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# Communication and Nurse–Client Relationship

*Performance Checklist*

## UNIT ONE Therapeutic Communication

### UNIT ASSESSMENT

- ☐ Determined individual's ability to process information at cognitive level.
- ☐ Evaluated mental status data to establish baseline for intervention.
- ☐ Evaluated ability of client to communicate on a verbal level.
- ☐ Observed what is happening with client here and now.
- ☐ Identified developmental level of client so interaction expectations would be realistic.
- ☐ Assessed anxiety level of client, knowing that anxiety would interfere with communication.
- ☐ Assessed client's cultural background.

### INTRODUCING YOURSELF TO A CLIENT

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Obtained client assignment. | | | |
| 2. Read chart and reviewed physician's orders. | | | |
| 3. Checked client care plan. | | | |
| 4. Clarified any questions about client assignment. | | | |
| 5. Proceeded to client's room and checked room number. | | | |
| 6. Introduced myself to client. | | | |
| 7. Introduced myself as I entered client's room if he/she was blind. | | | |
| 8. Began to establish a nurse–client relationship using clear, open communication. | | | |

## BEGINNING A CLIENT INTERACTION

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Following introduction related purpose of interaction.
2. Told client specifically what I would be doing in terms of his or her care.
3. Asked if client understood or had any questions.
4. Encouraged client to describe how he or she was feeling at the time (especially focused on pain level).
5. Encouraged client to participate in his or her care—verbally and nonverbally.
6. Paid attention to communication as well as the procedure being performed.
7. Assessed nonverbal fit with verbal behavior.
8. Completed communication by asking client for feedback.
9. Completed interaction by telling client when I would return.
10. Followed through on agreed meeting time so as to build client trust.

## ASSESSING CULTURAL PREFERENCES

### Procedure

1. Reviewed client history related to cultural orientation.
   a. Ethnic heritage and language.
   b. Family organization and role of members.
   c. Dietary practices and knowledge about nutrition.
   d. Education, formal and informal.
   e. Healthcare practices and beliefs.
2. Determined client's perception of illness based on cultural beliefs.
3. Validated verbal and nonverbal communication from client based on cultural understanding.
4. Used an interpreter if communication was unclear.
5. Examined expectations of healthcare based on the client's cultural influences.

## ASSESSING SPIRITUAL ISSUES

### Procedure

1. Asked client relevant questions concerning spiritual issues.
   a. Did client have a spiritual component in his life?
   b. If so, did this help him during illness?
   c. Is there any person or spiritual advisor I could contact for him?
   d. Could I do anything to support spiritual beliefs?
2. Asked if there were any spiritual issues he would like to discuss. If answer was yes, set a time to talk.

## ASSISTING A CLIENT TO DESCRIBE PERSONAL EXPERIENCES

### Procedure

1. Encouraged client to describe perceptions and feelings.
2. Focused on communication but used an indirect approach.
3. Used minimal verbal activity.
4. Assisted client to clarify feelings.

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 5. Maintained an accepting, nonjudgmental attitude. | | | |
| 6. Gave broad opening statements and asked open-ended questions. | | | |

## ENCOURAGING A CLIENT TO EXPRESS NEEDS, FEELINGS, AND THOUGHTS

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Focused on feelings during interactions. | | | |
| 2. Assisted client to identify thoughts and feelings. | | | |
| 3. Picked up on verbal cues, leads, and signals from the client. | | | |
| 4. Conveyed attitude of acceptance and empathy toward the client. | | | |
| 5. Noted what was said as well as what was not said. | | | |
| 6. Assisted client to become aware of differences between behavior, feelings, and thoughts. | | | |
| 7. Gave honest, nonjudgmental feedback to client. | | | |

## USING COMMUNICATION TO INCREASE THE CLIENT'S SENSE OF SELF-WORTH

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Used body language as well as verbal communication to convey empathy. | | | |
| 2. Respected client's personal "space," but remained available to client. | | | |
| 3. Encouraged client to apply problem-solving approach to different situations. | | | |
| 4. Was nonjudgmental. | | | |
| 5. Mutually identified goals to meet client's individual needs. | | | |
| 6. Kept all agreements with client. | | | |
| 7. Was client's advocate. | | | |
| 8. Gave client positive feedback when appropriate. | | | |

# UNIT TWO Nurse–Client Relationship

## UNIT ASSESSMENT

☐ Determined purpose of establishing a nurse–client relationship.

☐ Considered overall condition of client to determine if he or she would be able to benefit from a nurse–client relationship.

☐ Identified client expectations of a therapeutic relationship to determine if I would be able to meet these needs.

☐ Examined my own feelings and expectations to evaluate potential effect on such a relationship.

## INITIATING A NURSE–CLIENT RELATIONSHIP

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Assessed client's symptoms and problems, and communicated a willingness to help alleviate these discomforts. | | | |
| 2. Established a beginning relationship. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 3. Established mutual goals as a basis for the relationship. | | | |
| 4. Demonstrated consistency in behavior. Did what I said I would do, and only made promises I was willing to keep. | | | |
| 5. Encouraged client's participation in his or her care. | | | |
| 6. Approached client in a warm, accepting manner. | | | |

## FACILITATING A NURSE–CLIENT RELATIONSHIP

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Assumed role of facilitator in relationship. | | | |
| 2. Accepted client as having value and worth as an individual. | | | |
| 3. Provided safe environment conducive to client's willingness to share. | | | |
| 4. Maintained relationship on a professional level. | | | |
| 5. Kept interaction reality-oriented, that is, in the here and now. | | | |
| 6. Listened actively, that is, responded to client's cues. | | | |
| 7. Used nonverbal communication to support and encourage client. | | | |
| a. Recognized meaning and purpose of nonverbal communication, especially in assessing pain. | | | |
| b. Kept verbal and nonverbal communication congruent. | | | |
| 8. Focused content and direction of conversation on client's cues, not on social topics. | | | |
| 9. Interacted on client's intellectual, developmental, and emotional level. | | | |
| 10. Focused on "how," "what," "when," "where," and "who" rather than "why." | | | |
| 11. Taught client problem solving to correct maladaptive patterns. | | | |
| 12. Assisted client to identify, express, and cope with feelings. | | | |
| 13. Helped client develop alternative coping mechanisms that are more adaptive. | | | |
| 14. Recognized a high level of anxiety, and assisted client in dealing with it. | | | |

## TERMINATING A NURSE–CLIENT RELATIONSHIP

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Worked closely with client in discharge planning and planning termination of relationship from its beginning. | | | |
| 2. Anticipated problems of termination and planned for their resolution. | | | |
| 3. Was aware that client's behavior may reflect fear of being unable to cope at home, overdependence, depression, and withdrawal. | | | |
| 4. Did not terminate relationship too abruptly or allow it to persist beyond the client's needs. | | | |
| 5. Completed a satisfactory termination of relationship. | | | |

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# Admission and Discharge

*Performance Checklist*

## UNIT ONE Admission and Transfer

### UNIT ASSESSMENT

- ☐ Observed and recorded client's physical, emotional, and intellectual status.
- ☐ Observed and recorded client's ability to adapt to the environment of a hospital unit. Observed for disabilities or limitations.
- ☐ Identified medications client is currently taking.
- ☐ Assessed client's level of comfort or discomfort.
- ☐ Determined client's understanding of his or her disease and its limitations.
- ☐ Assessed condition prior to transfer and obtained a thorough report of client's progress and status when received from another unit.

### ADMITTING A CLIENT

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Introduced myself to the client and family and began to establish a therapeutic nurse–client relationship. | | | |
| 2. Checked physician's orders for treatments to be instituted immediately. | | | |
| 3. Introduced client and family to staff and to roommate if present. | | | |
| 4. Explained equipment and hospital routines. | | | |
| 5. Completed general nursing assessment. | | | |
| 6. Assisted client to don hospital gown. | | | |
| 7. Obtained client's health history and physical assessment. | | | |
| 8. Obtained client's weight and height. | | | |
| 9. Obtained urine specimen and vital signs. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 10. Informed laboratory that client was available for chest x ray and routine blood work, if not obtained earlier. | | | |
| 11. Initiated client's care plan; identified client's problem areas and needs. Identified if client at risk for falls. | | | |
| 12. Notified physician that client had been admitted, and obtained orders if policy permits. | | | |
| 13. Reassessed client's level of comfort and ability to adapt to hospitalization. | | | |
| 14. Completed client teaching for all unfamiliar procedures or interventions. | | | |
| 15. Filled out kardex card and client care plan. | | | |
| 16. Documented information on appropriate forms in chart. | | | |

## TRANSFERRING A CLIENT

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Obtained physician's order, if needed. | | | |
| 2. Contacted admitting office to arrange for transfer. | | | |
| 3. Communicated with transfer unit to determine the best time for moving the client. | | | |
| 4. Informed and talked to client of impending transfer. | | | |
| 5. Gathered equipment, belongings, and records. | | | |
| 6. Washed hands. | | | |
| 7. Obtained necessary staff assistance for smooth transfer. | | | |
| 8. Transferred client to wheelchair or gurney unless client was remaining in bed for the transfer. Used protective belt, if necessary. | | | |
| 9. Covered client to provide warmth and to avoid exposure during transfer. | | | |
| 10. Notified head nurse when I arrived on the new unit. | | | |
| 11. Introduced and acquainted client with new roommates. | | | |
| 12. Introduced client to new staff, especially the nurse who would be caring for the client that day. | | | |
| 13. Gave complete report to staff, using client care plan and kardex. Gave information concerning individualized care needs, client problems, progress, when next medications or treatments were due. | | | |
| 14. Notified physician when client's transfer was completed. | | | |
| 15. Notified switchboard and admitting office when transfer was completed. A written transfer slip was sent to the appropriate departments. | | | |
| 16. Notified dietary department, x ray, and the laboratory if tests were scheduled or results pending. | | | |
| 17. Determined that valuables receipt was either with client or on chart. | | | |

## UNIT TWO Height and Weight

### UNIT ASSESSMENT

☐ Checked need for daily or weekly body weight measurements.

☐ Determined appropriate method for obtaining client's weight (bedside scale, bed scale).

☐ Determined ability to stand for height measurement.

### OBTAINING HEIGHT AND WEIGHT

#### Preparation

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Weighed client in the morning before breakfast. | | | |
| 2. Asked client to void before weighing. | | | |
| 3. Used same scale each time I weighed client. | | | |
| 4. Made sure client wore same type of clothing (e.g., gown or robe) for each weighing. | | | |
| 5. If client was bedridden, weighed linens used for covering the client each time client was weighed. | | | |
| 6. Changed wet gowns or heavily saturated dressings before weighing the client. | | | |

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Transported client to scale or brought scale to bedside. | | | |
| 2. Balanced scale so that weight was accurate. | | | |
| 3. Placed clean paper towel on scale or allowed client to wear shoes. | | | |
| 4. Assisted client to stand on scale. | | | |
| 5. Moved weights until weight bar was level or balanced. | | | |
| 6. Recorded weight on appropriate record. | | | |
| 7. Asked client to face front on scale. | | | |
| 8. Instructed client to stand erect. | | | |
| 9. Placed height bar level on top of client's head. | | | |
| 10. Read client's height as measured. | | | |
| 11. Recorded height on appropriate record. | | | |
| 12. Threw away paper towel on scale and assisted client back to room. | | | |

## UNIT THREE Discharge

### UNIT ASSESSMENT

☐ Verified order for client's discharge.

☐ Identified discharge destination (home, rehabilitation unit, extended care setting, etc.).

☐ Assessed client's feelings about discharge.

☐ Reviewed care plan or clinical path to determine client's progress toward goal achievement during hospitalization.

☐ Identified client's teaching needs for discharge.

☐ Assessed need for healthcare assistance in the home.

☐ Determined that discharge needs have been addressed by dietitian, OT, PT, social worker, or other specialist.

☐ Verified that client is ready for discharge.

☐ Tried to determine reason for client's intent to leave the hospital against medical advice.

## DISCHARGING A CLIENT

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

### Preparation

1. Determined physician's discharge orders have been written.
2. Notified family or significant other to arrange transportation. If unavailable, notified discharge coordinator for arrangements.
3. Notified all hospital departments: admitting, cashier, dietary.
4. Ensured that all laboratory work, x rays, treatments, and procedures were completed prior to discharge.
5. Obtained adaptive aids or supplies for client.
6. Provided opportunities for client to discuss impending discharge.
7. Completed client teaching if applicable.

### Procedure

1. Reviewed details of discharge with client.
2. Completed written instructions on Discharge Instructions form.
3. Reviewed any teaching and answered questions about medications, diet, bathing, any activity restrictions (e.g., lifting, sexual activity, driving), etc.
4. Explained how to recognize complications and what to do if they occur.
5. Had client sign Discharge Instructions form and provided client with a copy.
6. Placed agency copy of client's signed Discharge Instructions form on client's chart.
7. Assisted client to retrieve safeguarded valuables per agency policy.
8. Terminated relationship with client.
9. Followed agency's procedure for client discharge, including time and method of leaving hospital unit.
10. Documented time and method of client's discharge, destination, individual accompanying, and any supplies, prescriptions, etc. sent with client.
11. Notified appropriate departments of client's discharge.

## DISCHARGING A CLIENT AGAINST MEDICAL ADVICE (AMA)

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

### Procedure

1. Notified physician if client insisted on leaving the hospital.
2. Ascertained from client exactly why he or she wanted to leave hospital.
3. Explained and validated physician's reasons that continued hospital care was necessary.
4. Explained risks of leaving hospital AMA.
5. Offered client the appropriate form and requested him or her to sign it if client still insisted on leaving.
6. Noted that client refused to sign form and had it witnessed if client refused to sign form.
7. Placed copy of form on client's chart.
8. Documented verbatim statement in nurses' notes.
9. Offered teaching and prepared materials to client.
10. Notified appropriate people—physician, nursing supervisor, administration—when client left premises.
11. Escorted client to the door as you would any discharged client.
12. Notified relatives of client's discharge if concerned for client's safety.

# 6

# Client Education and Discharge Planning

*Performance Checklist*

## UNIT ONE Client Education

### UNIT ASSESSMENT

- ☐ Assessed high-risk criteria for client education.
- ☐ Determined need for client teaching program.
- ☐ Identified client learning style and preferences.
- ☐ Assessed knowledge and skill level of client.
- ☐ Assessed motivation to learn.
- ☐ Assessed readiness and openness to learning.
- ☐ Identified health beliefs and practices.
- ☐ Assessed developmental and educational level of client.
- ☐ Determined appropriate methodology for client teaching sessions.
- ☐ Identified appropriate adjunctive materials, such as audiovisual aids, to enhance learning process.
- ☐ Assessed appropriate setting for individual client.

### COLLECTING DATA AND ESTABLISHING RAPPORT

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Identified personal characteristics. | | | |
| 2. Identified support systems available, both personal and community. | | | |
| 3. Identified values and attitudes toward self and others having his or her particular disease or condition. | | | |
| 4. Assessed knowledge base—anatomy and physiology (normal and disease-related) and disease process—by asking specific questions. | | | |
| 5. Evaluated capacity and ability to perform specific skills, including those previously learned. | | | |
| 6. Assessed knowledge of rationale behind specific skills. | | | |
| 7. Evaluated patterns of coping. | | | |

## DETERMINING READINESS TO LEARN

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Determined client's physiologic readiness. | | | |
| 2. Evaluated client's psychologic readiness. | | | |
| 3. Assessed client's willingness to make changes and be compliant with teaching plan. | | | |
| 4. Assessed family's ability and willingness to participate in teaching. | | | |
| 5. Assessed extent of support and care family members would provide for client at home. | | | |

## ASSESSING LEARNING NEEDS

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Assessed client's learning needs related to diagnosis, hospitalization, surgical procedures, or treatments. | | | |
| 2. Interviewed client to determine daily life routines. | | | |
| 3. Determined client's age and developmental level. | | | |
| 4. Determined client's learning style. | | | |
| 5. Completed cultural assessment. | | | |
| 6. Determined client's educational and literary levels. | | | |
| 7. Assessed client's ability to speak and read English. | | | |
| 8. Used assessment data and assessment instrument to jointly determine client's learning needs: educational, physical, psychosocial, and financial. | | | |
| 9. Formulated needs as goals. | | | |
| 10. Prioritized learning needs or goals. | | | |
| 11. Reviewed with client alternative resources available to accomplish goals. | | | |
| 12. Determined ability of facility, family, staff, or multidisciplinary team to meet goals or learning needs. | | | |
| 13. Identified potential barriers to learning. | | | |
| 14. Obtained verbal or written contract with client for educational program. | | | |
| 15. Referred client to other resources or agencies when appropriate. | | | |

## DETERMINING APPROPRIATE TEACHING STRATEGY

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Considered pertinent factors when determining appropriate strategy:<br>a. How client learns best<br>b. Content to be transmitted and how it is best learned<br>c. Client attention span and retention ability<br>d. Client's reading level<br>e. Materials and resources available<br>f. Appropriate use of staff<br>g. Participation by other health care team members<br>h. Most appropriate time for teaching | | | |
| 2. Used appropriate reading materials for client. | | | |
| 3. Determined which type of teaching strategy would be effective in given situation:<br>a. Group process<br>b. Lecture/discussion | | | |

c. Demonstration/return demonstration
d. Role-playing
e. Games

4. Selected appropriate teaching adjuncts.

## SELECTING THE EDUCATIONAL SETTING

### Procedure

1. Chose appropriate setting based on selected teaching strategy and available facility space.
2. Evaluated types of setting most appropriate to individual client and client's learning needs.
3. Considered informal setting.
4. Considered formal setting.

## IMPLEMENTING THE TEACHING STRATEGY

### Procedure

1. Gathered teaching materials appropriate for client's learning needs and teaching strategy.
2. Sat with client in designated setting, and established warm and accepting relationship.
3. Specified previously established mutual goals and behavioral objectives of program.
4. Clarified or re-clarified contract, agreements, or expected outcomes with individual or group.
5. Assessed teaching situation for any modifications needed and adjusted plans accordingly.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

6. Taught content or components of plan to client.
7. Used appropriate communication skills throughout session.
8. Requested feedback (evaluation interchange) during teaching process.
9. Planned for short, frequent teaching sessions.
10. Adhered to agreed-on starting and ending times; negotiated any changes.
11. Provided closure to teaching situation by summarizing and reiterating agreements made, actions to be taken, or subsequent events to follow.
12. Provided positive reinforcement if not done previously.
13. Terminated teaching session by establishing time for next client contact.
14. Did post-assessment of participation, and planned for corrections and improvements in presentation.
15. Reinforced teaching throughout hospitalization.
16. Sent teaching plan and written material home with client and family.
17. Placed copy of written instructions, signed by client, in chart.
18. Provided copy of written material to home health agency as necessary.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

## EVALUATING TEACHING AND LEARNING

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

### Procedure

1. After demonstrating skill(s), asked client to complete a return demonstration. Evaluated client's ability to perform tasks.
2. Asked client and/or family to explain demonstration using own words.
3. Asked client and/or family specific questions regarding information provided.
4. Developed a simple pre- and post-test to determine client's knowledge base.
5. Developed hypothetical situations for client to problem solve.
6. Used an evaluation tool, if appropriate.
   a. Evaluated forms, format, and types of tools available for evaluation.
   b. Chose an evaluative tool based on goals and objectives of teaching program.

