Mobility Aids and the Elderly Client

Mobility is a phenomenon familiar to nurses working with the elderly in both institutional and community practice settings. Yet for all its seeming familiarity, the concept of mobility has not been well defined for use in nursing practice. Rather, what predominates in the literature as the foci of nursing practice are mobility deficits and immobility. The emphasis on immobility appears paradoxical when one considers that its antithesis, mobility, lacks conceptual clarity. Given this backdrop, it seems necessary to clarify, refine, and develop the conceptual basis of mobility as a starting point for theory development.

Foundational work in concept development related to mobility was undertaken by the authors, Schwartz-Barcott and Kim’s (1986) model for concept development, consisting of three inter-related phases— theoretical, fieldwork, final analytical—guided the overall work. The beginning theoretical phase involved an analysis of the concept, using the approach outlined by Walker and Avant (1988). The concept analysis involved examining the broad cross-disciplinary usages of the concept of mobility found in the literature and, from this, deriving its common attributes, antecedents, and consequences. Attributes refer to characteristics

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which define the concept and differentiate it from other concepts. Antecedents are made up of conditions, events and incidents which trigger the occurrence of the concept, while consequences can be considered the outcomes of the expression of the concept. A detailed discussion of the analysis can be found in Rush & Ouellet (1993). Subsequently, fieldwork was undertaken in an attempt to determine if there was empirical support for the findings from the concept analysis within the practice arena.

The purpose of this overall fieldwork phase was to explore the meaning of mobility from the perspective of both elderly clients and nurses. The broad study set out to explore the following questions:

1. How do elderly clients describe their own mobility, its transitions and spatio-temporal fluctuations, and its effects on day-to-day living? How do patients differentiate varying levels of mobility?

2. How do nurses view their elderly clients’ mobility and differentiate levels of mobility?

This article represents a secondary analysis of findings from the second research question.

**METHODOLOGY**

Both elderly clients and their primary nurses comprised the sample for the overall study. However, only the nurses’ data are reported here.

The 11 nurse participants in this study worked with the New Brunswick Extramural Hospital (EMH) serving a large rural-urban community area in Atlantic Canada. Comprising approximately one-third of the nurses who were employed by the hospital, the nurses carried a caseload consisting predominantly of older clients living outside of institutional settings. This sample size was appropriate to achieve saturation given that the purpose of this qualitative study was to gain an in-depth understanding of the meaning nurses give to client mobility. EMH nurses were approached by an administrative officer of EMH and invited to volunteer for the study. Although nurse participants were self-selected, the heterogeneity of the group in terms of educational background and practice experience contributed to the phenomenon of interest being well-represented. Nurse informants had from 1 year to over 20 years of experience, and included both diploma and baccalaureate prepared nurses. Also, nurse volunteers proved to be reliable and motivated sources of information about the phenomenon of mobility. Those who agreed to participate and gave their written consent were interviewed by one of the researchers for approximately an hour. By means of a loosely semi-structured, open-ended interview, they were asked to respond to questions such as:

1. What is your understanding of the term mobility in general?

As nurses described their clients’ perceptions and responses to mobility aids a consistent link was made to stigmatization.

2. How would you describe patient mobility?

3. How do you determine a patient’s level of mobility?

4. How do you monitor changes in a patient’s level of mobility over time?

5. How do you identify differences in mobility between patients?

Content validity of the interview guide had been established by a panel of three experts.

Interviews were transcribed verbatim and the data were analyzed using thematic content analysis as outlined by Burnard (1991). From the initial open coding of the data, analysis proceeded with the merging of common themes into categories. Three categories emerged from the data: definition and descriptors of mobility, criteria for determining qualitative differences in mobility, and antecedents and consequences of mobility. This categorization system was then used to code the data. Inter-rater reliability with an independent rater was established using the Kappa statistic, and for each of the three categories (.72, .66, .82) was found to be substantial (Brennan & Hays, 1992).

A recurring theme that nurses identified as an antecedent of mobility was “meaning of mobility aids.” A secondary content analysis was conducted in an attempt to expand and explore this theme more fully. A unit of analysis was any reference the nurses made to mobility aids and emerging from this further analysis were four categories: the stigma of mobility aids, clients’ adjustment behaviors to mobility aids, forces influencing adjustment to mobility aids, and potential benefits of mobility aids. The categories and their respective themes appear in the Table. Given that the nurses referred
to assistive devices as “mobility aids,” in this article the term “aids” is used to honor the nurses’ choice.

