chapter

# 18 Lifting, Moving, and Positioning Patients

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## Objectives

*Upon completing this chapter, you should be able to:*

**Theory**

1. Describe the anatomy and function of the musculoskeletal system.
2. Explain the importance of proper body mechanics, alignment, and position change for both patient and nurse.
3. Discuss the principles of body movement and positioning, giving an appropriate example for each principle.
4. Identify ways to maintain the patient's correct body alignment in bed or in a chair.
5. Describe the proper method for transferring a patient between wheelchair and bed.

**Clinical Practice**

1. Correctly position a patient in the following positions: supine, prone, Fowler, and Sims.
2. Assist patients to sit up in bed.
3. Demonstrate complete passive range-of-motion (ROM) exercises for a patient.
4. Correctly transfer a patient from a wheelchair to a bed.
5. Transfer a patient from a bed to a stretcher.
6. Demonstrate the correct techniques for ambulating a patient and for breaking a fall while ambulating.

## Skills

| | |
|---|---|
| Skill 18-1 | Positioning the Patient |
| Skill 18-2 | Moving the Patient Up in Bed |
| Skill 18-3 | Passive Range-of-Motion (ROM) Exercises |
| Skill 18-4 | Transferring the Patient to a Wheelchair |
| Skill 18-5 | Transferring the Patient to a Stretcher |
| Skill 18-6 | Ambulating the Patient and Breaking a Fall |

## Key Terms

**alignment** (ă-LĪN-mĭnt, p. 259)
**ambulate** (ĂM-bŭ-lāt, p. 262)
**bone** (p. 259)
**bursa** (BŬR-să, p. 259)
**cartilage** (CĂR-tĭ-lĭj, p. 259)
**contractures** (kŏn-TRĂK-chŭrz, p. 261)
**dangling** (p. 271)
**Fowler position** (FŌW-lĕr, p. 263)
**gait** (p. 262)
**gait belt** (p. 279)
**joint** (p. 259)
**kinesiology** (kĭ-nē-sī-Ŏ-lō-jē, p. 259)
**lateral position** (LĂ-tĕr-ăl, p. 263)
**ligaments** (LĬG-ă-mĕntz, p. 259)
**logrolling** (LŎG-rō-lĭng, p. 268)
**necrosis** (nē-KRŌ-sĭs, p. 262)
**pivot** (PĬV-ŏt, p. 261)
**pressure ulcers** (PRĔ-shŭr ŬL-sĕrz, p. 261)
**prone position** (PRŌN, p. 264)
**semi-Fowler position** (SĔ-mī FŌW-lĕr, p. 263)
**shearing force** (SHĒR-ĭng, p. 262)
**side-lying (lateral) position** (SĪD-lī-ĭng, p. 263)
**Sims position** (p. 263)
**skeletal muscles** (p. 259)
**supine position** (SOO-pīn, p. 263)
**symmetry** (SĬM-ĭ-trē, p. 262)
**tendons** (p. 259)
**transfer belt** (p. 279)

Lifting, moving, and positioning patients are integral parts of your workday. To provide the best patient care and prevent self-injury, you must know the principles of body mechanics. Coordinated movement involves using the bones, joints, and skeletal muscles properly. Many institutions are moving toward a "no manual lifting" policy or to the use of a lift team to decrease health care worker back injuries from repetitive lifting. Until equipment or lift teams are in place in all health care institutions, there will be instances when a nurse must lift a patient without assistance or use of a mechanical device. The following principles and practices serve as guides to help prevent injury.

Chapter 18 worksheet.



## Critical Thinking Activities

*Read each clinical scenario and discuss the questions with your classmates.*

### Scenario A

You are caring for a 43-year-old man who has an infected leg wound following a hiking accident. He is to keep his leg elevated and is under Contact Precautions. He has recently retired from the military and has just moved to the area. He is bored and restless. How would you help meet his psychosocial needs?

### Scenario B

What would you do if you observed the physician's glove become contaminated during a sterile procedure and the physician appeared unaware that this had occurred? Be specific.