# UNIT TWO Discharge Planning

## UNIT ASSESSMENT

☐ Determined if client required discharge planning.

☐ Determined if client was in high-risk category.

☐ Assessed special needs of client for individualized planning.

☐ Assessed need for multidisciplinary health care workers.

☐ Determined information needed for compiling discharge summary.

## PREPARING A CLIENT FOR DISCHARGE

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

### Procedure

1. Obtained admission history, physical, and hospital progress notes.
2. Determined risk factors for discharge planning.
3. Referred high-risk clients to discharge coordinator or social service department if appropriate.
4. Developed discharge plan (if not already completed) including short- and long-term goals in conjunction with physician and client.
5. Evaluated degree to which client education plan was implemented; reinforced aspects that were incomplete or referred to home agency.
6. Identified need for follow-up care after discharge in conjunction with physician.
7. Made appropriate agency referrals.
8. Completed discharge referral form, and communicated directly with referral agency about client.
9. Developed written discharge instructions for client and family.
10. Updated client care plan, and sent copy to referral agency.
11. Sent client teaching plan and materials to referral agency.
12. Documented discharge summary.

## COMPLETING A DISCHARGE SUMMARY

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Documented complete physical, psychosocial assessment at time of discharge. | | | |
| 2. Reviewed vital sign ranges, and stated latest vital signs. | | | |
| 3. Identified activity level of client. | | | |
| 4. Described use of adaptive devices or equipment needs. | | | |
| 5. Reviewed client teaching plan. Provided explanation of areas where teaching was adequate and where additional reinforcement was required. | | | |
| 6. Identified prescribed medications, dosage, and administration times. Provided information on client's knowledge of medication. | | | |
| 7. Described goal achievement based on client care plan. Described action taken if goal not achieved. | | | |
| 8. Identified referral agencies contacted. | | | |
| 9. Provided information regarding instructions on physician office visits, appointments to health care agencies, or support services. | | | |
| 10. Described client's condition at time of discharge. | | | |
| 11. Documented discharge instructions provided to client and family. | | | |
| 12. Described method of discharge (i.e., wheelchair) and person accompanying client at discharge. | | | |
| 13. Stated means of discharge transportation (e.g., private car, ambulance). | | | |
| 14. Specified discharge facility where client was going. | | | |

7

# Safe Client Environment and Restraints

*Performance Checklist*

## UNIT ONE A Safe Environment

### UNIT ASSESSMENT

- ☐ Identified client's age, medications, previous or chronic sensory impairments, previous level of mobility, ambulatory aids used, and general health history.
- ☐ Assessed client's reliability as an accurate health historian.
- ☐ Identified any alteration in or impending loss of sensory or motor abilities due to illness or injury.
- ☐ Observed and recorded client's present level of consciousness, orientation, mobility, and sensory or motor restrictions.
- ☐ Evaluated client's ability to comprehend instruction about how to use potentially dangerous equipment.
- ☐ Evaluated client's ability to make judgments.
- ☐ Assessed need for specific precautions to promote a safe environment.
- ☐ Assessed type of fire extinguisher needed for specific types of fires.
- ☐ Assessed need for protection while administering care to clients with radioactive implant.

### PREVENTING CLIENT FALLS

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Assessed clients for risk factors for falls. | | | |
| 2. Oriented new clients to their surrounding, including use of call light. | | | |
| 3. Instructed ambulatory clients in use of toilet and shower controls and emergency signals in bathroom. | | | |
| 4. Positioned bed in low position when you were not providing direct client care. | | | |
| 5. Determined whether side-rails were appropriate. | | | |
| 6. Kept half side rails up for all heavily sedated, elderly, confused, and immediate-post surgical clients according to facility policy. | | | |
| 7. Placed articles, such as call light, cups, and water within client's reach. | | | |
| 8. Padded bed rails for client with high risk for seizures. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 9. Reminded client and hospital personnel to lock beds, wheelchairs, and gurneys and to release the lock only after client was secured for transport. | | | |
| 10. Told clients who were weak, sedated, in pain, or who were postoperative to ask for assistance before getting out of bed. | | | |
| 11. Used two staff members to transport client on gurney or gurney or wheelchair when nonattached equipment, such as chest-tube system or IV poles, was required to accompany client in transport. | | | |
| 12. Responded to client's summons as soon as possible. | | | |
| 13. Made sure floors were free of debris that might cause clients to slip and fall. Wiped up spilled liquids immediately. Encouraged housekeepers to use signs for slippery areas. | | | |
| 14. Checked to see that client's unit and hallway were neat and free of hazardous obstacles, such as foot stools, electrical cords, or shoes. | | | |
| *for the High-Risk Client* | | | |
| 15. Attended to acute changes in client's behavior (e.g., hallucinations, abrupt disorientation or altered responses, cognitive impairment). Monitored client frequently. | | | |
| 16. Continuously oriented the disoriented client. | | | |
| 17. Assessed and responded to fluid and elimination needs every two hours. | | | |
| 18. Employed bed, chair, and wander alarms. | | | |
| 19. Assigned aides or elicited the assistance of sitters or family to monitor the high-risk client; made certain they informed you when they left the client's side. | | | |
| 20. Relocated high-risk client to room close to nurses' station. | | | |
| 21. Utilized a recliner chair for client safety. | | | |
| 22. Kept intercom open between client's room and nurse's station. | | | |
| 23. Secured physician's specific orders if restraints were deemed absolutely necessary. | | | |

## PREVENTING THERMAL/ELECTRICAL INJURIES

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Made sure that all electrical appliances were routinely checked and maintained. Checked safety inspection expiration dates on biomedical equipment. | | | |
| 2. Had all electric appliances brought to hospital by client (radios, electric razors, etc.) checked by hospital maintenance staff. | | | |
| 3. Made sure water in tub or shower was not more than 110°F (95°F for those with circulatory insufficiency). | | | |
| 4. When heating pads, sitz bath, or hot compresses were used, checked client frequently for redness. | | | |
| 5. Informed clients and visitors about hospital's smoking regulations. Did not allow confused, sedated, or severely incapacitated clients to smoke without direct supervision. | | | |
| 6. Stored all combustible materials securely to prevent spontaneous combustion. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 7. Made sure that all staff and employees participated in and understood fire safety measures, such as extinguishing fires and evacuating clients. | | | |
| 8. Reported and did not use equipment that produced shock or had defective plug or cord. | | | |
| 9. Did not apply direct heat to ischemic tissue. | | | |
| 10. Turned equipment off before unplugging it. | | | |
| 11. Ensured that equipment requiring high current were plugged into separate outlets. | | | |
| 12. Used only three-pronged grounded plugs. | | | |

## PROVIDING SAFETY FOR CLIENTS DURING A FIRE

### Procedure

| | | | |
|---|---|---|---|
| 1. Followed hospital policy and procedure for type of fire safety program and for ringing fire alarm to summon help. | | | |
| 2. Secured burning area by closing all doors and windows. | | | |
| 3. Shut off all possible oxygen sources and electric appliances in fire area. | | | |
| 4. Removed all clients from immediate area to a safe place. Became familiar with fire exits. | | | |
| 5. Used carrying method most comfortable for nurse and safe for client.<br>a. Placed blanket (or bedspread) on floor. Lowered client onto blanket. Lifted up head end of blanket and dragged client out of danger. | | | |
| b. Used two-person swing method. Placed client in sitting position. Formed a seat by having two people clasp forearms or shoulders. Lifted client into "seat" and carried out of danger. | | | |
| c. Carried client using "back-strap" carry method. Stepped in front of client. Placed client's arms around nurse's neck. Grasped client's wrists and held tight against nurse's chest. Pulled client onto nurse's back and carried to safety. | | | |
| 6. If possible, employed appropriate extinguishing method without endangering myself. | | | |
| 7. Became familiar with the different types of fire extinguishers and their location.<br>a. Class A<br>b. Class B<br>c. Class C<br>d. Class ABC combination | | | |
| 8. Kept fire exits clear at all times. | | | |

## PROVIDING SAFETY FOR CLIENTS RECEIVING RADIOACTIVE MATERIALS

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Reviewed guidelines on radiation safety. | | | |
| 2. If nurse or family member was assisting with a radioactive procedure, they put on a shield. | | | |
| 3. If a radioactive implant was used in a client, all nurses and visitors were protected with a shield. Limited exposure with client. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 4. Kept track of how much time was spent in presence of radioactive material. Requested film badge if in area where ionizing radiation was used frequently. | | | |
| 5. Constantly assessed and supported clients who were undergoing radiation therapy. | | | |
| 6. Followed guidelines for working with clients with unsealed sources of iodine 131. | | | |

## UNIT TWO Restraints

### UNIT ASSESSMENT

- ☐ Assessed client's risk for falls on an ongoing basis.
- ☐ Assessed need for fall prevention measures.
- ☐ Identified least restrictive appropriate type of restraint needed.
- ☐ Assessed area under and surrounding a restraint to ensure it was not restrictive.
- ☐ Evaluated client's response to restraint use.

### MANAGING CLIENTS IN RESTRAINTS

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Gathered appropriate restraint. | | | |
| 2. Sought client's cooperation with restraint procedure, if possible. | | | |
| 3. Applied restraints according to specific directions. | | | |
| 4. Monitored and assessed the client every 15 minutes. | | | |
| 5. Released restraint at least every two hours and provided:<br>a. Toileting<br>b. Fluids and food<br>c. Hygiene care such as brushing teeth or washing face and hands<br>d. Check of circulation and skin, skin care<br>e. Check for body alignment<br>f. Range-of-motion to all joints, particularly those in restraints | | | |
| 6. Avoided application of force on long bone joints when applying or repositioning a restraint. | | | |
| 7. Took vital signs every 8 hours unless indicated more frequently. | | | |
| 8. Bathed client every 24 hours. | | | |
| 9. Did not interrupt the client's sleep unless indicated by his/her medical condition. | | | |
| 10. Ensured that a new order was written and the physician or LIP completed a medical assessment every 24 hours. | | | |
| 11. Obtained a physician's order and discontinued restraints as soon as it was clinically indicated. | | | |
| 12. Documented all assessments and findings on appropriate forms. | | | |

### APPLYING A TORSO BELT RESTRAINT

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked physician's orders and client care plan for torso/belt restraint. | | | |
| 2. Obtained belt. | | | |
| 3. Explained necessity for belt restraint to client. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 4. Applied belt restraint as follows:<br>a. Slipped waist belt through flat buckle, adjusting to client's size.<br>b. Snapped hinged plate shut by hooking plain end of key over crossbar and lifting upward.<br>c. Attached side belts to bed frame in similar manner.<br>d. Released restraint by hooking green end of key over crossbar from below and pulling downward. | | | |
| 5. Documented use of belt restraint in nurses' notes every 15 minutes, including time, rationale, client monitoring, client response, care given, and rationale for discontinuing restraint. | | | |

## USING WRIST RESTRAINTS

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Attempted all other methods of client protection or less restrictive measures before applying restraints. | | | |
| 2. Checked physician's order for wrist or ankle soft restraint. [If necessary, placed restraint on client, then phoned physician or LIP for orders within one hour of application of restraint.] | | | |
| 3. Obtained soft restraints. | | | |
| 4. When applying restraint, placed padded section over the wrist or ankle. | | | |
| 5. Secured restraint by pinching long pronged adapter and inserting into buckle end of restraint, or followed manufacturer's directions. | | | |
| 6. Attached other end of restraint under moveable portion of bed frame by using a half-bow knot. | | | |
| 7. Released restraint every 2 hours to check limb for circulation and skin condition, provided range of motion, changed position, and met client's needs. | | | |
| 8. Documented use of wrist restraints in nurses' notes. Identified all less restrictive actions tried before restraints. | | | |
| 9. Monitored client every 15 minutes. | | | |

## USING MITT RESTRAINTS

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked physician's order, or after placing mitt restraint on client, phoned physician or LIP for orders. | | | |
| 2. Determined if less restrictive actions could be used. | | | |
| 3. Washed hands. | | | |
| 4. Obtained appropriate size mitt restraint and gauze padding, if necessary. | | | |
| 5. Identified client by checking identaband. | | | |
| 6. Explained steps and purpose of procedure to client (to gain his or her cooperation) if client was able to understand. | | | |
| 7. Raised bed to high position. | | | |
| 8. Lowered side rail. | | | |
| 9. Checked condition of skin and circulation in involved extremity. | | | |

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

10. Wrapped fingers with gauze to absorb moisture and prevent abrasion if necessary.
11. Applied mitt; secured wrist ties snugly, but maintained circulation.
12. For hand control, tied restraints to immovable part of bed frame, not to side rail.
13. Placed call bell within access and monitored client every 15 minutes.
14. Removed mitt every 2 hours to check adequacy of circulation and skin condition, and provided range of motion and met fluid and elimination needs.
15. Reapplied mitt.
16. Raised bedrail and lowered bed, according to facility policy.
17. Washed hands.
18. Charted on nurses' notes every 15 minutes: client behavior necessitating restraint; all less-restrictive measures taken; condition of skin and adequacy of circulation of involved extremity; time and site of mitt application; time of release and reaction of client.

## USING ELBOW RESTRAINTS

### Procedure

1. Checked physician's orders.
2. Obtained elbow restraints.
3. Explained necessity of restraints to child's parents.
4. Placed restraints over elbow of both arms. Inserted tongue blades into pockets of restraint when necessary.
5. Wrapped restraints snugly around arm. Secured by tying restraints at top.
6. Tied or pinned restraints to their shirts for small infants and children.
7. Released restraints every 2 hours to allow joint mobility.
8. Assessed position of restraints, circulation, skin condition, and sensation every hour.
9. Provided diversionary activity for small child.
10. Encouraged parents or hospital personnel to hold child to promote a feeling of security.
11. Documented use of restraints, release of restraints, and skin and circulatory condition in nurses' notes every 15 minutes.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

## APPLYING A VEST RESTRAINT

### Procedure

*for Client in Bed*

1. Checked physician's order or applied vest and called physician or LIP within one hour for order.
2. Determined if less restrictive actions could be used.
3. Explained necessity for jacket restraint to client and family.
4. Placed vest over gown.
5. Placed safety vest on client so that closed side of vest was in back and front side of vest crossed over chest, or according to manufacturer's direction.

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 6. Brought strap through slit in front of vest. | | | |
| 7. Tied straps to immovable part of bed frame at waist level using slip knot. | | | |
| 8. Observed client every 15 minutes to ensure proper fit of jacket. | | | |
| 9. Released vest restraint every 2 hours. | | | |
| 10. Documented use of and rationale for restraints in nurses' notes every 15 minutes. | | | |
| 11. Documented client assessment and attendance to fluid and elimination needs regularly. | | | |
| *for Client in Wheelchair* | | | |
| 1. Placed client in wheelchair with buttocks against chair back. | | | |
| 2. Placed vest on client, assuring that there was adequate space between vest and client. | | | |
| 3. Pulled straps at 45-degree angle to rear of seat, pulled vest tails under arm rests, and crossed tails in back of chair. | | | |
| 4. Wrapped tails around immovable kickspur. | | | |
| 5. Tied each tail to kickspur using half-bow knot. | | | |
| 6. Checked client every 15 minutes to ensure vest was on correctly and client was not in compromising situation. | | | |
| 7. Documented every 15 minutes according to policy. | | | |

## APPLYING MUMMY RESTRAINTS

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Placed blanket on a secure surface. | | | |
| 2. Folded down one corner of blanket until tip reached middle of blanket. | | | |
| 3. Placed baby in a diagonal position with head halfway off folded edge of blanket. | | | |
| 4. Brought one side of blanket over infant's arm and trunk, and tucked it under other arm and around back. | | | |
| 5. Tucked bottom part of blanket up onto infant's abdomen. | | | |
| 6. Folded second side over infant and tucked it snugly around body. | | | |
| 7. Washed hands. | | | |
| 8. Used restraint only until procedure was completed. | | | |

# 8

# Bathing, Bedmaking, and Maintaining Skin Integrity

*Performance Checklist*

## UNIT ONE Bedmaking

### UNIT ASSESSMENT

- ☐ Assessed client's need to have linen changed.
- ☐ Determined if client's present condition permitted a change of bed linen.
- ☐ Determined how many and what type of linens were required.
- ☐ Checked client's unit for available linens.
- ☐ Determined client's prescribed level of activity and any special precautions in movement.
- ☐ Assessed client's ability to get out of bed during linen change.

### FOLDING A MITERED CORNER

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Tucked sheet tightly and smoothly under mattress at top or bottom of bed, depending on where mitered corner was needed. | | | |
| 2. Grasped edge of sheet with my hand and brought sheet onto mattress so that edge formed a right angle. | | | |
| 3. Tucked lower edge of sheet under mattress. | | | |
| 4. Placed my finger on sheet where it meets mattress and lowered top of sheet over my finger. | | | |
| 5. Removed finger without disturbing folds. | | | |
| 6. Tucked sheet securely under mattress. | | | |

## CHANGING A PILLOWCASE

### Procedure

1. Picked up center of closed end of pillowcase.
2. Continued to firmly grip end of pillowcase; then with my other hand gathered pillowcase from open end and folded it back (inside-out) over closed end.
3. Picked up center of one end of pillow with my hand, holding gathered pillowcase.
4. Pulled pillowcase over pillow with my other hand. Did not place pillow or case under my arm, chin, or in teeth.
5. Adjusted pillow corners in pillowcase by placing my hand between case and pillow.