RESULTS: FINDINGS AND DISCUSSION

The Stigma of Mobility Aids

As nurses described their clients’ perceptions and responses to mobility aids a consistent link was made to stigmatization. Nurses expressed this as society’s negative response to people using an aid to accomplish the simplest of mobility tasks or maneuvers. This negative response originates when there is a discrepancy between what society expects and what it actually sees (Saylor, 1990). Generally, society expects people to be mobile and to move without the need of an assistive device. When mobility begins to decline to the point that a mobility aid is required, then these expectations cannot be met or fulfilled, and this becomes the basis for stigmatization related to the use of mobility aids.

Health care professionals share the values and expectations of their society. This was no less true with the group of nurses who were interviewed. An element of stigmatization permeated the age-related norms and expectations that nurses ascribed to mobility and the use of mobility aids by the elderly. One nurse described it in the form of ageism—a stereotype associating aging with diminishing mobility capability:

...and with the elderly, it’s almost expected that they will gradually deteriorate in mobility. That’s one thing—you see it all the time with the elderly population as they grow older, they become less mobile. And it’s almost expected and usually if you go in or if you know you have a patient who is 80 or 90 years old, you sort of look around, you figure they’ve got a cane somewhere. You know, it’s almost to be expected.

According to the nurses, with the elderly, the stigma of old age is compounded by the stigma of using an aid. This was captured by one nurse in the following way “there is something about a cane and being an older person, stigma attached to it...” Despite the increased awareness of the special needs of the aging population and ensuing physical and architectural changes to the environment to accommodate mobility aids, there remains a stigma attached to having to use an aid to accomplish the simplest of tasks. One nurse described the stigma of mobility aids in this way:

...it (mobility aid) is visual, it is visual in that other people can see that they are getting old or that there is something wrong with them. It is a tangible thing whereas maybe their vision isn’t quite as good but they can cover that up but they actually have to go out with a walker, with a wheelchair, with a cane, something that is visual. I know a lot people who will say “I can’t go out with that” and when you get right down to it it’s because they don’t want to be seen out with that apparatus...”

It is evident that mobility aids become a visible symbol for stigmatization; they cannot be disguised or hidden. Utilizing an aid is a form of exposure; it is disclosing to the public a weakness, a change, a decline in one’s mobility capacity. For some, it is a loss of normalcy. For others it is a loss of pride, of dignity. One gentleman said to his nurse “I feel so stupid in a wheelchair and people look at me.”

Furthermore, nurses linked this stigmatization with society’s tenden-

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**TABLE**

Meaning of Mobility Aids

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<thead>
<tr>
<th>Categories</th>
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<tr>
<td>The stigma of mobility aids</td>
<td>a) Concealing</td>
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<td>Client adjustment behaviors</td>
<td>b) Resisting</td>
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<td>e) Accepting</td>
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<td>Forces influencing responses</td>
<td>a) Duration of use</td>
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<td>to mobility aids</td>
<td>b) Gender</td>
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<td>c) Health professional frame of reference</td>
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<td>Potential benefits</td>
<td>a) Spatio-temporal dynamics</td>
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<td></td>
<td>b) Independence</td>
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<td>c) Energy conservation</td>
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Nurses described clients who let their aids pile up in the corner, or who hid them behind the door, or who, when asked, knew that the aid was somewhere to be found but were indifferent to finding out where.

Client Adjustment Behaviors

As would be expected, clients’ views and perceptions of mobility aids influenced how they adjusted to them. Nurses described a number of adjustment behaviors used by clients in dealing with mobility aids. So strong were the clients’ responses to aids that many of them refused to use them and concealed them by ensuring that they were out of sight and out of reach. Nurses described clients who let their aids pile up in the corner, or who hid them behind the door, or who, when asked, knew that the aid was somewhere to be found but were indifferent to finding out where. This phenomenon was illustrated in the following way:

...quite often you do have to intervene with aids for them...They will take the walker, or four times during the night that a wheelchair is so much easier just to get them in and out but they are so determined that the wheelchair just means that the end for them, that they have to give up and I think a lot of them are just not willing...

Another adjustment behavior that nurses observed was the tendency for clients to cover their need for a mobility aid. This was evident in their use of the environment rather than the mobility aid to get around. Holding on to walls and strategically placed furniture for maneuvering in the environment was a more acceptable and helpful strategy for clients than resorting to aids even though the stationary mobility aids were serving the same purpose as the portable aid. One client’s response to the nurse’s question, “Do you think you should be using your cane?” was:

Oh no. I am just fine. See I put my hand here and I know that I have got to put my hand here and put my hand here and they know exactly where to put their hand...It seems to work for some of them. This reflects an attempt to minimize and make the need for a mobility aid less significant.