### Scenario C

Your home care patient is an older man with a large abdominal wound that needs daily dressing changes. He lives with his wife, but she has severe arthritis in her hands and is unable to perform the procedure. You are scheduled for three visits per week. How would you solve the problem of getting his daily dressing change done on the days you are not scheduled to visit?

## OVERVIEW OF STRUCTURE AND FUNCTION OF THE MUSCULOSKELETAL SYSTEM

### WHICH STRUCTURES ARE INVOLVED IN POSITIONING AND MOVING PATIENTS?

- The musculoskeletal system contains skeletal muscles, ligaments, tendons, bones, joints, and cartilage.
- **Bone** is a dense and hard type of connective tissue. There are four basic types of bones—short, long, flat, and irregular—and they are made up of compact and spongy bone.
- A **joint** is the place of union of two or more bones in the body. Joints can be freely movable, slightly movable, or immovable.
- **Bursae** are small fluid-filled sacs that provide a cushion at friction points in freely movable joints.
- **Skeletal muscles** are striated muscles that are made of bundles of muscle fibers surrounded by a connective tissue sheath.
- **Tendons** are cords of fibrous connective tissue that connect a muscle to a bone to allow for joint movement.
- **Ligaments** connect bones or cartilage to provide support and strength.
- **Cartilage** is a fibrous connective tissue that acts as a cushion.

### WHAT ARE THE FUNCTIONS OF BONES FOR POSITIONING AND MOVING PATIENTS?

- Bones provide the scaffolding or framework to the body (Figure 18-1).
- The skeleton gives the body shape and supports the internal organs and skin.
- The bones provide places for the ligaments and tendons to attach, thereby allowing movement.
- The primary function of a joint is to provide movement and flexibility to the skeleton.

### WHAT ARE THE FUNCTIONS OF MUSCLES FOR POSITIONING AND MOVING PATIENTS?

- Skeletal muscle contraction is accomplished through the stimulation of its many muscle fibers.
- Contraction of skeletal muscles provides movement, stabilizes joints, produces body heat, and maintains posture.

### WHAT CHANGES IN THE SYSTEM OCCUR WITH AGING?

- Bone strength and mass are lost because of mineral resorption. This may lead to osteoporosis, which is more common in women.
- The loss of bone density predisposes the elderly patient to fractures. The fractures do not heal as quickly because of the decreased mineral uptake.

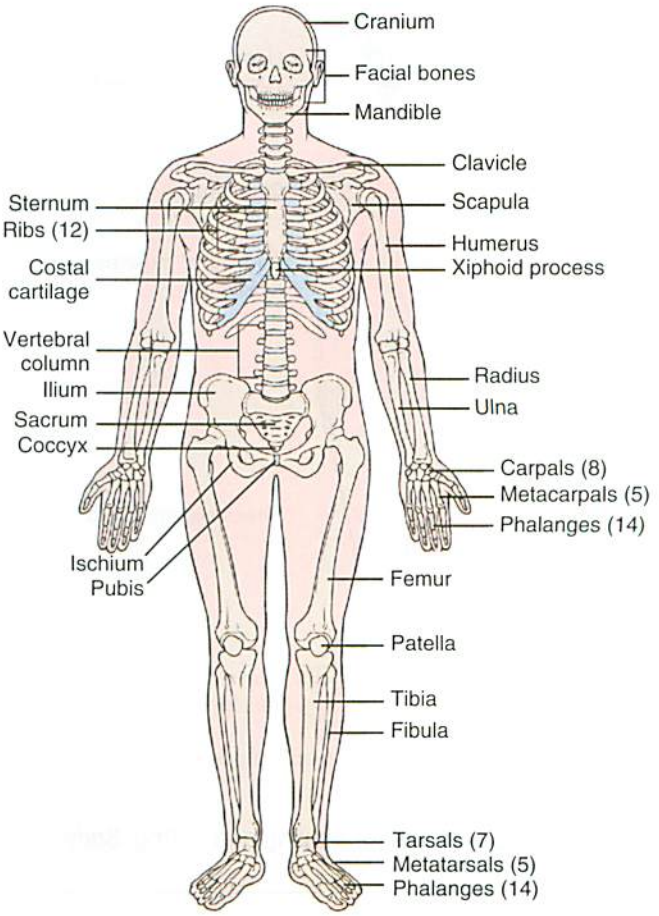



FIGURE 18-1 Anterior view of a normal skeletal system.