## MAKING AN UNOCCUPIED BED

### Procedure

1. Lowered both side rails and placed bed in flat position.
2. Loosened linen on all sides, including head and foot of bed.
3. Removed spread and blanket. If they were to be reused, folded them and placed on chair.
4. Removed top, draw, and bottom sheet, and placed them in linen hamper.
5. Pushed mattress to head of bed. Centered mattress if necessary.
6. Smoothed out any wrinkles and recentered mattress pad on bed surface.
7. Made up one side of bed, then moved to other side of bed and made it.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

8. Placed contour bottom sheet on mattress, and continued making bed at step 13. If using a flat bottom sheet, placed center fold of sheet on the middle of mattress with end of sheet even with end of mattress.
9. Unfolded bottom sheet, and covered mattress.
10. Tucked top of sheet under head of bed.
11. Mitered corner of bottom sheet at head of bed.
12. Tucked remaining side of bottom sheet well under mattress.
13. If client needed a drawsheet, centered drawsheet on bed and opened drawsheet top to opposite side. Tucked sheet under mattress. Smoothed out any wrinkles.
    a. If a pull sheet was needed, folded drawsheet in half or quarters. Positioned sheet on middle of bed.
    b. If absorbent pad was needed, centered it on bed over draw or pull sheet.
14. Moved to other side of bed. Pulled linen toward me and straightened out linen.
15. Tucked top of sheet under head of bed if using a flat sheet.
16. Mitered corner of bottom sheet at head of bed if not using a contour sheet.
17. Tucked remaining bottom sheet well under mattress by gathering sheet into my hand, leaning away from bed, and pulling sheet downward, then tucked sheet under mattress.
18. If drawsheet was used, tightened and tucked the same as bottom sheet.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 19. Straightened out absorbent pad and pulled sheet, if used. | | | |
| 20. Placed top sheet, blanket, and spread full length on top of bed. | | | |
| 21. Left a cuff of top sheet and spread at head of bed. | | | |
| 22. Tucked sheet, spread, and blanket well under foot of mattress, one side at a time. | | | |
| 23. Mitered corners at foot of bed, one side at a time. | | | |
| 24. Made a small pleat or slightly loosened linen to allow room for client's feet. | | | |
| 25. Fanfolded linen to foot of bed. | | | |
| 26. Changed pillowcase. | | | |
| 27. Returned bed to lowest position. Reattached call signal to linens. | | | |
| 28. Pulled side rail up on side farthest from client. | | | |
| 29. If unit was unassigned, left top linen pulled up, covering bed. | | | |
| 30. Disposed of soiled laundry. | | | |

## MAKING A SURGICAL BED

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Brought linens to room and placed on clean chair. | | | |
| 2. Arranged chair and linen hamper conveniently for use. | | | |
| 3. Raised bed to highest position. | | | |
| 4. Placed bottom sheet on bed, using same method as for making an unoccupied bed. | | | |
| 5. Placed a drawsheet and absorbent pad on bed. | | | |
| 6. Laid top sheet, blanket, and bedspread over top of bed. | | | |
| 7. Folded linen from foot, head, and one side of bed up toward center of bed. | | | |
| 8. Folded bottom and top edges nearest me to opposite side, forming a triangle. Picked up center point of triangle. | | | |
| 9. Fanfolded linen to side of bed. | | | |
| 10. Left bed in HIGH position to facilitate easy transfer of surgical client from gurney to bed. | | | |
| 11. Changed pillowcase and left on chair or at foot of bed. | | | |
| 12. Moved all objects away from bedside area. | | | |
| 13. Washed hands. | | | |

## CHANGING AN OCCUPIED BED

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Lowered side rail on my side of the bed, but made sure side rail on opposite side was in UP position. | | | |
| 2. Loosened top linens. | | | |
| 3. Removed spread, sheet, and blanket at the same time the bath blanket was pulled over client. If they were to be reused, folded them and placed on the chair. | | | |
| 4. Placed top sheet in linen hamper. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 5. Pushed mattress to head of bed. Centered mattress if necessary. | | | |
| 6. Assisted client to side of bed, placed in side-lying position facing away from me as near the far side rail as possible. | | | |
| 7. Loosened bottom linens on my side of the bed. | | | |
| 8. Pushed dirty linen under or as close as possible to client. | | | |
| 9. Smoothed out wrinkles and recentered pad on bed surface if mattress pad was used but not changed. | | | |
| 10. Placed clean bottom sheet on mattress while client lying on opposite side of bed. Placed center fold of sheet on middle of mattress with end of sheet even with end of mattress. | | | |
| 11. Unfolded bottom sheet and covered mattress. Made sure clean bottom sheet was underneath any used linen. | | | |
| 12. Tucked top of sheet under head of bed, or positioned contour sheet around corner of mattress. | | | |
| 13. Mitered corner of bottom sheet at head of bed if flat sheet was used. | | | |
| 14. Tucked remaining bottom sheet well under mattress from head to foot. | | | |
| 15. Centered drawsheet on bed, if the client requires a drawsheet, and fanfolded half of sheet under client. Tucked side of sheet under mattress. Smoothed out any wrinkles.<br>a. Folded drawsheet in half or quarters if a pull sheet was needed. Positioned sheet in middle of bed. Fanfolded half of pull sheet under client. | | | |
| b. Fanfolded absorbent pad and centered it on bed under client's buttocks. Placed pad close to client for ease in pulling it through to other side of bed, absorbent side up and plastic side down. | | | |
| 16. Helped client roll over to other side of bed. | | | |
| 17. Told client why there was a hump of linen in center of bed. Made client comfortable. | | | |
| 18. Raised side rail. Moved to other side of bed. | | | |
| 19. Moved linens to other side of bed by gently pulling linens toward me. | | | |
| 20. Lowered side rail, and loosened bottom sheets. | | | |
| 21. Pulled dirty linen to side of bed and rolled into a bundle at the foot of bed or placed linen in linen hamper. | | | |
| 22. Never placed dirty linen on floor. | | | |
| 23. Pulled clean linen across mattress and straightened under client. | | | |
| 24. Mitered top corner of bottom sheet or tucked contour sheet over mattress edge. | | | |
| 25. Gathered bottom sheet into my hand, leaned away from bed, and pulled linens downward at an angle. Tucked remaining bottom sheet well under mattress. If a drawsheet was used, tightened and tucked it in same way. | | | |
| 26. Helped client into a supine position and adjusted pillow. | | | |
| 27. Placed top sheet, blanket, and spread over client. Left at least a 6-inch cuff of top sheet at head of bed. | | | |
| 28. Removed bath blanket, and straightened top sheet and blanket. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 29. Mitered corners at foot of bed. | | | |
| 30. Pulled up all layers of linen at client's toes. Made a small pleat. | | | |
| 31. Raised side rail. | | | |
| 32. Removed pillow from bed, and changed pillowcase. | | | |
| 33. Returned bed to lowest position. Reattached call signal to linens. | | | |
| 34. Positioned client for comfort. | | | |
| 35. Disposed of soiled laundry. | | | |
| 36. Removed gloves, if used, and washed hands. | | | |

## UNIT TWO Bath Care

### UNIT ASSESSMENT

- ☐ Assessed client's need for bathing and other personal hygiene activities.
- ☐ Checked client's activity order. Noted special precautions related to movement or exercise.
- ☐ Assessed client's ability to perform his or her own care and determined how much assistance he or she needed.
- ☐ Discussed client's preferences for bathing procedure, bath, and personal articles.
- ☐ Checked client's room for availability of bathing articles and linens.
- ☐ Assessed client's skin.

### FOLDING A WASHCLOTH MITT

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| **Procedure** | | | |
| 1. Unfolded washcloth. | | | |
| 2. Placed one corner of cloth in palm of my hand, just above my fingers. | | | |
| 3. Wrapped one edge of cloth around palm and fingers. | | | |
| 4. Anchored cloth with thumb. | | | |
| 5. Brought far edge of cloth up and tucked under edge in palm of hand. | | | |
| 6. Folded into small square, if washcloth too small to fold. | | | |

### PROVIDING MORNING CARE

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| **Procedure** | | | |
| 1. Offered bedpan or urinal and assisted client as needed. | | | |
| 2. Donned gloves before giving bedpan or urinal. | | | |
| 3. Moved bed to comfortable working height, and lowered side rail. | | | |
| 4. Put equipment on over-bed table within reach. | | | |
| 5. Washed client's face and hands or assisted as needed. Dried face and hands. | | | |
| 6. Offered oral hygiene. Assisted as needed, and wore gloves if assisting. | | | |
| 7. Held emesis basin so client could rinse after brushing teeth. | | | |
| 8. Assisted client to comfortable position. | | | |
| 9. Repositioned bed, and replaced side rails. | | | |
| 10. Removed equipment and drew curtains. | | | |
| 11. Removed gloves, if used, and washed hands. | | | |

## BATHING AN ADULT CLIENT

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Placed bath blanket over client and over top linen. Loosened top linen at edges and foot of bed.<br>a. Removed dirty top linen from under bath blanket, starting at client's shoulders and rolling linen down toward client's feet.<br>b. Asked client to grasp and hold top edge of bath blanket to keep it in place while I pulled linen to foot of bed.<br>c. Placed dirty linen in laundry hamper. | | | |
| 2. Helped client to side of bed closest to me. Kept side rail on far side of bed in UP position. | | | |
| 3. Removed client's hospital gown. Kept client covered with bath blanket. Placed gown in laundry bag. | | | |
| 4. Removed pillow if client could tolerate it. | | | |
| 5. Placed towel under client's head. | | | |
| 6. Donned clean gloves if risk of exposure to body fluids existed when bathing client. | | | |
| 7. Made a mitt with washcloth. Folded washcloth around my hand. | | | |
| 8. Bathed client's face.<br>a. Washed around client's eyes, using clear water. With one edge of facecloth, wiped from the inner canthus toward the outer canthus. Using a different section of the washcloth, repeated procedure on other eye. Dried client's face thoroughly.<br>b. Washed, rinsed, and dried client's forehead, cheeks, nose, and area around lips. Used soap with client's permission.<br>c. Washed, rinsed, and dried area behind and around the client's ears.<br>d. Washed, rinsed, and dried client's neck. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 9. Removed towel from under client's head. | | | |
| 10. Bathed client's upper body and extremities. Placed towel under area to be bathed.<br>a. Washed both arms by elevating client's arm and holding client's wrist. Used gentle strokes from the wrist toward the shoulder, including the axillary area.<br>b. Washed, rinsed, and dried client's axillae. Applied deodorant and powder if desired.<br>c. Washed client's hands by soaking them in the basin or with a washcloth. Cleaned client's nails.<br>d. Kept client's chest covered with the towel, washed, rinsed, and thoroughly dried client's chest (especially under breasts). Applied powder or cornstarch under breasts if desired. | | | |
| 11. Bathed client's abdomen. Using a towel over chest area and bath blanket, covered areas I was not bathing. Washed, rinsed, and dried abdomen and umbilicus. Replaced bath blanket over client's upper body and abdomen. | | | |
| 12. Bathed client's legs and feet. Placed towel under leg to be bathed. Draped other leg, hip, and genital area with the bath blanket.<br>a. Carefully placed bath basin on the towel near the client's foot.<br>b. With one arm under the client's leg, grasped the client's foot and bent knee. Placed foot in basin of water.<br>c. Bathed client's leg, moving toward hip. Rinsed and dried client's leg.<br>d. Washed client's foot with washcloth. Rinsed and dried foot and area between toes thoroughly.<br>e. Carefully moved basin to other side of bed, and repeated procedure for client's other leg and foot. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 13. Changed bath water. Raised side rails when refilling basin. | | | |
| 14. During the bath, continuously assessed client's skin and musculoskeletal system. Paid careful attention to client's verbal statements and nonverbal expressions. | | | |
| 15. Helped client turn to a side-lying or prone position. Placed towel under area to be bathed. Covered client with a bath blanket. | | | |
| 16. Washed, rinsed, and dried client's back, moving from the shoulders to the buttocks. | | | |
| 17. Provided back massage now or after completion of bath. | | | |
| 18. Bathed client's genital area. Covered all body parts except area to be bathed. Placed towel under client's hips. | | | |
| *for a Female Client*<br>a. Bathed perineum from pubis to rectum.<br>b. Used separate washcloth area for each stroke.<br>c. Discarded soiled washcloth as needed.<br>d. Cleaned labia.<br>e. Washed, rinsed, and dried all areas.<br>f. Ensured all skin folds were dried thoroughly. | | | |
| *for a Male Client*<br>a. Placed towel under penis.<br>b. Held penis by shaft.<br>c. Used circular motion to wash, rinse, and dry meatus and glans in outward direction.<br>d. Gently replaced foreskin to original position.<br>e. Cleansed shaft from tip to base.<br>f. Washed, rinsed, and patted dry the scrotum. | | | |
| 19. Removed gloves and placed in receptacle. | | | |
| 20. Dressed client in clean hospital gown. | | | |
| 21. Cleaned and stored bath equipment. Disposed of dirty linen. | | | |
| 22. Proceeded with any other personal hygiene activities as needed. | | | |
| 23. Replaced call light, lowered bed, and placed side rails in UP position before leaving client. | | | |
| 24. Removed gloves, if used, and washed hands. | | | |

## BATHING AN INFANT

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Tested water temperature with wrist or elbow. | | | |
| 2. Lifted infant using football hold. | | | |
| 3. Removed all clothing except shirt and diaper. | | | |
| 4. Covered infant with towel or blanket, never letting go of infant during bath. | | | |
| 5. Cleaned infant's eyes, using a cotton ball moistened with water. Wiped from inner to outer canthus, using a new cotton ball for each eye. | | | |
| 6. Made a mitt with the washcloth. | | | |
| 7. Washed infant's face with water. | | | |
| 8. Suctioned nose, if necessary, by compressing suction bulb prior to placing it in nostril. | | | |
| 9. Washed infant's ears and neck, paying attention to folds; dried all areas thoroughly. | | | |
| 10. Removed shirt or gown. | | | |
| 11. Removed diaper by picking up infant's ankles in my hand. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 12. Picked up infant and placed feet first into basin or tub. Immersed infant in a tub of water only after umbilical cord had healed. Picked up infant by placing hand and arm around infant, cradling infant's head and neck in my elbow. Grasped infant's thigh with my hand. | | | |
| 13. Washed and rinsed the infant's body, especially skin folds. | | | |
| 14. Washed infant's genitalia.<br>a. For a female infant: Separated labia and with a cotton ball moistened with soap and water, cleansed downward once on each side. Used a new piece of cotton on each side.<br>b. For an uncircumcised male infant: Did not force foreskin back. Gently cleansed the exposed surface with a cotton ball moistened with soap and water.<br>c. For a circumcised male infant: Gently cleansed with plain water. | | | |
| 15. Wrapped infant in towel and used football hold when washing infant's head. Soaped own hands and washed infant's hair and scalp, using circular motion. Rinsed hair and scalp thoroughly. | | | |
| 16. Placed infant on a clean, dry towel with head facing the top corner and wrapped infant. | | | |
| 17. Used corner of towel to dry infant's head with gentle, yet firm, circular movements. | | | |
| 18. Replaced infant's diaper and redressed in a new gown or shirt. | | | |
| 19. Provided comfort by holding infant for a time following bath procedure. | | | |
| 20. Washed hands. | | | |

## BATHING USING DISPOSABLE SYSTEM

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Opened package and removed one cloth at a time. | | | |
| 2. Removed bath blanket at each site when cleansing with cloth. | | | |
| 3. Replaced bath blanket when cloth removed. | | | |
| 4. Used new cloth for each body section in proper sequence. | | | |
| 5. Discarded cloth after cleansing each area and replaced bath blanket over each part of body after cleansing. | | | |
| 6. Placed clean gown on client. | | | |
| 7. Positioned client comfortably. | | | |
| 8. Discarded cloths in appropriate receptacle. | | | |
| 9. Washed hands. | | | |
| 10. Documented bath on nurses' notes. | | | |

## BATHING IN A HYDRAULIC BATHTUB CHAIR

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Brought client to tub room in wheelchair. | | | |
| 2. Filled tub with water and checked temperature. | | | |
| 3. Released chair to lowest point beside tub, and placed towel on floor under chair. | | | |
| 4. Moved client into bathtub chair, and attached seat belt. | | | |
| 5. Swung chair into position over tub. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 6. Directed client to move legs down, then lowered chair into low position in the tub filled with water. | | | |
| 7. Reversed chair out of the tub when client was finished bathing. | | | |
| 8. Assisted client to towel dry. | | | |
| 9. Put clean gown, robe, and slippers on client and transported to room. | | | |
| 10. Washed hands. | | | |

## UNIT THREE Skin Integrity

### UNIT ASSESSMENT

- ☐ Assessed for signs of skin breakdown or eruption of lesions.
- ☐ Assessed color of skin.
- ☐ Assessed color of mucous membranes.
- ☐ Checked for alterations in skin turgor.
- ☐ Evaluated for complaints of itching, tingling, or numbness.
- ☐ Evaluated texture of skin.
- ☐ Assessed client's general hygienic state.
- ☐ Observed client's skin for increased or decreased pigmentation and discoloration.
- ☐ Evaluated client's condition to determine appropriate support surface or specialty bed.

### MONITORING SKIN CONDITION

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Explained monitoring process to client. | | | |
| 2. Provided privacy for client and washed hands. | | | |
| 3. Removed linens and gown if necessary. Covered client with bath blanket. | | | |
| 4. Compared color of client's skin with normal range of color within individual's race. Observed for pallor (white color), flushing (red color), jaundice (yellow color), ashen (gray color), or cyanosis (blue color). | | | |
| 5. Placed back of fingers or hand on client's skin to check temperature. Considered temperature of the room and of hands. | | | |
| 6. Correlated abnormalities in skin color with changes in skin temperature. | | | |
| 7. Observed for areas of excessive dryness, moisture, wrinkling, flaking, and general texture of skin. | | | |
| 8. Gently picked up a small section of skin with thumb and finger. Observed for ease of movement and speed of return to original position to check for skin turgor. | | | |
| 9. Pressed finger firmly against client's skin for several seconds (especially ankle area). After removing finger, observed for lasting impression or indentation. | | | |
| 10. When checking skin temperature and texture of skin, noted client's response to heat, cold, gentle touch, and pressure. | | | |
| 11. Observed amount of oil, moisture, and dirt on skin surface. | | | |
| 12. Noted presence of strong body odors or odors in skin folds. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 13. Used disposable blunt-ended probe such as a comb to detect small moving white specks. | | | |
| 14. Observed for areas of broken skin (lesions) or ulcers. Checked if lesions were present over entire body or if they were localized to a specific area. | | | |
| 15. Checked for skin discolorations (e.g., ecchymosis, petechiae, purpura, erythema, and altered pigmentation). | | | |
| 16. Washed hands. | | | |

## PREVENTING SKIN BREAKDOWN

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Inspected skin daily; observed client's most vulnerable body surfaces for ischemia, hyperemia, or broken areas. | | | |
| 2. Changed client's body position at least once every 2 hours to rotate weight-bearing areas, using turning techniques that minimize skin injury. Observed all vulnerable areas at this time. Included right and left lateral, prone, supine, and swimming-type positioning if possible. | | | |
| 3. Massaged client's skin and pressure-prone areas, if skin was not reddened, when client changed position. | | | |
| 4. Lubricated any dry, unbroken skin to prevent breakdown. | | | |
| 5. Applied lotion to bedridden client's sacrum, elbows, and heels several times during day. | | | |
| 6. Cleansed skin with warm water and mild pH balanced cleansing agent, and applied moisturizers and barrier cream as ordered. | | | |
| 7. Protected healthy skin from drainage secretions. | | | |
| 8. Used protective padding on heels and elbows as needed. | | | |
| 9. Kept linens clean, dry, and wrinkle-free. | | | |
| 10. Encouraged active exercise or range-of-motion exercise. | | | |
| 11. Encouraged client to eat a well-balanced diet with protein-rich foods and adequate fluids. | | | |
| 12. Taught client and family how to prevent pressure areas and pressure ulcer formation. | | | |
| 13. Washed hands. | | | |

## PREVENTING SKIN TEARS

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Used lift sheet or The Booster lift device when moving clients at risk for developing skin tears. | | | |
| 2. Removed tape from dressings carefully; used only paper or nonadherent dressing for at-risk clients, if possible. | | | |
| 3. Assisted clients with ambulation if unsteady gait. Removed objects in pathway. | | | |
| 4. Ensured clients used glasses, if necessary, when ambulating or transferring into chair. | | | |
| 5. Placed padding on beds, wheelchairs, or equipment. | | | |

6. Donned gloves and applied moisturizing agent to dry skin to keep moist.
7. Removed gloves and placed in appropriate receptacle.
8. Washed hands.
9. Documented findings in chart.