Associated with the social stigma surrounding use of mobility aids was withdrawal by the clients. At the same time as clients withdrew from the larger environment, they withdrew into their immediate environment. One nurse’s description spoke of this response to stigmatization:

...they do withdraw more and they don’t want to be visually seen with a walker or what ever and so maybe there is a play that they would like to see or film or a speaker but they don’t want to go...
By not using the aid and in fact concealing it, the elderly were better able to ignore their declining mobility...

- Withdrawing into one's environment provides security and a sense of control and preserves self-identity as reflected in this statement: 

  "...and once that they (the elderly) have those aids, especially those in-house aids, there is no problem with home, it is the out-of-house aids that they have to worry about but the in-house aids, most of them are more than willing to use them and really gives them that feeling that I can do this, I can look after myself, I can toilet myself and that kind of thing..."

  In the home environment elderly people are away from public exposure and in a place they control and therefore feel safer and less threatened. Feeling safer may also be linked to having the environment arranged and equipped to meet their specific needs and preferences so they can function better and safer there than anywhere else.

  Nurses spoke of clients using an aid after initial resistance. Accepting to use the aid did not necessarily mean acceptance of the aid. Some clients accepted to use an aid because they had no other choice—almost resigning themselves to it. Others experienced an ambivalence between acceptance and non-acceptance. This tension was evident in one nurse's comment "They tried everything to teach him how to use a three-pronged cane and he still walks and drags it behind." Genuine acceptance came with seeing the need for the aid, testing it out and seeing the benefits. At this point, clients were able to integrate mobility aids as a part of the self as evident in the following description:

  "He's accepted it (aid). I think sometimes the patient sees the need, they will get a cane or this type of thing because they perceivethere's a problem with their mobility and it will help them to get around, and they do want to be as independent and mobile as they can be...so if they see this as being beneficial they will come around and decide this was a good idea, wonder why "I didn't do this before."

  Elderly clients' responses to mobility aids, as observed by the nurses, do not differ greatly from those documented in the literature on coping with chronic illness, specifically responses dealing with the accompanying social stigma (Saylor, 1990). A possible explanation for the similarities may be the prevalence of chronic illness affecting mobility in the elderly, a factor which could not be isolated when examining the use of mobility aids. It was also difficult to determine whether these responses were generated entirely from having to use mobility aids or whether the stigma attached to them also played a role in the behaviors observed.

Factors Influencing Responses to Mobility Aids

  Nurses identified a number of factors that appeared to mediate the way that clients responded to mobility aids. One important factor was the anticipated length of time the mobility aid would need to be used. The mobility aid was perceived differently depending on whether it was being used on a temporary or more permanent basis. Perceived long-term, more permanent use of the aids elicited more negative client responses. A nurse captured this by her description of one man with declining mobility, "...and he hates the walker and he won't use the walker and...he gets on with a cane now but he just gets so mad at those things..." Nurses reported more positive responses when aids were being used on a temporary basis as was the case with clients following hip replacement or postoperative hip fracture. Most of these clients know that the use of aids for rehabilitation back to an improved level of functioning is of limited duration, requiring a 6-week course of progressing from walker to cane to unassisted mobility. These clients readily use the aids because they see them as the vehicle to return them to their maximal capacity. This was evident in the following nurse's description:

  "And some are quite happy to take off with their cane and feel quite independent with the cane. Some feel quite independent with a walker, psychologically contribute all their advancement from a broken hip to that walker and I find there is a certain time that passes when they can part with that walker and sort of brave it themselves and realize that they have done all the work...

  Adjustment is also influenced by certain demographic factors such as the person's gender and age. Nurses reported that generally male clients were much less willing to use aids than females, whether going out with their cane or walker or taking a
wheelchair at the airport. This was exemplified by a nurse as:

I think women are more agreeable to going out with their walker or with their cane, with their Reeboks on, than men. Men still have that image...

Zimmer & Chappell (1994) documented a correlation between gender and assistive device use, with females tending to use them more frequently. Whether frequency of device use is a reflection of a willingness to use a device cannot be established at this point.

The effect of age on client adjustment was not clearly evident although nurses felt that younger people tended to perceive mobility aids as a source of freedom while the older person saw them as more restrictive. In Zimmer & Chappell’s (1994) work, it was the younger cohort of seniors who attempted to do without devices. One possible reason they cited was psychological in that using a device could be perceived as an affirmation of growing old.

