



Checklist

Elimination: Positioning and Removing a Bedpan

Step by Step

SATISFACTORY /

UNSATISFACTORY

EVALUATOR'S COMMENTS

Positioning and Removing a Bedpan

*Provide privacy as needed.

*Introduce yourself to the client.

*Perform hand hygiene and put on appropriate PPE if indicated.

*Verify client identification.

*Determine whether the client has allergies.

*Provide client education.

Gather needed supplies.

Take measures to protect the client's intravenous site, drains, and dressings during movement onto and off of the bedpan.

Cover the areas of the bedpan that will touch the client's skin with a facility approved substance to reduce shearing.

Raise the bed to a comfortable working height and lower the side rail on the side of the nurse's dominant hand.

If the client is able, ask them to raise their hips using the overhead trapeze frame, if present. Place an absorbent pad onto the bed under the area of the client's buttocks and the bedpan under the buttocks with the broad portion of the bedpan positioned toward the patient and the open rim positioned toward the foot of the bed.

If the client needs assistance, place a hand under the sacral area to help with raising the client's hips and use the other hand to slide the absorbent pad and bedpan under the raised hips with the broad portion of the bedpan positioned toward the patient and the open rim positioned toward the foot of the bed.

Elevate the head of the bed to 45° to 90°, placing the client in a near-sitting position, as tolerated.

**Document the relevant information (assessment findings, pharmacological and nonpharmacological interventions) in the client's medical record.*

Step by StepSATISFACTORY /
UNSATISFACTORY

EVALUATOR'S COMMENTS

If the client is unable to assist with lifting their hips, explain the steps to position the bedpan:

Determine which direction would be easiest for the client to roll, keeping in mind any limitations such as paralysis, fracture, or postsurgical limitations.

If necessary, move to the opposite side of the bed to ensure that the client will be rolling away from you. Raise the side rail before moving to the opposite side of the client's bed.

Lower the head of the bed to the lowest position tolerated by the client and assist the client to roll to one side.

Ask the client to hold on to the side rail to aid with maintaining a side-lying position until the bedpan is placed. If the client is unable to hold onto the side rail, use the nondominant hand to support the client in the lateral position.

Place an absorbent pad under the client's buttocks.

Place the bedpan underneath the client and against the buttocks, ensuring that it is centrally aligned with the broad portion of the bedpan placed toward the back of the buttocks and the open rim positioned toward the foot of the bed.

Assist the client to roll onto the back and on top of the bedpan while keeping one hand on the bedpan until the client has completely rolled over onto the bedpan.

Raise the head of the bed, if tolerated by the client, to a near-sitting position.

Raise the side rail, provide the call light, and provide for privacy.

If a call light is unavailable or the client is weak or confused, stay within distance of the client so that the client may call out when finished using the bedpan.

If the client has an alteration in communication, check the client every 2 minutes until the client is finished using the bedpan.

When the patient is finished using the bedpan, lower the head of the bed to the level that was used when placing the bedpan.

**Document the relevant information (assessment findings, pharmacological and nonpharmacological interventions) in the client's medical record.*

Step by Step

	SATISFACTORY / UNSATISFACTORY		EVALUATOR'S COMMENTS
Assist the client to roll over while stabilizing the bedpan in a flat position on the bed with one hand.			
Support the client's lower back with one hand while removing the bedpan and placing it on a chair or stool next to the bed.			
Place a towel over the bedpan and make sure that no part of the contents is touched if output is being measured.			
Provide toilet tissue for drying the perianal area and assist as needed.			
Cleanse the perineal area and buttocks according to facility policy.			
If assisting a female, cleanse from front to back and change the cloth after each wipe.			
Clean and dry the area between the client's legs.			
Observe the integrity of the perianal skin.			
Assist the client to resume a position of comfort.			
Raise the side rail and lower the bed to its lowest position.			
Measure output if prescribed.			
Clean the bedpan and store for future use.			
Provide the client with a washcloth or disposable hand wipes to use to cleanse the hands. Discard disposable hand wipes and place used washcloths in the soiled laundry bin after use.			
Perform hand hygiene.			
*Ensure that the client is in a safe position and has the call light within reach prior to leaving the room.			

**Document the relevant information (assessment findings, pharmacological and nonpharmacological interventions) in the client's medical record.*

References

- Caple, C., & Pravikoff, D. (2018). Nursing practice and skill: Patient positioning (noncritical care patients): Supine. EBESCO Skill Competency Checklist: Bedpan or Urinal: Assisting With.
- Mennella, H., & Schub, T. (2017). Nursing practice and skill: Bedpan or urinal: Assisting with. Cinahl Information Systems.