## MANAGING SKIN TEARS

### Procedure

1. Washed hands and donned gloves.
2. Removed old dressing being careful to not cause additional skin damage. Moistened dressing with saline before removing if dressing sticks to skin.
3. Assessed for signs of infection.
4. Cleansed skin tear with saline or nontoxic wound cleanser. Avoided putting pressure on skin while cleaning tear.
5. Placed steri-strips over edges of skin flap to approximate edges of tear and surrounding tissue.
6. Applied moist wound dressing over tear site.
7. Secured nonadherent dressing with gauze.
8. Changed dressings according to hospital policy.
9. Removed gloves and placed in appropriate receptacle.
10. Washed hands.
11. Documented findings in chart.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

# UNIT FOUR Evening Care

## UNIT ASSESSMENT

- ☐ Reviewed client's usual routines prior to sleep.
- ☐ Evaluated client's understanding and acceptance of safety precautions, such as use of side rails.
- ☐ Assessed client's needs for comfort and security.
- ☐ Assessed client's physical and emotional status during evening care.
- ☐ Assessed condition of client's back, especially bony prominences.

## PROVIDING EVENING CARE

### Procedure

1. Offered bedpan or urinal if client was unable to use bathroom. Assisted with handwashing.
2. If client needed or requested a bath, provided assistance as needed.
3. Assisted with mouth and dental care as needed.
4. Removed equipment, extra linens, and pillows if possible. Removed stockings, elastic wraps, and binders.
5. Changed dressings. Performed any required procedural techniques.
6. Washed client's face, hands, and back. Provided back massage.
7. Assisted client with combing or brushing hair if desired.
8. Replaced antiembolic (elastic) stockings and binders.
9. Replaced any soiled linen, or straightened and tucked remaining linen. Fluffed pillow and turned cool side to client.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 10. Straightened top linens. Provided additional blankets if desired. | | | |
| 11. Removed any additional equipment. Placed call signal and water (if allowed) within client's reach. | | | |
| 12. Administered sleeping medication if ordered and requested by client. | | | |
| 13. Assessed client for pain. | | | |
| 14. Assisted client into a comfortable position. | | | |
| 15. Ensured that the client's environment was safe and comfortable. | | | |
| 16. Raised side rails, placed bed in LOW position, and turned lighting to low. | | | |
| 17. Removed gloves, if used, and washed hands. | | | |

## PROVIDING BACK CARE

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked client's skin for reddened areas before beginning back rub. | | | |
| 2. Explained purpose of a back rub, and asked client if he or she would like one. | | | |
| 3. Provided privacy. | | | |
| 4. Warmed hands by washing them in warm water. | | | |
| 5. Warmed lotion by holding bottle under water. | | | |
| 6. Raised bed to comfortable height, and assisted the client into a comfortable prone or semiprone position. Kept farthest side rail in UP position. | | | |
| 7. Draped bed clothes for warmth, and untied the client's gown. Washed client's back with warm water and soap if necessary. | | | |
| 8. Placed lotion on hands. | | | |
| 9. Kept hands in constant skin contact with client from beginning backrub until it was completed. | | | |
| 10. Repeatedly moved hands up on either side of client's spine, across shoulders, and down lateral aspects of back using the effleurage stroke, applying firm and steady pressure. | | | |
| 11. Then rubbed hands over the scapular area, extending over upper shoulders, using a circular motion. | | | |
| 12. Moved hands down center of client's back to sacral area. | | | |
| 13. Massaged with a figure-eight motion from sacrum out over each buttock. | | | |
| 14. When stimulation was desired, back and buttocks were lightly struck with the fleshy sides of hands, called tapotement. Using an alternating rhythm, moved up and down the back several times. In addition, kneading was accomplished by picking up skin between thumb and fingers as you moved up the back, a movement called petrissage. | | | |
| 15. Rubbed lightly up and down back a few strokes before lifting hands from client's back. | | | |
| 16. Assessed skin for color, turgor, skin breakdown. | | | |
| 17. Closed client's gown, pulled up bedcovers, and assisted client to change position if desired. Placed side rails in UP position. Placed bed in LOW position. | | | |
| 18. Returned lotion to the proper area. | | | |
| 19. Washed hands. | | | |

# 9

# Personal Hygiene

*Performance Checklist*

## UNIT ONE Oral Hygiene

### UNIT ASSESSMENT

- ☐ Assessed whether client wears dentures.
- ☐ Evaluated client's knowledge of oral hygiene techniques.
- ☐ Assessed condition of client's oral cavity, teeth, gums, and mouth.
- ☐ Assessed for color, lesions, tenderness, inflammation, intactness of teeth, and degree of moisture or dryness of oral cavity.
- ☐ Observed external and internal lips.
- ☐ Assessed palate (roof and floor of mouth), and inspected under tongue.
- ☐ Assessed entire oral mucosa, noting inside of cheek.
- ☐ Observed tongue. Noted tip, sides, back position, and underside.
- ☐ Evaluated condition of gums and teeth.
- ☐ Assessed condition of throat as client says "Ah."
- ☐ If dentures or orthodontic appliances were used, observed relationship of appliances to client's oral cavity (i.e., fit, irritation, condition of dentures).

### PROVIDING ORAL HYGIENE

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Washed hands and donned clean gloves. | | | |
| 2. Requested that client open mouth wide and held emesis basin under chin. | | | |
| 3. Instructed client to complete following steps, or provided care if necessary. Directed bristles of toothbrush toward gum line for all areas to be brushed. | | | |
| 4. Kept brush positioned over only two or three teeth at a time. Used small rotating movements to cover outside surfaces of all teeth. | | | |
| 5. Cleaned inner surfaces of all back teeth, using brushing method described above. | | | |
| 6. Used a firm back-and-forth motion to clean flat chewing surfaces. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 7. Used bristles on end of toothbrush and rotated brush back and forth across teeth to clean inner surfaces of front teeth. | | | |
| 8. Lightly brushed all areas of tongue, being careful to avoid stimulating gag reflex. | | | |
| 9. Rinsed client's mouth thoroughly with water. | | | |
| 10. Inspected oral cavity, and repeated brushing if necessary. | | | |
| 11. Flossed thoroughly, using approximately 12–15 inches of floss loosely wrapped around one finger of each hand. | | | |
| 12. Flossed between each tooth by looping floss around each edge of tooth and sliding floss down to gum line. | | | |
| 13. Rinsed client's mouth thoroughly with water. | | | |
| 14. Wiped off client's mouth and chin. | | | |
| 15. Washed client's toothbrush, rinsed, and put it and toothpaste away and returned any additional equipment. | | | |
| 16. Removed gloves and placed them in appropriate receptacle. | | | |
| 17. Washed hands. | | | |
| 18. Checked to see that client was comfortable. | | | |

## FLOSSING CLIENT'S TEETH

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Washed hands, donned gloves, and placed client in sitting position and moved bed to HIGH position. | | | |
| 2. Placed a towel under client's chin and an emesis basin within reach. | | | |
| 3. Cut dental floss into two 12- to 18-inch lengths. | | | |
| 4. Instructed client to (or you did for client) complete the following steps.<br>a. Wrapped one length of floss around index fingers of both hands.<br>b. Held floss taut between two hands, and gently pulled back and forth between each tooth.<br>c. Moved floss up and down sides of teeth to clean plaque.<br>d. Flossed each tooth several times until all particles of food were removed. | | | |
| 5. Assisted client to rinse mouth and expectorate into emesis basin. | | | |
| 6. Removed basin and wiped client's mouth with towel. | | | |
| 7. Removed gloves, placed them in appropriate receptacle, and washed hands. | | | |
| 8. Lowered bed and returned client to comfortable position. | | | |

## PROVIDING DENTURE CARE

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

4. If client was unable to clean his or her own dentures, placed them in an unbreakable container immediately and carried them to the sink. Placed paper towel or washcloth on bottom of sink to cushion surface in case denture was accidentally dropped.
5. Held one denture in hand. With other hand, used toothbrush or special denture brush and cleaning agent, such as a commercially prepared paste or solution, to brush denture. Used same brushing motion as with natural teeth.
6. Rinsed denture thoroughly in cold water.
7. If dentures were to remain out of mouth for a period of time, as at night, stored them in clearly labeled, unbreakable container of cold water.
8. If dentures were to be worn immediately, helped client to rinse oral cavity with warm water or mouthwash.
9. Gently brushed client's gums and tongue.
10. Helped client replace dentures.
11. Removed gloves, and placed them in appropriate receptacle.
12. Washed hands.

## PROVIDING ORAL CARE FOR UNCONSCIOUS CLIENTS

### Procedure

1. Gathered equipment.
2. Washed hands and donned gloves.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

3. If possible, positioned client on his or her side in a semi-Fowler's position. If this was not possible, turned client's head to the side.
4. Placed a bulb syringe or suctioning equipment nearby to use for suctioning oral cavity as needed.
5. Placed small amount of toothpaste on brush and brushed external surfaces of client's teeth in routine manner, using less water on brush. Did not put fingers in client's mouth.
6. Used a padded tongue blade to separate the upper and lower sets of teeth to clean inner surfaces of teeth. Brushed teeth and tongue in usual manner.
7. Rinsed client's mouth carefully, using very small amounts of water that could be suctioned.
8. Lubricated client's lips with petroleum jelly.
9. Provided oral care frequently—as often as every 2 hours if necessary.
10. Removed gloves, and placed them in appropriate receptacle.
11. Washed hands.

# UNIT TWO Hair Care

## UNIT ASSESSMENT

☐ Reviewed general physical assessment findings.

☐ Elicited information from client regarding loss of hair, tenderness of scalp, or itching.

☐ Determined client's ability to perform own hair care.

☐ If unable to care for own hair, found out who usually assists client.

☐ Observed client's hair and scalp, noting following:

- Texture
- Color
- Degree of thickness and hair distribution
- Degree of gloss or shine
- Dryness or oiliness
- Areas of irritation, rash, or scaliness on the scalp or surrounding skin
- Matting or snarls
- Pediculosis (lice)

☐ Assessed client's usual hair care routines, products, and appliances.

☐ Assessed method for providing hair care (e.g., in bed, on gurney, in wheelchair).

☐ Determined client teaching needs regarding hair care.

## PROVIDING HAIR CARE

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

*for Routine Hair Care*

1. Placed all hair care items within reach.
2. Placed towel over client's shoulders.
3. Brushed or combed client's hair from scalp to hair ends, using gentle, even strokes.
4. Styled hair in a manner suitable to client.
5. Replaced hair care items in appropriate place, and cleaned items as needed.
6. Washed hands.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

*for Tangled Hair*

1. Held client's hair above tangle to prevent discomfort.
2. Using a wide-toothed comb, gently combed tangle. Used short, gentle strokes. Worked out tangle from end of hair shafts toward scalp. Worked on small amount of tangle at one time.
3. Applied small amounts of vinegar or alcohol to client's hair to make combing tangle easier.
4. Styled client's hair in a manner that prevents further tangling (e.g., a loose braid placed in an area that does not put pressure on the head).

*for Coarse or Curly Hair*

1. Combed hair in small sections to remove tangles.
2. Used a comb or pick to comb hair in small sections.
3. Applied a small amount of oil to dry or flaking areas of scalp.
4. Used a wide-toothed comb or pick to gently lift hair and smooth it out evenly.
5. If corn-rowing was desired, made small rows of braids close to the scalp in the client's choice of design.

## SHAMPOOING HAIR

### Procedure

*for Client in a Chair*

1. Had shampoo items readily available.
2. Draped one towel over client's shoulders and around neck. Placed another towel within reach.
3. Faced client away from sink. Locked wheels of wheelchair.
4. Padded edge of sink with towel or bath blanket.
5. Asked client to lean head and neck against sink.
6. Using washcloth to protect client's eyes, wet hair, and gently made lather with shampoo.
7. Rinsed hair thoroughly, and repeated if necessary.
8. Towel dried, added hair conditioner if desired, and rinsed again.
9. Using dry towel, patted hair dry, and wrapped hair in towel turban style to transport client back to bed.
10. Used hair dryer if available.
11. Styled as desired.
12. Replaced equipment.

*for Client on a Gurney*

1. Had shampoo items readily available.
2. Positioned gurney with head end at sink.
3. Locked wheels on gurney.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

4. Padded edge of sink with towel or bath blanket.
5. Moved client's head just beyond edge of gurney to allow water to run off more easily.
6. Put pillow or rolled blanket under client's shoulders to help elevate and extend head.
7. Draped one towel over client's shoulders and around neck. Placed another towel within reach.
8. Used washcloth to protect client's eyes. Wet hair and gently made lather with shampoo.
9. Rinsed hair thoroughly and repeated if necessary.
10. Towel dried hair, added conditioner if desired, and rinsed again.
11. Used dry towel to pat hair dry and wrapped it turban style to transport client back to room.
12. Used hair dryer if available.
13. Styled as desired.
14. Replaced equipment.

*for Client on Bed Rest*

1. Placed shampoo board, if available, under client's head to allow water and soap to run off into basin at side of bed.
2. Draped one towel over client's shoulders and around neck. Placed another towel within reach.
3. Placed client's head on shampoo board.
4. Using washcloth to protect client's eyes, wet hair, and gently made lather with shampoo.
5. Rinsed thoroughly, and repeated if necessary.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

6. Towel dried hair, added conditioner if desired, and rinsed again.
7. Using dry towel, patted hair dry, and wrapped it turban style.
8. Removed equipment from bed.
9. Changed client's gown and linen if wet.
10. Used a hair dryer if available. Ensured that electric equipment was checked by maintenance department before using.
11. Styled as desired.
12. Replaced all equipment.

*for Client Using Disposable System*

1. Heated shampoo package in microwave for no more than 30 seconds.
2. Opened package and checked if cap was too warm.
3. Placed cap on head. Ensured all hair was contained within cap. For longer hair, placed cap on top of head and then tucked up all hair inside cap.
4. Gently massaged cap with hands, 1–2 minutes for short hair and 2–3 minutes for longer hair.

## SHAVING A CLIENT

### Procedure

1. If using safety edge razor:
   a. Donned gloves and applied warm, moist towel to client's skin to soften hair.
   b. Applied thick layer of soap or shaving cream to shaving area.
   c. Holding skin taut, used small, firm strokes in direction of hair growth.
   d. Gently removed soap or lather with warm, damp towel. Inspected for areas you may have missed.
2. If using electric razor:
   a. Used rotating motion of razor and started from lateral aspect of face, moved toward chin and upper lip area.
   b. Cleaned razor.
3. Applied aftershave lotion or powder as desired.
4. Repositioned client for comfort if needed.
5. Removed gloves and replaced equipment.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

## UNIT THREE Pediculosis

### UNIT ASSESSMENT

☐ Observed head (scalp), body (beard, eyebrows, arms, legs), and pubic areas for following signs:

Small, hemorrhagic areas on skin
Scratches on skin
Habitual itching and scratching
Insect-type bites or pustular eruptions behind ears or hairline
Small, white dandruff-like particles

☐ Assessed client's personal hygiene, living conditions, contact or exposure to others with lice (e.g., school-aged children, sexual partners, siblings).

## REMOVING LICE AND SCABIES

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Donned clean gloves.
2. Removed and bagged the client's clothing and linens. (Client's clothes did not need to be bagged separately and placed in isolated bags if standard precautions were used.)
3. Notified physician and other healthcare providers of lice or scabies infestation.
4. Began treatment as ordered by physician.

   *for Using Lindane Lotion for Scabies*
   a. Removed all oil-based hair dressings and skin lotions or creams, dried skin and cooled before applying lindane.
   b. Shook lotion container well. Applied thin film of lotion over entire body, excluding face and urethral meatus. Ensured all body creases and folds had adequate lotion applied.
   c. Rubbed in thoroughly; allowed skin to dry and cool after application. Left on skin for 8–12 hours.
   d. Showered or bathed to remove lotion.

   *for Using Lindane Shampoo for Lice*
   a. Shampooed hair by wetting hair and then applying shampoo. Worked drug into hair thoroughly and allowed to remain on hair for 4 minutes. Before rinsing hair, added small amount of water to form a thick lather, then rinsed hair thoroughly.
   b. Used "nit comb" or tweezers to remove remaining nit shells.
   c. Monitored body and hair for signs of lice. If living lice were present after 7 days, repeated shampoo.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

   d. Instructed client or family to monitor for side effects: eczematous eruptions, headache, nausea, vomiting, irritation of the ear, nose, and throat.

   *for Using Permethrin (Nix) for Lice or Scabies*
   a. Shampooed hair with regular shampoo, rinsed, and toweled dry.
   b. Shook lotion well before applying. Used Nix on hair only, not on skin.
   c. Saturated damp hair with lotion and kept in place for 10 minutes.
   d. Rinsed hair thoroughly and dried with clean towel.
   e. Inspected hair shafts daily for at least 7 days.
   f. Initiated regular shampooing within a day.
   g. Instructed client or family to monitor for side effects of drug: pruritus, transient tingling, burning, stinging, numbness, erythema.
5. Disinfected combs and brushes with the shampoo.
6. Removed gloves.
7. Washed hands.
8. Instructed client or parent to check hair and use "nit comb" every 2 to 3 days until lice were gone and checked skin for removal of scabies.
9. Washed clothes and linens in hot water (130°F) or dried them using high heat.
10. Placed stuffed toys in hot dryer.
11. Instructed client or family to vacuum furniture and floors to rid house of lice.
12. Administered Bactrim if ordered.
13. Discussed the cause, treatment, and preventive measures regarding lice infestation with client and family.

## UNIT FOUR Foot Care

### UNIT ASSESSMENT

- ☐ Reviewed data from general physical assessment.
- ☐ Observed color of client's feet and lower extremities.
- ☐ Assessed temperature of each foot.
- ☐ Noted color, shape, condition, contour, and length of toenails.
- ☐ Assessed speed of color return when nail bed was depressed (capillary refill).
- ☐ Inspected skin of entire foot (including corner of toes, between toes, and heels) for irritation, cracking, lesions, corns, calluses, deformities, and edema.
- ☐ Assessed mobility of ankle and toes for foot drop, plantar flexion, or eversion.
- ☐ Assessed cleanliness of feet.
- ☐ Inspected client's shoes for excessive wear and proper fit.
- ☐ During assessment, gathered data from client about level of comfort, pain, or tenderness.