The health care professional’s frame of reference was another factor that appeared to influence eventual utilization of mobility aids by the clients. Nurses’ approaches were instrumental in creating a climate that made clients more receptive to using an aid. Nurses consistently allowed clients to exercise autonomy in relation to aids. So even if the nurse felt that the client would be more independent and safer when using an aid they respected the right of the client to choose if and when they would use the aid as indicated in the following statement:

She has not been encouraged to become independent. I don’t see any reason why she can’t drive with hand controls...I mean there’s nothing wrong with her mental ability, her vision...so why can’t she be taught to drive with hand controls? I mentioned it a couple of times but I don’t want to push it because that’s a thing she has to decide.

When clients remained indecisive about using aids, the nurse’s tendency was to ensure safety of the client’s environment. This involved, for example, removing small items in the environment that were in the way, stabilizing pieces of furniture that the client was using to get around, or removing a scatter rug. All of these changes were negotiated with the clients. This strategy reflected the nurse’s recognition of the client’s lack of readiness to use mobility aids and their desire to preserve the client’s dignity.

Holding on to walls and strategically placed furniture for maneuvering in the environment was a more acceptable and helpful strategy for clients than resorting to aids even though the stationary mobility aids were serving the same purpose as the portable aid.

The way that nurses looked at mobility aids also influenced client utilization of them. Nurses looked at aids not as “aids for the declining” but as “tools for living.” To this end, nurses would de-emphasize the mode of mobility and emphasize the goal that would be made possible by using the aid. One nurse described a male client who had not been out in months because the only way he could get out would be by means of a wheelchair which he was not prepared to use:

...we talked about the new mall and put more emphasis on the ballgame where his grandchildren were playing and didn’t talk about how we were going to get there but it was all organized. Well that man in the two years that I have been here, he enjoys an outing every weekend. His whole quality of life has changed...But if we had mentioned the mobility aid as the priority...

Potential Benefits of Mobility Aids

Nurses attached real value to mobility aids. They saw the value of the aid in enhancing the spatial and temporal components of mobility. Nurses saw mobility aids as beneficial in assisting the client to re-establish a balance in their pattern of temporal arrangements. This was particularly the case when clients required an enormous amount of time to accomplish the simplest of tasks on their own even though using the aid would have considerably reduced that time. For some, the wheelchair was equated with going to places and participating in activities which otherwise would not be possible because of time constraints. For others, the use of a wheelchair meant getting from point A to point B in a much faster period of time as described by one nurse:
She (client) has been taking a wheelchair at the airport...simply because it is a long walk up some of those ramps for an older person and they only have a certain amount of time to make connections.

A second benefit identified by nurses was that mobility aids enabled clients to, at a minimum, maintain their spatial capacity, and at best expand it. Nurses found that a decrease in mobility restricted the older person's spatial boundaries. As elderly clients slowed their pace over time and perceived distances to be greater and tasks more complicated to perform, their space became more circumscribed. With the use of aids, clients could get out and their space was expanded beyond the physical confines of the home environment. In extending the physical boundaries, the mobility aid helped maintain or enhance social interaction and space as illustrated by the following example:

We have one gentleman who has had this severe COPD and we finally got him an able walker...you see him up in the mall and trucking around and you talk to him and he's quite happy with this...it has really given him a new lease on life.

Similarly, York (1989) found that enhanced spatial boundaries was an outcome of using mobility aids. Moreover, the type of aid impinged on the distance traveled with wheeled mobility methods resulting in greater movement in the outdoor environment.

The promotion of independence was yet another benefit of mobility aids described by nurses. By increasing significantly the individual's movement within space, mobility aids fostered independence. A reference made to the aid in contributing to autonomous movement was expressed as:

...and to be able to do those things by herself (wheel herself to bingo)...that helps her maintain her independence and keep up with things that mean a lot to her. Maintaining independence preserves self-integrity and self-identity.

Mobility aids were also seen to be valuable in promoting energy conservation. Chronic conditions contributing to fatigue make mobility more difficult, if not, impossible. Nurses saw mobility aids as especially helpful in conserving the client's energy level for activities that they enjoyed and really wanted to do. For example, rather than being exhausted from trying to walk long distances to get to the mall, the wheelchair and public transportation (Dial-a-bus) system were used by many clients and energy could be saved for activities at the mall. Some studies demonstrated that ambulating with such assistive devices as canes, crutches, or walkers, increase energy expenditure (Annesley, Almada-Norfleet, Arnall, & Cornwall, 1990; Hinton & Cullen, 1982). In this study, the use of wheeled devices was perceived to conserve energy. Moreover, the intent of the study was not to measure energy expenditure objectively.

