTRUCTIONS – RESIDENT ABLE TO PERFORM ACTIVITY WITH VERBAL INSTRUCTIONS (e.g., “place your hands on the arms of the chair, place your feet on the floor directly in front of you, push yourself up/stand up”).

LEVEL 3: PHYSICAL GUIDANCE – RESIDENT REQUIRES STAFF TO HELP INITIATE THE MOVEMENT BUT DOES NOT REQUIRE STAFF TO PHYSICALLY LIFT OR HOLD IN POSITION (e.g., staff member places residents’ hands on the chair arms, places residents’ feet in position in front of them, guides but does not lift resident into a standing position).

LEVEL 4: FULL PHYSICAL ASSISTANCE – RESIDENT REQUIRES STAFF TO PROVIDE PHYSICAL ASSISTANCE TO LIFT AND/OR SUPPORT INTO POSITION.

Note: The use of assistive devices (e.g., walker, cane) is acceptable and does not affect level of staff assistance.