### PROVIDING FOOT CARE

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Placed towel or bath mat on floor in front of client. | | | |
| 2. Placed basin of warm water on towel. | | | |
| 3. Helped client place feet in basin. | | | |
| 4. Added emollient agent to water if desired. | | | |
| 5. Assisted client with other personal hygiene activities while feet were soaking. Let feet soak for 10 minutes. | | | |
| 6. Using washcloth, gently washed client's feet with soap and water. | | | |
| 7. Dried each foot thoroughly with second towel. Dried between each toe. | | | |
| 8. Using nail clippers, cut straight across nails. | | | |
| 9. Cleaned underneath and on sides of nails using file or orangewood stick. | | | |
| 10. If necessary, pushed back cuticles using orangewood stick. Smoothed rough edges with emery board. | | | |
| 11. Applied lotion to entire foot, focusing on calloused or dry areas. | | | |
| 12. Assisted client in putting on clean socks and shoes or slippers. | | | |
| 13. Replaced equipment. | | | |
| 14. Assisted client to bed or positioned for comfort in chair. | | | |
| 15. Washed hands. | | | |

### PROVIDING NAIL CARE

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked hospital policy on nail cutting; requested that podiatrist see client if appropriate. | | | |
| 2. Washed hands and donned gloves. | | | |
| 3. Positioned client for comfort. | | | |
| 4. Exposed one extremity at a time. | | | |
| 5. Soaked nails if softening was needed. Dried nails. | | | |
| 6. Cut toenails straight across with scissors or clippers. | | | |

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

7. Smoothed cut edges as necessary with file or emery board; was careful not to injure surrounding tissue.
8. Cleaned under nail with orangewood stick to remove any debris.
9. Repositioned client.
10. Removed and cleaned equipment.
11. Removed gloves and washed hands.

## UNIT FIVE Bedpan and Urinal

### UNIT ASSESSMENT

☐ Determined client's usual voiding pattern.

☐ Assessed client's ability to assist with the procedure.

### USING BEDPAN AND URINAL

#### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Donned gloves.
2. Obtained bedpan or urinal and warmed metal bedpan or urinal by running warm water around edges of receptacle.
3. Provided privacy.
4. Elevated head of bed.
5. Placed client in supine position, if possible; or positioned client on edge of bed or in chair.
6. Instructed client to sit on bedpan or use urinal. If client needed assistance, followed these steps:

   *for Using a Bedpan*
   a. Placed absorbent pad under hips if needed.
   b. Raised client's hips and slipped arm under client or turned client on his or her side. Rolled client onto pan.
   c. Placed rolled towel or blanket under client's sacrum.

   *for Using a Urinal*
   a. Placed base of urinal flat on bed between client's thighs.
   b. Positioned client's penis over urinal.
7. Placed signal light and toilet tissue within easy reach.
8. When client had voided, removed receptacle and assisted with wiping as necessary.
9. Provided opportunity for client to wash his or her hands.
10. Repositioned client for comfort, pulled back curtains.
11. Measured intake and output if required.
12. Emptied bedpan or urinal, cleaned equipment, and returned it to proper area in client's room.
13. Removed gloves and washed hands.

### ASSISTING CLIENT TO A COMMODE

#### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Placed commode at foot of bed. Was sure to lock wheels on the commode if needed.
2. Placed slippers on client's feet.

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 3. Moved client to edge of bed and assisted to a sitting position. | | | |
| 4. Instructed client to grasp my shoulders. | | | |
| 5. Placed hands securely around client. | | | |
| 6. Pivoted client in front of commode. | | | |
| 7. Lowered client onto commode, using correct body mechanics; ensured client was securely positioned on commode. | | | |
| 8. Placed toilet tissue within easy reach. | | | |
| 9. Covered client with bath blanket for warmth and modesty. | | | |
| 10. Placed call bell within easy access of client. | | | |
| 11. Provided privacy by closing curtains and shutting door. | | | |
| 12. Washed hands. | | | |

## UNIT SIX Perineal and Genital Care

### UNIT ASSESSMENT

- ☐ Reviewed general assessment data about client.
- ☐ Observed client for signs of perineal itching, burning on urination, or skin irritation. Asked client if he or she experienced any of these problems.
- ☐ Assessed client's ability to bathe himself or herself and to perform perineal care.
- ☐ While providing privacy, assessed the perineal genital area for abnormal secretions, ulcerations, skin excoriations and sensitivity, drainage (amount, consistency, odor, color), swelling, enlarged lymph glands, catheter patency, and comfort.
- ☐ Assessed client's learning needs related to perineal and genital care.

### DRAPING A FEMALE CLIENT

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Brought bath blanket to bedside. | | | |
| 2. Identified client and explained procedure. | | | |
| 3. Provided privacy. | | | |
| 4. Placed bed in HIGH position, and lowered side rail nearest me. | | | |
| 5. Placed bath blanket over client's top linen so that one corner of blanket was pointed toward client's head to form diamond shape over client. | | | |
| 6. Instructed client to hold onto bath blanket. Fanfolded linen to foot of bed. | | | |
| 7. Requested that client flex knees and keep them apart with feet firmly on bed. | | | |
| 8. Wrapped lateral corners of bath blanket around feet in a spiral fashion until they were completely covered. | | | |
| 9. Washed hands. | | | |

### PROVIDING FEMALE PERINEAL CARE

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Placed protective pad or towel and bedpan under client's hips. | | | |
| 2. Donned gloves. | | | |
| 3. Lifted corner of drape. | | | |
| 4. Placed washcloth into basin and rubbed with soap. | | | |
| 5. Folded washcloth into mitt. | | | |

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

6. Separated labia with one hand to expose urethral and vaginal openings.
7. With other hand, washed labia minora; wiped from front to back in downward motion, using warm water or soap and water and washcloth or cotton balls. Was sure to use different corner of the washcloth or different cotton balls for each downward stroke.
8. Changed washcloth if first one was soiled.
9. Placed washcloth in water and continued washing.
10. Washed external labia and anus.
11. Thoroughly patted area dry with second towel.
12. Removed equipment and covered client.
13. Removed gloves.
14. Positioned client for comfort.
15. Washed hands.

## PROVIDING INCONTINENCE CARE

### Procedure

1. Removed soiled gown and placed in linen hamper.
2. Opened package.
3. Cleaned soiled area by cleansing from front to back, using a different cloth for each area of the perineum. Discarded soiled washcloths and packaged in appropriate receptacle.
4. Placed new gown on client and changed linen as needed.
5. Placed client in position of comfort.
6. Removed gloves and placed in appropriate receptacle.
7. Washed hands.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

## PROVIDING MALE PERINEAL CARE

### Preparation

1. Asked client to empty bladder.
2. Provided privacy.
3. Washed hands and donned gloves.
4. Covered client with bath blanket or towel.

### Procedure

1. Placed washcloth in basin with soap.
2. Wrung out washcloth to remove excess water.
3. If client has not been circumcised, retracted his foreskin carefully to expose glans penis.
4. Gently but securely held shaft of penis in one hand.
5. Using circular motion, started at tip of penis and washed downward toward shaft with soap and water. Did not repeat washing over an area without using clean area of the washcloth.
6. Rinsed out washcloth and rinsed area.
7. Replaced foreskin over glans penis.
8. Washed around scrotum.
9. Washed anus last.
10. Rinsed and dried all areas thoroughly.

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 11. Removed articles and covered client. | | | |
| 12. Repositioned client for comfort. | | | |
| 13. Removed gloves, and placed in appropriate receptacle. | | | |
| 14. Washed hands. | | | |

# UNIT SEVEN Eye and Ear Care

## UNIT ASSESSMENT

- ☐ Assessed if client is using eyeglasses or contact lenses, has an artificial eye, or is experiencing any eye problems.
- ☐ Observed client's eyes for symmetry and clarity.
- ☐ Assessed the skin surrounding client's eyes for excessive dryness, scaling, and irritation.
- ☐ Observed eyes for discomfort, irritation, edema, crustation, sties, and lesions.
- ☐ Assessed eye socket for complications.
- ☐ Assessed artificial eye.
- ☐ Assessed client's knowledge related to care of contact lenses.
- ☐ Observed client's tear ducts and sclera for inflammation and excessive tearing.
- ☐ Assessed client's pupils for response to light.
- ☐ Observed client's eye movements or muscle action.
- ☐ Evaluated client's ability to hear.

## PROVIDING ROUTINE EYE CARE

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| **Preparation** | | | |
| 1. Determined client's eye care needs. | | | |
| 2. Explained method of eye care and how client can assist you. | | | |
| 3. Identified client. | | | |
| 4. Washed hands and donned gloves. | | | |
| **Procedure** | | | |
| 1. Used water or saline at room temperature. | | | |
| 2. Using washcloth or cotton balls dampened in water or saline, gently wiped each eye from inner to outer canthus. Used separate cotton ball or corner of washcloth for each eye. | | | |
| 3. If crusting was present, gently placed warm, wet compress over eye(s) until crusting was loosened. | | | |
| 4. Removed gloves and washed hands. | | | |

## PROVIDING EYE CARE FOR COMATOSE CLIENT

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| **Procedure** | | | |
| 1. Washed hands and donned gloves. | | | |
| 2. Cleansed eyes using a dampened washcloth or cotton balls dampened in water or saline. Gently wiped each eye from inner to outer canthus. Used separate cotton ball or corner of washcloth for each eye. | | | |
| 3. Used dropper to instill sterile ophthalmic solution (liquid tears, saline, methyl cellulose) every 3–4 hours as ordered by physician. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 4. Kept client's eyes closed if blink reflex was absent. If eye pads or patches were used, explained their purpose to client's family. Did not tape eyes shut. | | | |
| 5. Removed gloves and washed hands. | | | |
| 6. Removed patch and evaluated condition every 4 hours. | | | |

## PROVIDING POSTOPERATIVE SOCKET CARE

### Procedure

| | | | |
|---|---|---|---|
| 1. Explained procedure to client. | | | |
| 2. Provided privacy. | | | |
| 3. Placed client in a semi to high Fowler's position. | | | |
| 4. Instructed client to not rub his/her eyelids from nose toward side of face. | | | |
| 5. Instructed client to close his/her eyes before wiping eye toward nose in a horizontal direction. | | | |
| 6. Wiped lids toward nose with a facial tissue or warm washcloth to remove secretions and tears. | | | |
| 7. Cleaned dried secretions from lid margins with a cotton-tipped applicator soaked in baby shampoo. | | | |
| 8. Instructed client to take any medications that are prescribed. | | | |
| 9. Applied Opticlude patch if desired. | | | |
| 10. Instructed client on how to replace conformer if it should fall out. | | | |
| a. Washed his/her hands. | | | |
| b. Lifted upper lid with thumb or forefinger of one hand. | | | |
| c. Slid conformer under upper lid. | | | |
| d. Held conformer in place and pulled down on lower lid. | | | |

## REMOVING AND CLEANING AN ARTIFICIAL EYE

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Placed towel on overbed table. Removed eye while working over table. | | | |
| 2. Held palm of nondominant hand below artificial eye. | | | |
| 3. Removed prosthesis using hand or a suction cup. | | | |
| 4. Washed prosthesis in water and a mild soap like Ivory liquid. A "hard contact" lens cleaning solution can be substituted for soap and water. | | | |
| 5. Moistened a facial tissue and rubbed prosthetic eye to remove surface secretions. Rinsed thoroughly with water before reinserting eye. | | | |
| 6. Inspected tissue in and around eye for swelling or drainage. | | | |
| 7. Washed eyelid and dried, wiping from inner to outer canthus. | | | |
| 8. Moistened prosthesis, lifted upper eyelid, and slid into place. | | | |
| 9. Removed gloves and disposed of supplies. | | | |
| 10. Washed hands. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| *for Heavy Mucus Deposit* | | | |
| 1. Washed hands and donned gloves. | | | |
| 2. Explained that client will have eye removed for several hours to soak. | | | |
| 3. Removed artificial eye using steps outlined in above skill. | | | |
| 4. Placed artificial eye in container with 3% hydrogen peroxide. Used sufficient quantities of hydrogen peroxide to completely cover eye. | | | |
| 5. Soaked prosthesis several hours or overnight in hydrogen peroxide solution if there was heavy mucus deposit. | | | |
| 6. Rinsed prosthesis thoroughly and placed in a container with 1/2 tsp. baking soda and cold water. Soaked for 30 minutes. | | | |
| 7. Wiped surface of prosthesis with a damp facial tissue to remove any residual protein deposits. | | | |
| 8. Rinsed well using water or soft contact lens saline solution. | | | |
| 9. Reinserted eye into socket. | | | |
| 10. Removed gloves and washed hands. | | | |

## REMOVING AND CLEANING HARD CONTACT LENSES

### Preparation

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked physician's orders and client care plan. | | | |
| 2. Gathered appropriate equipment. | | | |
| 3. Identified client. | | | |
| 4. Washed hands and donned gloves. | | | |

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Placed client in Fowler's position, and placed towel under client's chin. | | | |
| 2. Placed tip of forefinger across lower lid below its margin. | | | |
| 3. Placed top of forefinger of other hand on upper lid above its margin. | | | |
| 4. Assessed client for presence of a lens. | | | |
| 5. Using scissors motion, manipulated the two lids as client closed, opened, and rolled eyes. | | | |
| 6. Observed carefully when lens popped out to ensure it didn't get lost. | | | |
| 7. Dropped a few drops of contact lens cleaner on lens while holding lens on tip of index finger. | | | |
| 8. Rubbed contact lens between fingertip and thumb for 1 minute or according to directions on lens cleaner container. | | | |
| 9. Held lens gently between tips of index finger and thumb over empty basin, and rinsed by pouring water from container over the lens. | | | |
| 10. Was sure lens was rinsed thoroughly before reinserting it into eye. | | | |
| 11. If lens was not reinserted into eye, stored lens in clean, dry contact lens storage case. Made careful note that each lens was placed in properly marked side of container for that lens. | | | |
| 12. Removed gloves and washed hands. | | | |

## REMOVING AND CLEANING SOFT CONTACT LENSES

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Placed client in supine position, and placed towel under client's chin.
2. Washed hands and donned gloves.
3. Placed tip of thumb across lower lid below its margin.
4. Placed top of forefinger of same hand on upper lid above its margin.
5. Spread eyelids apart as wide as possible.
6. Placed thumb and forefinger directly on soft lens.
7. Gently removed soft lens from surface of eyeball by squeezing lens between thumb and fingertip.
8. Released eyelids.
9. Placed lens in palm of hand or placed disposable lens in trash.
10. Placed 2–3 drops of cleaning solution on lens.
11. Cleaned lens thoroughly by rubbing between fingertip and palm of hand for at least 20–30 seconds.
12. Rinsed lens thoroughly with sterile saline solution or rinsing solution.
13. Placed lens in disinfecting solution according to physician directions. Time varies from hours to one full day.
14. Rinsed lens thoroughly with rinsing solution.
15. Repeated procedure on second lens.
16. Used enzyme tablet or solution according to physician orders, usually weekly.
17. Cleaned lenses container daily and left open to dry. Replaced as directed by physician, either weekly or monthly.

## CLEANING AND CHECKING A HEARING AID

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Determined client's ability to perform all or part of cleaning procedure and taught procedure when necessary.
2. Washed hands and donned gloves.
3. Wiped casing with dry cloth.
4. Checked batteries if hearing aid had not been functioning. Inserted new batteries, matching positive (1) and negative (2) signs.
5. Examined cord for breaks; replaced as necessary.
6. Before inserting ear mold, cleansed outer ear gently with cotton-tipped applicator.
7. Turned receiver switch to ON. Assisted client to adjust volume control to desired level. If whistling or feedback noises occurred, checked for tightness of fit as ear mold probably has not been inserted properly.
8. Placed hearing aid in container when not in use, and stored it in bedside stand.
9. Washed hands and removed gloves.

# 10

# Vital Signs

*Performance Checklist*

## UNIT ONE Temperature

### UNIT ASSESSMENT

- ☐ Determined method most appropriate for obtaining temperature.
- ☐ Determined number of times temperature needed to be taken daily.
- ☐ Assessed temperature in relationship to time of day and age of client.
- ☐ Determined client has not taken hot or cold liquids or smoked 30 minutes prior.
- ☐ Compared temperature with other vital signs to establish baseline data.

### USING A DIGITAL THERMOMETER

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Washed hands. | | | |
| 2. Donned gloves if necessary. | | | |

*for Oral Temperature*

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| a. Waited 20–30 minutes to take an oral temperature if client had been eating, drinking, smoking, or exercising. | | | |
| b. Placed thermometer in client's mouth under tongue. | | | |
| c. Asked client to hold lips closed and left in place 3–5 minutes. | | | |
| d. Removed thermometer and read temperature displayed. | | | |

*for Axillary Temperature*

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| a. Assisted client or child to a comfortable position, and exposed axilla. | | | |
| b. Dried axilla if necessary. | | | |
| c. Placed thermometer bulb in center of axilla. Lowered client's arm down and across the chest. | | | |
| d. Left in place 8–9 minutes. | | | |
| e. Read temperature and returned thermometer to case. | | | |

f. Recorded client's temperature according to hospital procedure.
g. Washed hands.

## USING AN ELECTRONIC THERMOMETER

### Procedure

1. Washed hands and donned gloves, if necessary.
2. Removed thermometer from charger unit.
3. Placed carrying strap around my neck.
4. Grasped probe at top of stem using thumb and forefinger. Did not put pressure on top because it is the ejection button.
5. Firmly inserted probe in disposable probe cover.
6. Provided privacy if necessary.

   *for Oral Temperature*
   a. Instructed client to open mouth and slid probe under front of client's tongue and along gum line to sublingual pocket at base of tongue.
   b. Instructed client to close lips (not teeth). Lips closed at ridge on probe cover.

   *for Rectal Temperature*
   a. Donned gloves.
   b. Positioned client on side facing away from me, separated buttocks, and inserted covered and lubricated probe to 1/4 to 1 1/2 inches through anal sphincter.
   c. Positioned probe to side of rectum to ensure contact with tissue wall.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

7. Removed probe when audible signal occurred. Client's temperature was now registered on the dial.
8. Discarded oral probe cover into trash by pushing ejection button. Discarded rectal probe cover, tissue, and gloves in bathroom.
9. Wiped anal area to remove lubricant and stool.
10. Washed hands.
11. Recorded temperature, and then returned probe to storage well.
12. Returned thermometer unit to charging base. Ensured charging base was plugged into electric outlet.
13. Assisted client to comfortable position.