- Muscle cells are lost and replaced by fat. This leads to a loss of muscle strength and endurance.
- Muscle fiber elasticity is decreased or lost, causing decreased flexibility.
- Joint motion may decrease, limiting mobility, activity, and exercise.

## PRINCIPLES OF BODY MOVEMENT FOR NURSES

**Kinesiology** (also called body mechanics) is the study of the movement of body parts. There are two main reasons why the use of good body movement is important for you and your patient. The first reason is that the body functions best when it is in correct anatomic position or **alignment** (arrangement in a straight line, bringing a line into order). Correct body alignment is generally called "good posture" (Figure 18-2). The second reason for proper body movement is to prevent injuries. **One of the most common injuries for health care workers is lower back strain.** With proper use of body mechanics, many injuries can be avoided. (See the Evolve website for tips for keeping your back strong.)

In today's health care environment, more patients are being cared for at home. For these people and their caregivers to be safe, everyone must use correct lifting, moving, and positioning techniques (Box 18-1).

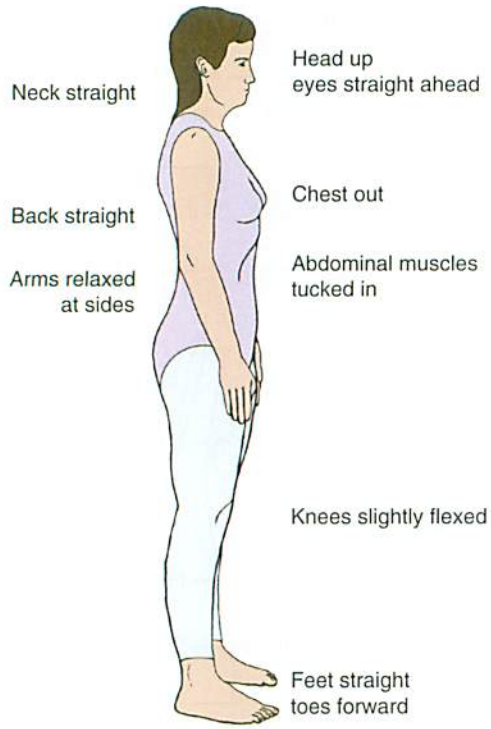



FIGURE 18-2 Correct standing body alignment.

**Box 18-1 Guidelines for Moving and Lifting: Body Mechanics**

- Obtain help whenever possible.
- Ask the patient to help if able.
- Bend or flex knees.
- Use the greatest number of muscles possible.
- Use thigh, arm, or leg muscles rather than back muscles.
- Use a wide base of support. Keep feet about shoulders' width apart.
- Use smooth coordinated movement; avoid jerking or sudden pulling motions.
- Keep elbows and work close to your body.
- Work at the same level or height as the object to be moved.
- Remember that pulling actions require less effort than pushing or lifting.
- Directly face the object or person to be moved.
- Keep trunk straight; do not twist when lifting or pulling.
- Use arms as levers when pulling the patient toward you. Lock the elbows and rock back on your heels, using the weight of your body to move the patient.

### OBTAIN HELP WHENEVER POSSIBLE

It is always desirable to get help when moving patients. Combining the efforts of two nurses to change a patient's position divides the work. Each nurse has less weight or fewer parts of the body to move. Sometimes it is difficult to find another person to assist you. It is always better to wait for help than to risk injury to yourself or the patient. Encourage the patient to assist when transferring and moving if possible. Use devices such as mechanical lifts and transfer or roller boards where available. Properly used, these items decrease the workload and prevent injury.