**RESEARCH AND CLINICAL IMPLICATIONS**

The overall study did not set out to examine the meaning of mobility aids for the elderly client but this theme emerged so strongly in nurses' descriptions that it could not be avoided. Given that the findings reported in this article represent a secondary analysis, caution must be exercised in generalizing the findings beyond the population studied. However, in qualitative research, the notion that the experience of one person can extend to others is recognized as valid. As such, these findings have relevance for both practice and research.

This work represents a beginning analysis of nurses' perceptions of elderly clients' responses to the use of mobility aids. Further research activities could involve validating the findings using another nurse population. Specifically, this would allow a focus on mobility aids and their meaning for elderly clients. More important, the elderly client's subjective experience of using mobility aids must be systematically explored and then compared with the nurse's perceptions to determine congruency.

Although this research must be considered preliminary, the emerging framework describing nurses' perceptions of the meanings elderly
clients assign to mobility aids, offers some direction for nurses working with the elderly. These findings might provide the impetus for nurses to examine their beliefs and biases surrounding mobility aids and the elderly. Are nurses reinforcing the social stigma surrounding mobility aids and transmitting this to clients? Is there an expectation by nurses that mobility aids are a natural part of growing old? This expectation, coupled with the way nurses perceive the value and benefits of using aids, might result in their automatically introducing an aid without being sensitive to the client’s perspective.

The data suggest that it is not sufficient to introduce a piece of equipment to promote mobility into an elderly client’s world without carefully considering the meaning the mobility aid has for the client. Hence, exploring the client’s thoughts, feelings, and perceptions about using a mobility aid would seem as important as assessing the client’s need for such an aid. At the same time nurses must be attuned to some of the specific forces (i.e., age, gender, anticipated duration of mobility aid use) that may influence the client’s response and adjustment to use of the mobility aid. Follow-up assessment would seem critical in appraising how the client is managing with the aid and allow for further exploration of the client’s response to the mobility aid. Observation of such subtle indicators as the client using the environment and not the aid to get around, concealing the aid, and expressing indifference toward the mobility aid may indicate resistance by the client and thus point to the need for exploring other strategies.

Some clients may profit from discussion about some of the specific benefits to be gained from using the mobility aid. Framing the potential benefits within a goal-directed approach to the mobility aid rather than a focus on the aid itself might be a more acceptable way to encourage its utilization and integration. With some understanding and experience of these potential benefits client negativity might be turned into client receptivity. Meanwhile, during the period of adjustment, it is imperative that nurses allow clients to exercise control over their mobility decisions while at the same time ensuring safety.

The categories and themes identified in the Table clearly show that there is a complex interplay of mental processes influenced by internal and external forces that must be explored more fully before an elderly client can perceive the mobility aid as a tool for living. Therefore, it is critical for practitioners to understand these complex interplays as they work with clients who are facing the prospect of having to use mobility aids.

CONCLUSION

As life expectancy increases, nurses working with elderly clients will continue to be challenged to maintain mobility, particularly in clients with chronic illness. Because of this, it is important to have research-based strategies to assist clients. Currently there is a dearth of nursing related research in the area of mobility and mobility aids. The findings from this study may provide the impetus for re-examining the concept of mobility, and its underlying assumptions as foundational to nursing practice.

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MOBILITY AIDS KEYPOINTS

1. Set within the context of concept development, this article reports the results of a secondary analysis of data from a qualitative study that explored the meaning of mobility from the perspective of clients and their primary nurses.

2. A recurring theme that emerged from the primary analysis of the 11 nurse participants’ interview data was “meaning of mobility aids” and a more in-depth analysis of this theme was undertaken.

3. Four categories clearly emerged from thematic content analysis of the data: the stigma of mobility aids, clients’ adjustment behaviors to mobility aids, forces influencing adjustment to mobility aids, and potential benefits of mobility aids.

4. The findings from this preliminary study have implications for both research and practice. Research geared specifically to exploring the elderly’s experience of using mobility aids is warranted. As for practice, nurses must be sensitive to the client’s perspective when the time comes for introducing a mobility aid and focus on the person in assessment and follow-up and not the aid itself.

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