## MEASURING AN INFANT OR CHILD'S TEMPERATURE

### Procedure

1. Determined appropriate thermometer and route for child.
2. Washed hands.
3. Explained procedure at child's level of understanding.
4. Removed probe from cover or attached probe tip to electronic thermometer.

   *for Oral Route* (only for child 3 year or older)
   a. Placed probe under tongue, one side or the other.
   b. Told child to close mouth or held thermometer in place; monitored child while taking temperature.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

c. Left digital thermometer in place 3–5 minutes or removed when audible signal occurred.

*for Rectal Route*

a. Placed infant or child in prone or side-lying position.
b. Lubricated probe.
c. Inserted thermometer 1/4 to 1/2 inch into rectum for infant; 1/2 to 1 inch for child and held thermometer in place.
d. Turned on scanner and followed directions.
e. Removed probe when tone was heard.

*for Axillary Route*

a. Assisted infant or child to a comfortable position and exposed axilla.
b. Dried axilla if necessary.
c. Placed thermometer in center of axilla; lowered child's arm down and across chest.
d. Left in place 8–9 minutes or until tone was heard.

5. Read and recorded temperature, indicating method.
6. Discarded probe into trash or returned to case.

## USING AN INFRARED THERMOMETER FOR EAR CANAL TEMPERATURE

### Procedure

1. Washed hands.
2. Attached disposable cover centering probe on film and pressed firmly until backing frame of probe cover engaged base of probe.
3. Turned client's head to one side and stabilized head.
4. Pulled pinna upward and back for adult or down and back for child.
5. Centered probe and advanced into ear canal to make a firm seal, directing probe toward tympanic membrane.
6. Pressed and held temperature switch until green light flashed and temperature reading displayed.
7. Removed thermometer. Discarded probe cover.
8. Returned thermometer to home base or storage unit for recharge.
9. Kept lens clean using lint-free wipe or alcohol swab, then wiped dry. Did not use povidone-iodine (Betadine).
10. Washed hands.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

## USING A HEAT-SENSITIVE WEARABLE THERMOMETER

### Procedure

1. Checked orders for continuous-reading thermometer.
2. Dried forehead or axilla.
3. Placed strip on forehead or deep in client's axilla.
4. Read correct temperature by checking color changes.
5. Recorded temperature on appropriate form of record.

## UNIT TWO Pulse Rate

### UNIT ASSESSMENT

- ☐ Assessed appropriate site to obtain pulse.
- ☐ Checked pulse with health status changes.
- ☐ Assessed for rate, rhythm, pattern, and volume.
- ☐ Took an apical pulse on clients with irregular rhythms or those on heart medications.
- ☐ Obtained baseline peripheral pulses in any client going for cardiac or vascular surgery or medical clients with diabetes, arterial occlusive diseases, such as Raynaud's or Buerger's disease, atherosclerosis, or aneurysm.
- ☐ Obtained an apical–radial pulse when deficits occurred between apical and radial measurements.
- ☐ Assessed the need to monitor pulses with an ultrasound or electronic device.

### TAKING A RADIAL PULSE

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Washed hands. | | | |
| 2. Checked client's identaband and placed client in comfortable position. | | | |
| 3. Asked about activity level within last 15 minutes. | | | |
| 4. Palpated arteries by using pads of the middle three fingers of my hand. Pressed artery against bone or underlying firm surface. | | | |
| 5. Counted pulse for 30 seconds, and multiplied by 2 to obtain pulse rate. | | | |
| 6. Counted radial pulse for at least 1 minute if rhythm was irregular or difficult to count. | | | |
| 7. Checked to see that client was comfortable. | | | |
| 8. Washed hands. | | | |
| 9. Recorded pulse rate, rhythm, and strength (volume). | | | |

### TAKING AN APICAL PULSE

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Gathered appropriate equipment. | | | |
| 2. Washed hands. | | | |
| 3. Checked identaband and provided privacy. | | | |
| 4. Explained procedure to client. | | | |
| 5. Placed client in a supine position and exposed chest area. If possible, stood at client's right side. | | | |
| 6. Located apical pulse, termed PMI, by palpating angle of Louis. Counted client's apical pulse.<br>a. Palpated second ICS and placed index finger to left of sternum.<br>b. Located apical pulse in 5th ICS.<br>c. Moved index finger to fifth ICS, MCL. | | | |
| 7. Warmed stethoscope in palm of hand. | | | |
| 8. Counted apical pulse.<br>a. Placed diaphragm of stethoscope firmly over apex of the heart.<br>b. Counted the rate for 1 minute when taking an apical pulse.<br>c. Determined if there was a regular pattern to any irregularity or if it was chaotically irregular. | | | |
| 9. Checked to see that client was comfortable. | | | |
| 10. Washed hands. | | | |
| 11. Recorded apical pulse rate, rhythm, and strength (volume). | | | |

## TAKING AN APICAL–RADIAL PULSE

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

### Procedure

1. Gathered appropriate equipment.
2. Washed hands.
3. Checked client's identaband.
4. Provided privacy.
5. Explained procedure to client especially if two nurses were taking the pulse.
6. Assisted client to a supine position and exposed chest area.
7. Placed watch where clearly visible to both nurses.
8. Warmed stethoscope in hand.
9. Located radial pulse. Second nurse located apical pulse at the fifth intercostal space and midclavicular line, and firmly placed diaphragm of stethoscope on the site.
10. With assistant, selected number on watch to start counting pulse (e.g., 12:00).
11. Signaled to other nurse with my hand when to start taking pulse and when to stop. Both nurses simultaneously counted pulse for 1 full minute.
12. Auscultated apical pulse and palpated radial pulse simultaneously.
    a. Noted a pulse deficit if rhythm is irregular.
    b. Assessed for other abnormal signs if pulse deficit present.
    c. Assessed pulse volume.
13. Subtracted radial rate from apical rate to obtain pulse deficit.
14. Positioned client for comfort.
15. Washed hands.
16. Charted apical and radial rate and pulse deficit.

## TAKING A PERIPHERAL PULSE

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

### Procedure

1. Gathered appropriate equipment.
2. Washed hands.
3. Checked client's identaband.
4. Provided privacy. Explained procedure.
5. Placed client in supine position with relaxed legs.
6. Palpated peripheral pulses: radial, carotid, brachial, femoral, popliteal, dorsalis pedis, posterior tibial. (For special cases, after carotid surgery, palpated temporal pulse also.)
7. Compared pulse sites bilaterally by palpating with pads of middle three fingers of my hand.
8. Pressed artery against the bone or underlying firm surface to occlude vessel and then gradually released pressure.
9. Palpated weak pulses gently.
10. Assessed if bilateral pulses were equal in amplitude (strength).
    a. Examined adjacent area if pulse not palpable.
    b. Marked pulse location.
    c. Compared presence and characteristics of previous findings.
11. Checked to see that client was comfortable.
12. Washed hands.
13. Recorded pulse rate, rhythm, pattern, and volume.

## MONITORING PERIPHERAL PULSES WITH DOPPLER ULTRASOUND STETHOSCOPE

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Gathered appropriate equipment.
2. Washed hands.
3. Checked client's identaband and explained procedure to client.
4. Provided privacy.
5. Uncovered extremity to be assessed.
6. Placed extremity in a comfortable position.
7. Plugged headset (stethoscope) into one of the two outlet jacks located next to volume control.
8. Applied conductive gel to client's skin.
9. Held probe (at tapered end of plastic core) against skin at a 90° angle to the blood vessel being examined.
10. Turned on Doppler stethoscope by pressing down the ON button.
11. Moved probe over site if pulse was not detected. Kept it in direct contact with skin and adjusted volume to detect blood flow.
12. Reapplied new gel if pulse was still not detected and, with light pressure, placed probe over site and turned switch ON. Increased volume control or checked if batteries were weak.
13. Marked site where pulsations were heard.
14. Cleaned gel from skin and probe. Replaced cover over extremity.
15. Positioned client for comfort.
16. Replaced Doppler stethoscope to appropriate location.
17. Washed hands.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

# UNIT THREE Respirations

## UNIT ASSESSMENT

- ☐ Assessed client's respiratory rate, depth, and position.
- ☐ Evaluated any abnormalities noted during inspection and palpation or by percussion and auscultation.
- ☐ Assessed presence of dyspnea or cyanosis.
- ☐ Assessed for presence of abnormal sounds, such as stertorous or sonorous breathing.
- ☐ Assessed if accessory muscles were used for breathing.

## OBTAINING THE RESPIRATORY RATE

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Washed hands.
2. Explained procedure to client.
3. Checked lighting to ensure it was adequate for procedure.
4. Maintained client's privacy.
5. Placed hand on chest or observed chest rise and fall and counted respirations.
6. Noted relationship of inspiration to expiration. Also noted depth and effort of breathing.

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 7. Counted respirations for one minute or 30 seconds and multiplied by 2. | | | |
| 8. Washed hands. | | | |
| 9. Compared respiratory rate with previous recordings. | | | |
| 10. Recorded respiratory rate. Recorded if rhythm or depth altered from normal. | | | |

## UNIT FOUR Blood Pressure

### UNIT ASSESSMENT

- ☐ Assessed blood pressure initially and whenever client's status changed.
- ☐ Assessed size of cuff needed for accurate reading.
- ☐ Assessed beginning and disappearance of Korotkoff's sounds during a blood pressure reading.
- ☐ Assessed presence of factors that could alter blood pressure readings.
- ☐ Noted any changes from prior assessments.

### MEASURING A BLOOD PRESSURE

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Gathered equipment—ensured the cuff was an appropriate size for the client. | | | |
| 2. Provided quiet environment. | | | |
| 3. Washed hands. | | | |
| 4. Checked client's identaband. | | | |
| 5. Explained procedure to client. | | | |
| 6. Placed client in relaxed reclining or sitting position. | | | |
| 7. Prepared client for procedure—allowed client to rest several minutes before beginning a reading. Client was instructed not to cross legs or talk during the procedure. | | | |
| 8. Exposed upper part of client's arm and positioned it with palm upward, arm slightly flexed with whole arm supported at heart level. | | | |
| 9. Chose appropriate-sized cuff and wrapped totally deflated cuff snugly and smoothly around upper part of arm (lower border of cuff 1 inch above antecubital space) with center of cuff bladder over brachial artery (pressure dial or mercury meniscus at 0). | | | |
| 10. Located and palpated brachial artery with fingertips (medial aspect of antecubital fossa). | | | |
| 11. Positioned stethoscope ear pieces in ears. | | | |
| 12. Ensured stethoscope hung freely from ears. | | | |
| 13. Closed valve on sphygmomanometer pump. | | | |
| 14. Inflated cuff rapidly (while palpating radial artery) to a level 30 mm Hg above level at which radial pulsations were no longer felt. | | | |
| 15. Noted level and rapidly deflated cuff, waited 60 seconds. | | | |
| 16. Placed bell (or diaphragm) of stethoscope lightly on the medial antecubital fossa where brachial artery pulsations were located and rapidly inflated cuff to 30 points above previous pressure. | | | |

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

17. Deflated cuff gradually at a constant rate by opening valve on pump (2–4 mm Hg/second) until the first Korotkoff sound was heard.
18. Read pressure at eye level when using manometer filled with mercury.
19. Continued to deflate cuff at a rate of 2 mm Hg/second. Did not reinflate without letting cuff totally deflate.
20. Noted point at which Korotkoff's sounds began (phase I), and when they disappeared completely (phase V).
21. Did not leave cuff inflated for a prolonged period.
22. Deflated cuff completely and waited at least 1–2 minutes before rechecking blood pressure.
23. Removed cuff from client's arm.
24. Checked that client was comfortable.
25. Compared blood pressure reading with previous recordings.
26. Washed hands.
27. Recorded blood pressure readings using two or three phases (120/80, 110/80/20). If appropriate, recorded blood pressure site, client position, and cuff size used.
28. Repeated procedure on opposite arm if it was an initial reading.

## PALPATING SYSTOLIC ARTERIAL BLOOD PRESSURE

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

### Procedure

1. Gathered appropriate equipment. Checked that cuff was appropriate size.
2. Washed hands.
3. Checked client's identaband.
4. Explained procedure to client.
5. Placed client in relaxed position and supported arm at heart level.
6. Wrapped cuff snugly and smoothly around upper part of the arm (1 inch above antecubital space) with center of bladder over brachial artery.
7. Kept pressure level in cuff at 0.
8. Located radial artery pulsations on cuffed arm.
9. Inflated cuff rapidly (while palpating radial artery), to a level 30 mm Hg above level at which radial artery pulsations were no longer felt.
10. Continued to palpate artery and released pressure from cuff slowly (2 mm Hg/second).
11. Removed cuff and returned equipment.
12. Washed hands.
13. Recorded systolic blood pressure reading as "palpated systolic pressure."

## MEASURING LOWER-EXTREMITY BLOOD PRESSURE

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Gathered appropriate equipment.
2. Washed hands.
3. Checked client's identaband.
4. Explained procedure to client.
5. Measured blood pressure in forearm by placing appropriate size cuff around forearm 13 cm from elbow; listened for Korotkoff's sounds over radial artery at wrist.
6. Wrapped cuff snugly and smoothly around lower leg with cuff's distal edge at the malleolus.
7. Located either dorsalis pedis or posterior tibial artery pulsations.
8. Inflated cuff rapidly while palpating foot artery, to a level 30 mm Hg above level at which artery pulsations were no longer felt.
9. Placed bell (or diaphragm) of stethoscope quickly on pulse site.
10. Deflated cuff slowly (2 mm Hg/second) while auscultating sounds over selected artery.
11. Removed cuff and returned equipment.
12. Checked to see that client was comfortable.
13. Recorded readings for first (systolic) and last (diastolic) sounds, noting site and client position.

*Alternative Methods*

14. Measured blood pressure in thigh by using large cuff with bladder placed over posterior midthigh. Listened with stethoscope at popliteal fossa with client in prone position or supine with knee flexed enough for stethoscope placement.
15. Compared blood pressures measured indirectly in the arm, leg, and thigh to reveal similar values.

## MEASURING BLOOD PRESSURE BY FLUSH METHOD IN SMALL INFANT

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Gathered equipment.
2. Washed hands.
3. Checked client's identaband.
4. Wrapped cuff snugly and smoothly just above wrist or ankle.
5. Elevated extremity above heart level.
6. Wrapped elastic bandage firmly around exposed hand or foot.
7. Lowered extremity to heart level when compression was complete.
8. Inflated cuff rapidly to 200 mm Hg.
9. Removed elastic bandage.
10. Deflated cuff slowly (not exceeding 5 mm Hg/second).
11. Instructed assistant to watch for appearance of flush in the extremity distal to cuff.
12. Documented that blood pressure was taken by flush method.

## USING A CONTINUOUS NONINVASIVE MONITORING DEVICE

### Procedure

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

1. Checked client's identaband and washed hands.
2. Gathered equipment.
3. Squeezed air from cuff.
4. Wrapped cuff securely around extremity (usually the arm).
5. Turned power switch ON.
6. Positioned the extremity at level of heart.
7. Set arterial pressure alarm limits by pushing *Alarm* to ON and set both HIGH and LOW parameters by depressing *Alarm* button until parameters read out on digital display.
8. Tested time cycles by turning wheel (found above alarm button) to 1 minute and checked for cycling effects. Then, to set automatic cycle time, moved wheel to desired time increments.
9. Pressed *Start* button for approximately 4 seconds to activate printer for readout of blood pressure.
10. Pressed *Start* button to begin timed blood pressure reading.
11. Alternated extremities if device was used for a prolonged period of time.
12. Checked skin frequently under cuff and position of cuff.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

# 11

# Physical Assessment

*Performance Checklist*

## COMPLETED HEALTH HISTORY

- ☐ Biographic information.
- ☐ Chief complaint.
- ☐ Present health status.
- ☐ Health history.
- ☐ Family history.
- ☐ Psychosocial factors.
- ☐ Nutrition.
- ☐ Domestic violence history.

## USED EXAMINATION TECHNIQUES

- ☐ Inspection.
- ☐ Palpation.
- ☐ Percussion.
- ☐ Auscultation.

## COMPLETED FOCUS ASSESSMENT

### Step 1

- ☐ Assessed level of consciousness.
- ☐ Observed eye contact and responsiveness.
- ☐ Assessed color and texture of skin.
- ☐ Checked IVs.
- ☐ Checked dressing or tubes.
- ☐ Determined orientation of time and place.
- ☐ Established nurse-client relationship.

### Step 2

- ☐ Assessed vital signs.
- ☐ Checked skin temperature and moisture.
- ☐ Checked bilateral pulses.
- ☐ Observed edema in face or neck.
- ☐ Individualized specific assessment according to client's diagnosis.

### Step 3

- ☐ With stethoscope assessed heart sounds, apical pulse, and breath sounds.
- ☐ Observed breathing patterns, symmetry of chest movement, and depth of respirations.
- ☐ Observed chest shape.
- ☐ Checked skin turgor.

### Step 4

- ☐ Assessed bowel sounds using palpation and percussion.
- ☐ Palpated bladder.
- ☐ Observed urine output.

### Step 5

- ☐ Assessed lower extremities.
- ☐ Assessed pedal edema.
- ☐ Checked traction for skin breakdown and alignment.

### Step 6

- ☐ Assessed posterior lung fields.
- ☐ Assessed skin for pressure areas.
- ☐ Evaluated client's ability to move in bed.

## COMPLETED NEUROLOGIC ASSESSMENT

### Level of Consciousness

- ☐ Verbal responses.
- ☐ Motor responses.

### Pupil Assessment

- ☐ Size of pupils.
- ☐ Shape of pupils.
- ☐ Equality of pupils.
- ☐ Reaction to light.

### Motor Function

- ☐ Muscle strength.
- ☐ Flexion and extension.
- ☐ Muscle tone.
- ☐ Coordination.
  - Hand
  - Foot
  - Hand positioning coordination
  - Leg positioning coordination
- ☐ Reflexes.
  - Blink reflex
  - Gag and swallow reflex
  - Plantar reflex (Babinski response)
  - Deep tendon reflex

### Sensory Function

- ☐ Pain.
- ☐ Temperature.
- ☐ Touch.
- ☐ Positioning.

### Vital Signs

- ☐ Respirations.
- ☐ Arterial blood gases.
- ☐ Temperature.
- ☐ Apical and radial pulses.
- ☐ Blood pressure.

## COMPLETED ASSESSMENT OF HEAD AND NECK

### Eye Assessment

- ☐ Visual acuity.
- ☐ External lesions.
- ☐ Equality of eyelid movement.
- ☐ Presence of discharge.
- ☐ Internal lesions.
- ☐ Differences between pupil size and reaction.

### Ear Assessment

- ☐ Auditory acuity.
- ☐ Presence of external lesions.
- ☐ Presence of discharge.

### Nose Assessment

- ☐ Structural changes.
- ☐ Presence of discharge.