FIGURE 18-3 Using leg muscles to prevent back strain.

### USE YOUR LEG MUSCLES

In positioning and transferring, use the muscles in your legs as much as possible. Instead of bending over at the waist to pick up something from the floor, bend at the knees and lower yourself until you can pick up the item without straining your back (Figure 18-3). Use the greatest number of muscles possible when lifting or moving an object. For instance, when turning a patient in bed, flex your knees and use the muscles in your legs as well as your arms. Without the power in your legs, the muscles in your arms will have more work. It is far better to use thigh, arm, and leg muscles rather than back muscles.

### PROVIDE STABILITY FOR MOVEMENT

Keep your feet about shoulders' width apart. This establishes a wide base of support and provides stability for movement. Think how easy it is to sway if you stand with your feet together and your eyes closed. Yet, if you spread your feet apart and close your eyes, you do not sway.

### USE SMOOTH, COORDINATED MOVEMENTS

**Use smooth, coordinated movements instead of jerking or sudden pulling motions.** To coordinate effort, tell the patient and other staff members to move, lift, or pull "on the count of 3." This will help to ensure that everyone is working at the same time to maximize the effort and decrease the individual load.

### KEEP LOADS CLOSE TO THE BODY

**Keep your elbows and work close to your body.** This keeps the workload close to your waist and

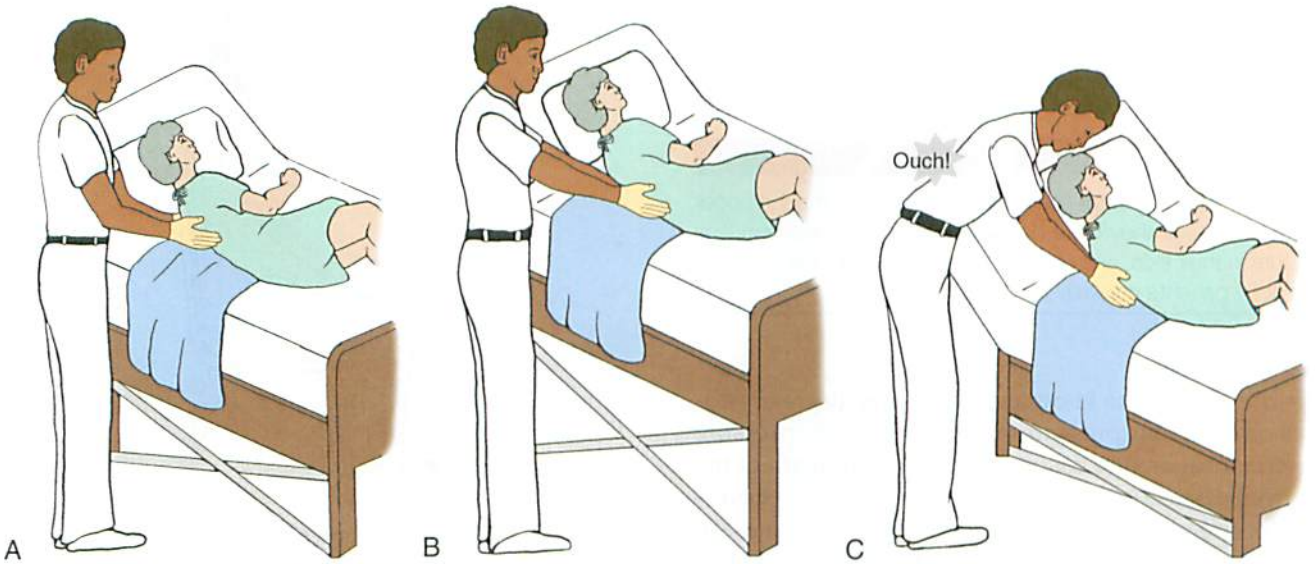



FIGURE 18-4 **A,** Correct working height. **B,** Work is too high. **C,** Work is too low.

center of gravity. Pick up your textbook and hold it close to your body. Although it is a heavy book, it is easily managed close to your center of gravity. Slowly extend your elbows forward. This moves the book farther from the center of gravity, and it becomes increasingly heavy. Do not fully extend your elbows or you will put stress and strain on your back muscles.