### Mouth and Lip Assessment

- ☐ Noted size, color, and location of external lesions.
- ☐ Noted size, color, and location of internal lesions.

### Neck Assessment

- ☐ Noted lesion or swelling.

### Completed Assessment of the Skin

- ☐ Color.
- ☐ Pigmentation.
- ☐ Turgor and mobility.
- ☐ Edema.
- ☐ Moistness and temperature.
- ☐ Sensation.
- ☐ Presence of lesions.

## COMPLETED ASSESSMENT OF THE CHEST: BREASTS, LUNGS, HEART

### Chest Assessment

- ☐ Respiratory rate.
- ☐ General appearance.
- ☐ Shape of chest.
- ☐ Position of ribs.
- ☐ Chest excursion.
- ☐ Tactile fremitus.

### Breast Assessment

- ☐ Size, symmetry, and contour.
- ☐ Color or edema.
- ☐ Venous pattern of skin.
- ☐ Size and shape of nipples.
- ☐ Noted rashes or discharge.
- ☐ Elasticity of nipples.

### Lung/Respiratory Assessment

- ☐ General assessment—respiratory rate.
- ☐ Respiratory depth or volume.
- ☐ Quality and location of lung sounds.
- ☐ Adventitious sounds.
- ☐ Bronchovesicular breath sounds.

☐ Vesicular breath sounds.

☐ Bronchial breath sounds.

### Heart Assessment

☐ Atrioventricular heart sounds.

$S_1$ heart sounds

☐ Semilunar heart sounds.

$S_2$ heart sounds

☐ Diastolic heart sounds.

$S_3$ heart sounds (ventricular gallop)

$S_4$ heart sounds (atrial gallop)

☐ Heart murmurs.

☐ Apical pulse; irregular.

☐ Peripheral pulses.

## COMPLETED ASSESSMENT OF THE ABDOMEN

☐ General contour.

☐ Circumference.

☐ Bowel sounds.

☐ Abdominal muscles.

## COMPLETED ASSESSMENT OF GENITOURINARY TRACT

☐ External urethra.

☐ Urine output.

☐ Presence of blood in urine.

☐ Bladder distention.

☐ Pain.

### Genital Assessment

☐ Any noted lesions or discharge.

Male genitalia

Female genitalia

## COMPLETED MENTAL–HEALTH ASSESSMENT

### General Appearance, Manner, and Attitude

☐ Physical appearance.

☐ Grooming.

☐ Personal hygiene habits.

☐ Posture.

☐ Speech.

☐ Relevance, content, and organization of responses.

### Expressive Aspects of Behavior

☐ General motor activity.

☐ Purposeful movements and gestures.

☐ Gait.

### Consciousness

☐ Level of consciousness.

### Thought Processes and Perceptions

☐ Coherency, logic, and relevance.

☐ Reality orientation.

☐ Perceptions.

### Thought Content and Mental Trend

☐ Degree of anxiety.

☐ Ideation.

☐ Concentration.

### Mood or Affect

☐ Variability in mood.

☐ Abnormal euphoria.

☐ Presence of depression.

### Memory

☐ Past and present memory.

☐ Retention.

☐ Recall.

### Judgment

☐ Judgment.

☐ Decision-making ability.

### Awareness

☐ Degree of insight.

☐ Thoughtful responses indicating an understanding.

### Intelligence

☐ Correct responses to questions.

☐ Fund of information.

### Sensory Ability

☐ Vision.

☐ Hearing.

☐ Tasting.

☐ Feeling.

☐ Smelling.

### Developmental Level and Lifestyle Patterns

☐ Addictive patterns.

☐ Nutritive patterns.

### Coping Devices

☐ Defense-coping mechanisms.

## COMPLETED OBSTETRICAL ASSESSMENT

### Baseline Data

☐ Breasts and nipples.

Contour and size

Presence of lumps

Secretions

☐ Abdomen.

Contour and size

Changes in skin color

Striae

Scar, rashes, or other skin disturbances

☐ Fundal height in centimeters.

☐ Perineum for scars, lesions, or discharge.

Weight

Vital signs, blood pressure (BP), temperature, pulse, and respiration

Lab findings

Urine: sugar, protein, albumin

Hematocrit (HCT)

Hemoglobin (Hgb)

Blood type and Rh factor

Pap smear

VD smears and screening

## Antepartum Assessment

☐ Weight.

☐ Blood pressure.

☐ Fundal height.

☐ Fetal position, using Leopold's maneuvers.

☐ Fetal heart rate by quadrant, location, and rate.

☐ Edema.

☐ Urine (clean catch midstream).

☐ Levels of discomfort.

## Intrapartum Assessment

☐ Lightening and dropping.

☐ Presence of mucous plug has been expelled from cervix.

☐ "Bloody show."

☐ Rupture membranes.

☐ Amniotic fluid.

Color

Quantity

☐ Fetal heart rate.

## Labor and Delivery Assessment

☐ Contractions evaluated.

Frequency

Duration

Intensity

### *Phases*

*First Stage Evaluated*

☐ Latent phase (0–4 cm dilation).

☐ Active phase (4–8 cm).

☐ Transitional phase (8–10 cm).

Bloody show.

Presence of nausea or vomiting.

Perineum.

Urge to bear down.

*Second Stage Evaluated (10 cm to delivery)*

☐ Presenting part.

☐ Caput (infant head).

Multipara

Primipara

☐ Fetal heart rate.

Bradycardia

Tachycardia

☐ Fetal heart rate tracing.

Deceleration

Variable deceleration

Loss of beat-to-beat variation

☐ Breathing.

☐ Pain and anxiety.

*Third Stage Evaluated (from delivery of baby to delivery of placenta)*

*Fourth Stage Evaluated (first hour postpartum)*

☐ Temperature.

☐ Pulse.

☐ Respiration.

☐ Blood pressure.

### Postpartum Assessment

- ☐ Vital signs.
- ☐ Fundus.
- ☐ Lochia.
- ☐ Quantity.
- ☐ Odor.
- ☐ Breasts and nipples daily.
- ☐ Perineum.
- ☐ Bladder.
- ☐ Bowels.
- ☐ Mother–infant bonding.
- ☐ Rh-negative status.

## COMPLETED NEWBORN ASSESSMENT

### Skin Assessment

- ☐ Color and lesions.
- ☐ Nails.
- ☐ Skin tone.

### Head and Neck Assessment

- ☐ Shape of head.
- ☐ Eyes.
- ☐ Placement of ears, shape and position.
- ☐ Nose.
- ☐ Mouth.
- ☐ Neck.
- ☐ Cry.

### Chest and Lung Assessment

- ☐ Chest.
- ☐ Respirations/lungs.

### Heart Assessment

- ☐ Rate, rhythm, and murmurs.

### Abdomen and Gastrointestinal Tract Assessment

- ☐ Abdomen.
- ☐ Gastrointestinal tract.

### Genitourinary Tract Assessment

- ☐ Kidneys and bladder.
- ☐ Genitalia.

  Urethral orifice

  Testes

### Spine and Extremities Assessment

- ☐ Spine.
- ☐ Extremities.
- ☐ Anus and rectum.
- ☐ Completed Apgar score on infant.

## COMPLETED PEDIATRIC ASSESSMENT

### General Measurements

- ☐ Height and weight.
- ☐ Temperature.
- ☐ Circumference of head and chest.
- ☐ Pulse.

☐ Respirations.

☐ Blood pressure.

## Appearance

☐ General appearance.

☐ Voice and cry.

☐ Odor.

## Skin Assessment

☐ Pigmentation.

☐ Lesions.

☐ Signs/symptoms of abuse.

☐ Consistency of skin.

☐ Nails.

☐ Hair (consistency appropriate to ethnic group).

☐ Lymph nodes.

## Head and Neck Assessment

☐ Scalp.

☐ Face.

☐ Eyes.

Gross screening of vision

Placement in eye socket

Iris

Movement

Eyelids

Conjunctiva

Cornea

Discharge

Pupils

Lens

☐ Sinuses.

Position

Discharge

Hearing

☐ Nose.

☐ Mouth.

Gums

Tongue

☐ Throat.

☐ Larynx.

☐ Neck.

☐ Thyroid.

☐ Movement.

## Lungs and Thorax Assessment

☐ Lungs.

☐ Sputum.

☐ Breasts.

## Heart Assessment

☐ Heart sounds.

☐ Femoral pulses.

☐ Edema.

☐ Clubbing of fingers.

☐ Cyanosis.

## Abdomen Assessment

☐ Skin condition.

☐ Peristaltic motion.

☐ Shape.

### Genitourinary Tract Assessment

☐ Female genitalia.

Discharge

☐ Male genitalia.

Presence of urethral orifice

Urethral opening

Foreskin

Placement of testes

Signs of abuse

☐ Urine output.

☐ Anus and rectum.

### Musculoskeletal System

☐ Extremities.

☐ Spine.

☐ Hips.

☐ Joints.

☐ Muscles.

## COMPLETED GERONTOLOGIC ASSESSMENT

### Head, Neck, and Neurologic Assessment

☐ Facial symmetry.

☐ Poor reflex reactions.

☐ Level of alertness—presence of organic brain changes: memory impairment.

☐ Motor function—strength.

### Skin Assessment

☐ Temperature, degree of moisture, dryness.

☐ Intactness, open lesions, tears, pressure ulcers.

☐ Turgor, dehydration.

☐ Pigmentation alterations, potential cancer.

☐ Pruritus.

☐ Bruises, scars.

*Condition of Nails (hard and brittle)*

☐ Presence of fungus.

☐ Overgrown or horny toenails, ingrown.

*Condition of Hair*

☐ Infestations (scabies, lice).

### Chest Assessment

☐ Shape of chest excursion.

☐ Lung and breath sounds.

☐ Quality of cough if present; sputum.

☐ Rib cage deformity.

☐ Dyspnea, hypoxia, and hypercarbia.

☐ Breast—size, symmetry, contour.

Presence of lumps

Size and shape of nipples

### Heart Assessment

☐ Heart sounds.

☐ Peripheral circulation, color, warmth.

☐ Apical pulse.

☐ Jugular vein distention.

- ☐ Orthostatic hypotension.
- ☐ Dizziness.
- ☐ Fainting.
- ☐ Edema.
- ☐ Activity intolerance.
- ☐ Dyspnea.
- ☐ Transient ischemic attacks (TIAs).

## Abdomen Assessment

- ☐ Indications of possible hiatal hernia.
- ☐ Bowel distention.
- ☐ Bowel sounds.

## Urinary Tract—Genital Assessment

- ☐ Condition of skin—dehydration.
- ☐ Urinary output; blood in urine; color; specific gravity; prothrombin time (PT).
- ☐ Incontinence.
- ☐ Bladder distention.
- ☐ Genital assessment.

## Musculoskeletal System Assessment

- ☐ Mobility level.

  Ambulate with more difficulty

  Limitation to movement

  Muscle strength cramps

  Gait becomes unsteady.
- ☐ Presence of kyphosis.
- ☐ Pain in joints.

12

# Body Mechanics and Positioning

*Performance Checklist*

## UNIT ONE Proper Body Mechanics

### UNIT ASSESSMENT

- ☐ Evaluated personnel's knowledge of principles of body mechanics.
- ☐ Evaluated personnel's knowledge of how to use correct muscle groups for specific activities.
- ☐ Assessed knowledge and corrected any misinformation about body alignment and how to maintain it with each position.
- ☐ Assessed knowledge of physical science and application to balance and body alignment.
- ☐ Assessed competency of spinal cord and associated musculature.
- ☐ Assessed muscle mass of long, thick, and strong muscles of the shoulders and thighs.

### ESTABLISHING BODY ALIGNMENT

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Determined need for assistance in moving or turning. | | | |
| 2. Established a firm base of support by placing both feet flat on floor, with one foot slightly in front of other. | | | |
| 3. Distributed weight evenly on both feet. | | | |
| 4. Slightly bent both knees. | | | |
| 5. Held abdomen firm and tucked buttocks in so that spine was in alignment. | | | |
| 6. Held head erect, and secured firm stance. | | | |
| 7. Used this stance as the basis for all actions in moving, turning, and lifting clients. | | | |
| 8. Kept weight to be lifted close to body. | | | |
| 9. Kept three natural curves of back in alignment. | | | |

10. Wore a back brace (if desired) to protect and support back and keep body in alignment.
11. Did not twist body when moving client.

## MAINTAINING PROPER BODY ALIGNMENT

### Procedure

1. Began with proper stance established in previous intervention.
2. Evaluated working height necessary to achieve objective.
3. Tested that this level minimized muscle strain by extending arms and checking that body maintained proper alignment.
4. Flexed knees if necessary to work at a lower level.
5. Made accommodations for working at high surface levels.
6. Worked close to body so that center of gravity was not misaligned and muscles were not hyperextended.
7. Used longest and strongest muscles (biceps, quadriceps, and gluteal) when moving and turning clients.
8. Rolled, pushed, and pulled objects instead of lifting whenever possible.

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

## USING COORDINATED MOVEMENTS

### Procedure

1. Planned muscle movements to distribute workload before I actually began turning, moving, or lifting clients.
2. Moved muscles in a smooth, coordinated manner.
3. Did not make jerky, uncoordinated movements.
4. Coordinated plans and movements before implementing them when working with another staff member.

## USING BASIC PRINCIPLES

### Procedure

1. Moved an object by pushing and pulling to expend minimal energy.
   a. Stood close to object.
   b. Placed myself in proper alignment stance.
   c. Tensed muscles.
   d. Pulled object toward me by leaning away from object and letting arms, hips, and thighs do the work.
   e. Pushed away by leaning toward object.
2. Used pivotal movement when changing direction. Moved muscles as a unit and in alignment, rather than rotating or twisting upper part of body.
3. Did not stoop by bending over when working at lower surface levels. Flexed body at knees and, keeping back straight, used thigh and gluteal muscles to accomplish task.

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 4. Used the muscles of arms and upper torso in an extended, coordinated movement parallel to body stance when reaching to prevent twisting or hyperextension of muscles. | | | |
| 5. Lifted or carried clients or objects with maximum use of body alignment principles. | | | |

## UNIT TWO Moving and Turning Clients

### UNIT ASSESSMENT

- ☐ Observed client and identified ways to improve client's position and alignment.
- ☐ Determined client's physical ability to assist me with positioning.
- ☐ Noted presence of tubes and incisions that altered positioning and alignment procedures.
- ☐ Assessed joint mobility.
- ☐ Assessed skin condition with each turn.

### TURNING TO SIDE-LYING POSITION

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Identified client and washed hands. | | | |
| 2. Explained rationale for procedure to client. | | | |
| 3. Lowered head of bed completely or to position that was as low as client could tolerate. | | | |
| 4. Elevated bed to a comfortable working height. | | | |
| 5. Moved client to side of bed. Put side rails up, and moved to other side of bed. | | | |
| 6. Flexed client's knees. | | | |
| 7. Placed one hand on client's hip and one hand on client's shoulder; rolled onto side. | | | |
| 8. Positioned pillow to maintain proper alignment. | | | |
| 9. Positioned client's arms so that they were not under body. | | | |

### TURNING TO A PRONE POSITION

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Identified client and washed hands. | | | |
| 2. Explained rationale for procedure to client. | | | |
| 3. Lowered head of bed completely or to a position that was as low as client could tolerate. | | | |
| 4. Elevated bed to a comfortable working height. | | | |
| 5. Moved client to side of bed away from side where he or she would finally be positioned. | | | |
| 6. Positioned pillows on side of bed for client's head, thorax, and feet. | | | |
| 7. Rolled client onto pillows, making sure that client's arms were not under his or her body. | | | |
| 8. Repositioned pillows as necessary for client's comfort. | | | |

### MOVING CLIENT UP IN BED

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Identified client. | | | |
| 2. Explained rationale for procedure to client. | | | |
| 3. Lowered head of bed so that it was flat or as low as the client could tolerate. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 4. Raised bed to a comfortable working height. | | | |
| 5. Removed pillow and placed it at the head of bed to prevent striking the client's head against bed. | | | |
| 6. Placed one arm under client's shoulders and other arm under client's thighs. | | | |
| 7. Flexed knees and hips. Moved feet close to bed. | | | |
| 8. Placed weight on back foot. | | | |
| 9. Instructed client to put arms across chest, bend legs, and put feet flat on bed. | | | |
| 10. Shifted weight from back to front foot as lifted client in bed. | | | |
| 11. Asked client to push with feet as you moved him/her. | | | |
| 12. Positioned client comfortably, replacing pillow and arranging bedding as necessary. | | | |

## MOVING CLIENT WITH ASSISTANCE

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Identified client. | | | |
| 2. Explained rationale for procedure to client. | | | |
| 3. Lowered head of bed so that it was flat or as low as client could tolerate. | | | |
| 4. Raised bed to a comfortable working height. | | | |
| 5. Removed pillow, and placed it at head of bed. | | | |
| 6. Positioned with two nurses or staff members. | | | |
| a. First position: Positioned one nurse on each side of client, each assuming position with broad base of support. Each nurse had one arm under client's shoulders and one arm under client's thighs. Asked client to bend knees. | | | |
| b. Alternative position: Positioned one nurse at client's upper body. Nurse's arm nearest head of bed was under client's head and opposite shoulder. Other arm was under client's closest arm and shoulder. Positioned other nurse at client's lower torso. Nurse's arms were under client's lower back and thighs. | | | |
| c. Alternative position: Placed folded drawsheet under client's body extending from shoulder line to just below buttocks. Positioned one nurse on each side of bed. Rolled up sides of lift sheet as close as possible to sides of client. Assisted client to flex knees if possible. Each nurse firmly grasped sheet at level of client's upper back with one hand and at level of buttocks with other hand. | | | |
| 7. Lifted client toward head of bed, and placed client in a comfortable position. | | | |

## TRANSFERRING CLIENT FROM BED TO GURNEY

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Positioned gurney at right angle to bed and locked brakes. | | | |
| 2. Elevated bed to height of gurney and locked wheels. | | | |
| 3. Placed bed in flat position and lowered side rails on side nearest nurses. | | | |
| 4. Positioned two to three nurses on the side toward which the client will move. | | | |

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 5. Positioned first nurse at head and shoulders, second nurse at hips, and third nurse at thighs and ankles. | | | |
| 6. Placed client's arms across chest. | | | |
| 7. Placed one foot toward gurney and assumed wide stance. | | | |
| 8. Flexed knees. | | | |
| 9. Placed arms under client so fingers wrapped around client's body. | | | |
| 10. Lifted client on count of three and brought close to nurses' chests. | | | |
| 11. Lifted client again and pivoted and stepped toward gurney on count of three. | | | |
| 12. Lowered client to center of gurney by flexing knees and hips. | | | |
| 13. Checked client alignment and fixed safety straps on gurney. | | | |

## MOVING TO GURNEY USING TRANSFER BOARD

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Explained procedure to client and showed client transfer board. | | | |
| 2. Covered client with sheet or bath blanket. | | | |
| 3. Covered board and gurney with sheets. | | | |
| 4. Positioned client on side of bed away from gurney in lateral position. | | | |
| 5. Supported client (first nurse); placed board as close to client as possible (second nurse). | | | |
| 6. Instructed client to turn onto back, directly onto board. | | | |
| 7. Positioned both nurses on side of gurney toward which client was to be transferred. | | | |
| 8. Assumed appropriate body mechanics (broad base of support, one foot in front of the other, knees and hips flexed). Placed weight on front foot. Transferred weight on count of three from front to back foot as you lifted board and pulled it toward you. | | | |
| 9. Centered client on gurney and removed board by pulling board out and up using handholds along edge of board and using good body mechanics. | | | |
| 10. Placed all side rails in UP position. | | | |

## DANGLING AT THE BEDSIDE

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Explained procedure to client. | | | |
| 2. Lowered bed to lowest position. | | | |
| 3. Moved client to edge of bed and instructed client to bend knees. | | | |
| 4. Turned client onto side, keeping knees flexed, or placed client in Fowler's position (head elevated at 45 degree angle). | | | |
| 5. Stood at client's hip level. Assumed broad base of support with forward foot closest to client. Flexed your knees, hips, and ankles. | | | |
| 6. Placed one of your arms under client's shoulders and other arm beneath client's thighs near knees. | | | |

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

7. Lifted client's thighs slightly and pivoted on ball of your feet as you moved client into sitting position. Used gluteal, abdominal, leg, and arm muscles to move client.
8. Stood in front of client until client was stable in upright position.
9. Took vital signs especially if this was first time client was dangled.
10. Dangled client for a few minutes before transferring to chair or ambulating.

## MOVING FROM BED TO CHAIR

### Procedure

1. Identified client.
2. Locked bed in place.
3. Placed chair at head of bed. Was sure to lock chair wheels or have someone hold chair as I moved client.
4. Turned client to side and flexed client's knees.
   a. Stood at client's hip level; placed one arm under client's shoulder and other arm over client's thighs with hand beneath knees.
   b. Assisted client to sitting position.
5. Dangled client until he or she was stable.
6. Gave client nonslip shoes or slippers.
7. Assisted client to reach across the chair and grasp chair arm if possible.
8. Placed hands under client's axilla or around client's back.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

9. Placed feet slightly to side and in front of client.
10. Rocked client and, on the count of three, pivoted client into chair.
11. Positioned client in chair to prevent pressure areas. If client had circulatory impairment, elevated legs while out of bed.

## USING A HOYER LIFT

### Procedure

1. Checked orders and care plan. Determined that lift could safely move the weight of the client.
2. Explained the procedure to the client.
3. Washed hands.
4. Brought Hoyer frame to bedside.
5. Provided privacy for client.
6. Locked wheels of bed.
7. Placed client's chair by bed. Allowed adequate space to maneuver the lift.
8. Raised bed to HIGH position and adjusted head and knee gatch so that mattress was flat.
9. Kept side rail on opposite side in UP position.
10. Rolled client away from me.
11. Placed lower edge of wide canvas piece under client's thighs.
12. Placed upper edge of the narrow canvas piece under client's shoulders.
13. Raised side rail on my side of bed.

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 14. Moved to opposite side of bed, and lowered side rail. | | | |
| 15. Rolled client to opposite side, and straightened out canvas pieces. Turned client to supine position. | | | |
| 16. Placed U base of the frame under the bed on side where chair was positioned. | | | |
| 17. Locked wheels of frame. Lowered side rail. | | | |
| 18. Attached canvas straps from swivel bar to each canvas piece using hooks. | | | |
| 19. Ensured straps were evenly placed on canvas pieces for sling extending from shoulders to knees. | | | |
| 20. Elevated head of bed. | | | |
| 21. Raised client by turning release knob clockwise to close pressure valve. | | | |
| 22. Pumped lift handle until client was lifted clear of bed. | | | |
| 23. Maneuvered client over chair. | | | |
| 24. Lowered client by turning release knob slowly counterclockwise. | | | |
| 25. Guided client into chair. | | | |
| 26. Aligned client into chair. | | | |
| 27. Removed the straps from bar and moved lift out of the way. | | | |
| 28. Checked for client's comfort in chair; placed call bell close at hand. | | | |
| 29. Washed hands. | | | |
| 30. Returned client to bed using reverse method. | | | |

## LOGROLLING THE CLIENT

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked order for logrolling client. | | | |
| 2. Checked Kardex and care for rationale for logrolling client. | | | |
| 3. Obtained sufficient assistance to complete the procedure with ease. | | | |
| 4. Placed pillow between client's knees before moving client. | | | |
| 5. Positioned two nurses on side of bed to which client would be turned. Positioned third nurse on other side of bed. | | | |
| 6. Designated person at head of bed to be in charge of coordinating move. | | | |
| 7. Assumed correct position for client move:<br>a. Nurse at head: one arm supported client's head, second arm supported shoulders and neck.<br>b. Second nurse: one hand grasped client's other shoulder, the other hand and arm around knee.<br>c. Third nurse: on the opposite side of the bed, nurse held drawsheet firmly to support torso in alignment. | | | |
| 8. Instructed client to place arms across chest. | | | |
| 9. Assumed broad stance, one foot ahead of other and knees flexed. | | | |
| 10. Rocked onto back foot, and with leg and arm muscles, moved client in one coordinated movement on signal of nurse at head of bed. | | | |
| 11. Maintained client's position in alignment with pillows, towels, or folded blankets. | | | |
| 12. Changed client's position frequently (minimum 2 hours) according to physician's orders. | | | |

## USING A FOOTBOARD

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

### Procedure

1. Assessed client's ability to place feet in dorsal flexion. If unable to do so, or plantar flexion was continuous, provided footboard.
2. Covered footboard with bath blanket to protect feet from rough surfaces.
3. Placed footboard on bed in place where client's feet could firmly rest on it without sliding down in bed.
4. Observed legs to ensure that they were not in flexed position when feet were against board.
5. Tucked top linen under mattress at foot of bed, and brought linen up over footboard to top of bed.
6. Put feet and ankles through range-of-motion exercises every 4 hours for clients on prolonged bed rest.
7. Observed heels and ankles frequently for signs of breakdown.

## PLACING A TROCHANTER ROLL

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

### Procedure

1. Placed client in supine or prone position.
2. Placed folded bath blanket on bed next to client.
3. Extended blanket from greater trochanter to thigh or knee.
4. Placed blanket edge under leg and buttocks to anchor.
5. Rolled bath blanket toward client by rolling it under.
6. Rotated affected leg to slight internal hip rotation.
7. Tightened roll by tucking roll under hip joint.
8. Allowed affected leg to rest against trochanter roll. Hip was in normal alignment, not internally or externally rotated.

# 13

# Exercise and Ambulation

*Performance Checklist*

## UNIT ONE Range of Motion

### UNIT ASSESSMENT

- ☐ Determined client's physical ability to perform exercises (i.e., level of consciousness, presence of casts, traction).
- ☐ Ascertained client's baseline level of joint movement and muscle strength.
- ☐ Noted amount of spontaneous movement shown by the client.
- ☐ Assessed client's understanding of ROM exercises.

### PERFORMING PASSIVE RANGE OF MOTION

#### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Washed hands. | | | |
| 2. Explained rationale for procedure to client. | | | |
| 3. Positioned client on his or her back with bed as flat as possible. Placed bed in HIGH position. | | | |
| 4. Exposed limb to be exercised. | | | |
| 5. Put all joints through range of motion slowly and gently, starting at head. | | | |
| 6. Protected against gravity and detrimental movement when performing range-of-motion exercises. | | | |
| 7. Provided support above and below joint using a cradling or cupping support while performing exercises. | | | |
| 8. Followed sequence of exercises for upper and lower body according to chart. | | | |
| 9. Put all joints through five full-range motion exercises to each joint at least twice daily. | | | |
| 10. Encouraged client to do active exercises as soon as possible. | | | |
| 11. Discontinued exercises if client complained of pain or discomfort. | | | |
| 12. Reassessed client's ability to perform ROM exercises and adjusted schedule accordingly. | | | |

## TEACHING ACTIVE RANGE OF MOTION

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

### Procedure

1. Explained rationale for procedure to client.
2. Demonstrated exercises that client should perform.
3. Watched as client did exercises.
4. Assisted with exercises as needed.
5. Corrected any problems noticed in client's performance.
6. Encouraged client to perform as much of the exercises as possible.
7. Instructed client to do range-of-motion exercises every 4 hours, exercising all joints.

# UNIT TWO Ambulation

## UNIT ASSESSMENT

- ☐ Assessed client's previous activity level.
- ☐ Checked physician's orders for activity.
- ☐ Assessed vital signs and physical ability to ambulate.
- ☐ Assessed need for safety belt.
- ☐ Assessed client for dizziness when moved into upright sitting position.
- ☐ Determined if client felt pain from operative site.
- ☐ Observed client's balance.
- ☐ Assessed any sensory deficits (visual, perceptual).

## MINIMIZING ORTHOSTATIC HYPOTENSION

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

### Procedure

1. Reviewed client's chart prior to ambulation to check for a history of orthostatic hypotension.
2. Washed hands and reviewed procedure with client.
3. Placed elastic stockings on client's legs if ordered.
4. Moved bed to LOW position.
5. *Slowly* raised head of bed to Fowler's position.
6. Moved client to edge of bed. Pivoted client to sitting position and assisted to dangle legs over the side of the bed.
7. Took client's blood pressure and pulse and observed for vertigo, fainting, pallor, etc.
8. *Slowly* assisted client to stand if there was no evidence of orthostatic hypotensive symptoms and began ambulation or transfer to a chair.

## AMBULATING WITH TWO ASSISTANTS

### Procedure

1. Washed hands.
2. Explained rationale for procedure to client.
3. Assisted client to sit on side of bed after placing bed in LOW position.
4. Assessed client for faintness. Kept client in this position until he or she was able to stand without becoming dizzy.

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 5. Positioned one nurse on each side of client and had each nurse grasp the client's upper arm with hand that is closest to client. | | | |
| 6. Had each nurse grasp client's hand with other hand. | | | |
| 7. Encouraged client to maintain erect posture and look straight ahead, not down. | | | |
| 8. Asked client to lift each foot to take a step so that client did not shuffle. | | | |
| 9. Walked client only as far as he or she was capable of walking and returning without exhaustion. | | | |

## AMBULATING WITH ONE ASSISTANT

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked client's chart for ambulation problems, orthostatic hypotension, or any specific physician's orders. | | | |
| 2. Washed hands. | | | |
| 3. Explained rationale for procedure to client. | | | |
| 4. Helped client sit on side of bed after placing bed in LOW position. | | | |
| 5. Assessed client for vertigo or faintness. Kept client in this position until he or she was able to stand without becoming dizzy. | | | |
| 6. Applied safety belt if client was unsteady. | | | |
| 7. Helped client to stand and observed balance. | | | |
| 8. Grasped client around waist to stabilize, and grasped arm with other hand to guide client. | | | |
| 9. Stood on weaker side, except for cerebrovascular accident (CVA) client—then stood on unaffected side. | | | |
| 10. Encouraged client to maintain good posture and to look straight ahead. | | | |
| 11. Instructed client to lift each foot to take a step, not to shuffle. | | | |
| 12. Walked client as far as he or she was capable of walking without becoming exhausted. | | | |

## AMBULATING WITH A WALKER

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Explained rationale for procedure to client. | | | |
| 2. Moved client to edge of bed and pivoted client so feet touched floor. | | | |
| 3. Placed walker directly in front of client. Instructed client to grasp hand grips on walker. | | | |
| 4. Instructed client to push self off bed. | | | |
| 5. Had client bend elbows slightly and move walker forward 6 to 8 inches. | | | |
| 6. Instructed client to move weaker side first by supporting body weight on hands and advancing weaker leg. | | | |
| 7. Instructed client to balance self and then move unaffected side by placing foot even with first foot. | | | |
| 8. Had client move walker forward and continued same pattern of ambulating. | | | |

## AMBULATING WITH A CANE

### Procedure

| | Performed yes | Performed no | Mastered |
|---|---|---|---|
| 1. Checked orders and client care plan. | | | |
| 2. Washed hands. | | | |
| 3. Explained the purpose of using a cane for ambulation, and answered client questions. | | | |
| 4. Demonstrated use of cane if client was unfamiliar with its use. | | | |
| 5. Assisted client to put on appropriate shoes and socks for walking. | | | |
| 6. Assisted client to standing position with feet firmly on the floor. | | | |
| 7. Instructed client to hold cane on the stronger side of the body. | | | |
| 8. Checked that cane extended from greater trochanter to floor with 20°–30° for elbow flexion. | | | |
| 9. Placed cane about 4 inches (10 cm) in front of the foot and slightly to the outside. | | | |
| 10. Determined that client could maintain balance and did not experience vertigo before taking the first step. | | | |
| 11. Assisted client to move cane 4 inches (10 cm) in front and then move affected leg forward, even with cane. | | | |
| 12. Instructed client to move his/her weight to affected leg and cane, then, to move unaffected leg forward, ahead of cane. | | | |
| 13. Assisted client to move cane forward, then to bring affected leg forward, even with cane. Repeated steps for walking with cane. | | | |
| 14. Accompanied client by walking beside him or her on the affected side. | | | |
| 15. Evaluated client's ability to use the cane and instructed about its use as needed. | | | |
| 16. Reinforced the client's achievement to assist him or her to gain confidence in ambulating. | | | |
| 17. Continued to accompany client until the time for walking was completed. | | | |
| 18. Assisted client to return to the room and to bed if indicated. | | | |
| 19. Positioned client for comfort. | | | |
| 20. Assessed client's response to ambulation. | | | |
| 21. Washed hands. | | | |
| 22. Charted client's progress, and evaluated plan for increased periods of ambulation in terms of client's capability. | | | |

# UNIT THREE Crutch Walking

## UNIT ASSESSMENT

- ☐ Assessed physical ability to use crutches and strength of the client's arm, back, and leg muscles.
- ☐ Observed client's ability to balance self.
- ☐ Noted any unilateral or unusual weakness or vertigo.
- ☐ Assessed which gait was appropriate for client.
- ☐ Assessed client's understanding of crutch-walking technique.

## TEACHING MUSCLE-STRENGTHENING EXERCISES

### Procedure

1. Explained the rationale for the exercises to client.
2. Checked client care plan for orders.
3. Demonstrated the exercises that client will practice.
   a. Quadriceps-setting exercises.
   b. Gluteal-setting exercises.
   c. Pushups in sitting position.
   d. Pushups in prone position.
4. Monitored as the client performed the exercises, and corrected any problems that occurred.
5. Assessed the client for increasing strength as he or she continued to practice the exercises.

## MEASURING CLIENT FOR CRUTCHES

### Procedure

1. Explained rationale for procedure to client.
2. Told client to put on shoes she or he would wear when using crutches.
3. Asked client to lie flat in bed with arms at sides.
4. Measured distance from client's axilla (armpit) to a point 6–8 inches out from heel.
5. Adjusted hand bars on crutches so that client's elbows were always slightly flexed.
6. Told client to stand with crutches under arms.
7. Measured distance between client's axilla and arm pieces on crutches. Was able to put two of my fingers in space between axilla and crutch bar.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

## TEACHING CRUTCH WALKING: FOUR-POINT GAIT

### Procedure

1. Explained rationale for procedure to client.
2. Demonstrated crutch–foot sequence to client.
   a. Moved the right crutch.
   b. Moved the left foot.
   c. Moved the left crutch.
   d. Moved the right foot.
3. Helped client practice the gait. Was ready to help with balance if necessary.
4. Assessed client's progress, and corrected mistakes as they occurred.

## TEACHING CRUTCH WALKING: THREE-POINT GAIT

### Procedure

1. Explained rationale for procedure to client.
2. Demonstrated crutch–foot sequence to client.
   a. Two crutches supported the weaker extremity.
   b. Balanced weight on the crutches.
   c. Moved both crutches and affected leg forward.
   d. Moved unaffected leg forward.
3. Assessed client's progress, and corrected any mistakes as they occurred.
4. Remained with client until crutch safety was ensured.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

## TEACHING CRUTCH WALKING: TWO-POINT GAIT

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

### Procedure

1. Explained rationale for procedure to client.
2. Demonstrated crutch–foot sequence to client.
   a. Advanced right foot and left crutch simultaneously.
   b. Advanced left foot and right crutch simultaneously.
3. Helped client practice gait.
4. Assessed client's progress, and corrected any mistakes as they occurred.

## TEACHING SWING-TO GAIT AND SWING-THROUGH GAIT

### Procedure

1. Explained rationale for procedure to client.
2. Demonstrated crutch–foot sequence to client.
   a. Moved both crutches forward.
   b. Swing-to gait: Lifted and swung body to crutches.
   c. Swing-through gait: Lifted and swung body past crutches.
   d. Brought crutches in front of body and repeated.
3. Helped client practice gaits.
4. Assessed client's progress, and corrected any mistakes as they occurred.

## TEACHING UPSTAIRS AND DOWNSTAIRS AMBULATION WITH CRUTCHES

| Performed | | Mastered |
|---|---|---|
| yes | no | |
| | | |

### Procedure

1. Explained rationale for procedure to client.
2. Applied safety belt if client was unsteady or required support.
3. Demonstrated procedure using three-point gait.

   *Going downstairs:*
   a. Started with weight on uninjured leg and crutches on same level.
   b. Put crutches on first step.
   c. Put weight on crutch handles and transferred unaffected extremity to step where crutches were placed.
   d. Repeated until client understood procedure.

   *Going upstairs:*
   a. Started with crutches and unaffected extremity on same level.
   b. Put weight on crutch handles and lifted unaffected extremity onto first step of stairs.
   c. Put weight on unaffected extremity and lifted other extremity and crutches to step.
   d. Repeated until client understood procedure.
4. Helped client practice.
5. Made sure that client had adequate balance. Was ready to assist if necessary.
6. Assessed client's progress, and corrected any mistakes as they occurred.

## TEACHING MOVING IN AND OUT OF CHAIR WITH CRUTCHES

### Procedure

1. Explained procedure to client.
2. Applied safety belt if client was unsteady with crutches.
3. Instructed client to follow these steps.

*for Moving into Chair*

a. Stood in front of the chair.
b. Placed both crutches in hand on affected side.
c. Held onto chair arm on affected side.
d. Lowered self into chair by bending knees and hips.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |

*for Moving out of Chair*

a. Moved forward in chair by using unaffected side to slide body to edge of chair.
b. Held onto chair arm on unaffected side.
c. Placed both crutches in hand on unaffected side.
d. Lifted self out of chair by grasping the chair arm and supporting self with crutches.
e. Placed crutches in front and slightly to side of body and began crutch walking.

| Performed yes | Performed no | Mastered |
|---|---|---|
| | | |