### KEEP LOADS NEAR YOUR CENTER OF GRAVITY

**Work at the same level or height as the object to be moved** (Figure 18-4). This keeps the workload near your center of gravity. Changing bed linens is a good example of this principle. In most institutions the bed's height is adjustable. When changing linen or moving a patient, temporarily raise the bed to waist level to keep the work near your center of gravity. Injuries are more likely to occur the farther away the work is from the center of gravity.

**Elder Care Points**

The elderly may need to be reeducated on how and what they may safely lift. As the body ages, there is a change in body posture (and center of gravity) and usually a decrease in muscle mass. Items that could be lifted safely during youth often cannot be lifted safely in the later years. Consider whether the elderly person has a spinal deformity or osteoporosis when determining how much weight is safe to lift.

### PULL AND PIVOT

**Pulling actions require less effort than pushing or lifting.** Whenever possible, use pulling motions. When transferring a patient to a stretcher, two nurses should stand on the far side of the stretcher to pull the patient toward them onto the stretcher. This movement is easier than pushing because it brings the patient closer to each nurse's center of gravity.

**Directly face the object or person to be moved.** It is much easier to move an object if you are facing in that direction. For example, place an object on the floor. Stoop down with the object in front of you and move the object forward. This is fairly easy. Now place the same object on the floor, stoop down, only this time with the object to the side. Moving the object forward is not as easy in this instance.

To move the object at your side forward, you would need to twist to the side. To maintain proper body mechanics, keep your trunk straight when lifting or pulling. Avoid twisting. Instead, if turning is needed, **pivot** (turn or change direction with your feet while remaining in a fixed place). Pivoting prevents twisting, which can lead to back strain and injury.

## PRINCIPLES OF BODY MOVEMENT FOR PATIENTS

Body movement and alignment are also important for patients. Many patients are unable to change position or move in bed independently. There are two basic principles for patients:

- Maintain correct anatomic position.
- Change position frequently.

If these principles are not observed, the patient may experience complications.

### HAZARDS OF IMPROPER ALIGNMENT AND POSITIONING

Hazards of improper alignment and positioning include:

- Interference with circulation, which may lead to **pressure ulcers** (ulcers that form from local interference with circulation)
- Muscle cramps and possible **contractures** (resistance to stretch in damaged muscle that pulls a joint into a fixed or "frozen" position)
- Fluid collection in the lungs

Contractures, muscle cramps, and respiratory problems as complications of immobility are discussed in Chapter 39.

**Elder Care Points**

The elderly have a greater risk for skin breakdown than younger patients because they have decreased muscle mass and less moisture in their skin, and their capillaries are more fragile. Handle elderly patients carefully.

### Pressure Ulcers

Pressure ulcers, also known as decubitus ulcers or bedsores, occur from pressure on the skin. This pressure causes a local area of tissue **necrosis** (local death of tissue from disease or injury). Most often the area of pressure occurs between a bony prominence and an external surface. Besides pressure, the other main factor in the development of pressure ulcers is a **shearing force.** Shearing is an applied force that causes a downward and forward pressure on the tissues beneath the skin. Shearing forces occur when a patient slides down in a chair, bedclothes are pulled from beneath the patient, or the patient is slid up to the head of the bed without lifting the body. Pressure ulcers are discussed in Chapter 19.

## APPLICATION OF THE NURSING PROCESS

### Assessment (Data Collection)

When assessing the standing patient's body alignment, begin by noting the head position in relation to the rest of the body (see Figure 18-2). Is the head centered and erect? Are the shoulders and hips parallel? Are the knees and ankles slightly flexed and parallel to the hips and shoulders? Do the arms hang comfortably at the patient's side? Are the feet slightly apart to provide a base of support? During the assessment, also observe for any muscle weakness or paralysis, and check **symmetry** (equality in size, form, and arrangement of parts on the opposite sides of a plane; a mirror image) of extremities.

**Think Critically**

How would you describe your posture right now? Is your body in correct alignment?

When a patient is sitting, again observe for symmetry (Figure 18-5). Determine whether the patient's head is erect and centered over the shoulders. Are the buttocks in the same plane as the shoulders, and are the thighs in line with the shoulders? The patient's weight should be distributed evenly over the buttocks and thighs. The knees should be flexed at about 90 degrees with the feet resting comfortably on the floor. Provide a footstool if the feet do not reach the floor. The arms should lie comfortably in the lap or be supported by the chair armrests.

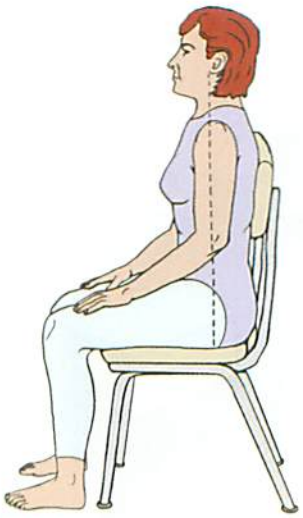


FIGURE 18-5 Correct sitting body alignment.

Patients often lie on their back when in bed. It is important to change this position frequently to prevent the problems associated with immobility. Support the head with one pillow so the neck is not hyperflexed. The vertebral column should be centered and in alignment, without observable curves. The mattress should support the body in this position.

Assess the patient's ability to **ambulate** (walk) and to change position independently. (A physician's order is needed for a patient to be out of bed.) Observe the patient walking. Is the head centered over the vertebral column? Is the **gait** (style of walking) even and unlabored? Is the patient balanced? Is there any weakness or favoring of one side? This will determine the patient's ability to ambulate independently or determine the type of assistance needed.

### Nursing Diagnosis

Nursing diagnoses commonly used for problems with body movement are as follows:

- Risk for injury
- Impaired physical mobility
- Risk for impaired skin integrity
- Impaired walking

The patient's defining characteristics are added to the nursing diagnosis stem to individualize the care plan. Nursing diagnoses for patients with problems of immobility are covered more extensively in Chapter 39.

### Planning

The data collected during the assessment phase give information about how to best promote independence or assist the patient. If the patient is not able to move independently, change the patient's position at least every 2 hours to avoid complications. Your assessment will indicate whether you can move the patient

independently or you will need assistance. During planning, decide how to change the patient's position and whether you can delegate this task to assistive personnel.

The home setting must also be considered when planning care for the patient. Will the family be able to turn or assist in turning the patient correctly after discharge? Will the patient or family need any assistive devices, and do they know how to use them? Will extra pillows need to be purchased to assist with positioning? Will the patient be able to get around in and out of the home independently? Assessment and planning will answer these questions.

Expected outcomes are written for each nursing diagnosis. Examples related to the above nursing diagnoses are as follows:

- Patient will experience no musculoskeletal injury.
- Former level of mobility will be reattained within 6 months.
- Skin integrity will remain intact.
- Patient will not experience an injury while ambulating.

## Implementation

### *Positioning*

Basically, changing position accomplishes four things: (1) it provides comfort; (2) it relieves pressure on bony prominences and other parts; (3) it helps prevent contractures, deformities, and respiratory problems; and (4) it improves circulation. It is essential to know how to correctly support and position the patient while maintaining good body mechanics.

**Clinical Cues**

Maintain the patient's privacy through draping while changing positions. Many positions can leave a patient feeling vulnerable, and draping demonstrates respect for the patient and supports privacy.

### *Common Positions and Their Variations*

While in bed, the patient can assume three basic positions: supine, side-lying, and prone.

The **supine position** is when patients are resting on their back. It is recommended after spinal surgery and after the administration of some types of spinal anesthetics. The supine position is similar to proper standing alignment except that the body is in the horizontal as opposed to the vertical plane.

Variations of the supine position are Fowler, semi-Fowler, and low Fowler positions. **Fowler position** is arranged by elevating the head of the bed 60 to 90 degrees. **Semi-Fowler position** is an elevation of 30 to 60 degrees, and low Fowler is an elevation of 15 to 30 degrees. Unless contraindicated, the knees can be raised 10 to 15 degrees in these positions. Alternatively, place a footboard at the bottom of the bed to brace the patient's feet in correct alignment. These positions improve cardiac output and respiration and promote urinary and bowel elimination. Do not place a patient who had abdominal surgery in a Fowler position unless ordered. Elevation of the knees above 15 degrees is contraindicated in elderly and postoperative patients because it is associated with decreased circulation of the lower extremities; check the orders. Fowler position may help the patient who had a stroke and has paresis to swallow food and secretions.

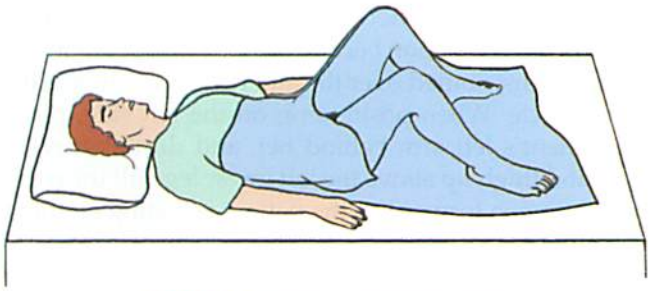


FIGURE 18-6 Dorsal recumbent position.

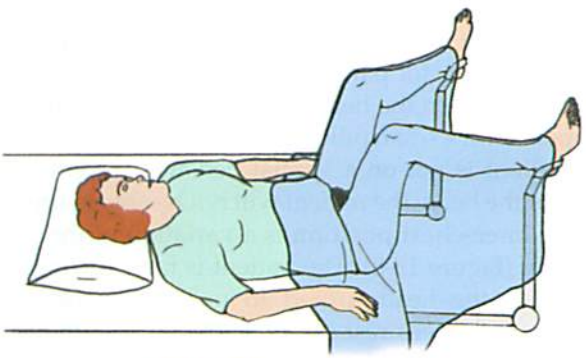


FIGURE 18-7 Lithotomy position.

**Dorsal recumbent** and **dorsal lithotomy positions** are other variations of the supine position. In the dorsal recumbent position, patients are on their back with knees flexed and soles of the feet flat on the bed (Figure 18-6). This is used for a variety of procedures and examinations. The dorsal lithotomy position (Figure 18-7) is used for examining the pelvic organs. It is like the dorsal recumbent position except the feet are usually placed in stirrups and the legs are spread farther apart and abducted. Patients with joint problems or arthritis may have difficulty assuming this position.

The **side-lying** or **lateral position** is achieved by having patients rest on their side. It alleviates pressure from bony prominences on the back. The major portion of the patients' weight is on the dependent shoulder and hip. Maintain the vertebral column in proper alignment as if they were standing. The oblique side-lying position removes pressure from the dependent shoulder and hip and is easier for patients to maintain.

**Sims position** is a variation of the side-lying position. It is used for rectal examinations, administering enemas, and inserting suppositories or for an unconscious

patient. The distribution of weight is different from in the side-lying position because in the Sims position the weight is distributed over the anterior ileum, humerus, and clavicle. When positioning on the left side, place the patient's left arm behind her, and draw her right knee and thigh up above the left lower leg. Tilt the chest and abdomen forward so the patient is resting on them as well.

The **prone position** is when the patient is lying face down. It provides an alternative for patients who are on prolonged bed rest or are immobilized. Spinal cord–injured patients often use this position. The position is generally not well tolerated because it is boring. In the prone position, for patients who have not had a spinal cord injury, turn the head to one side or the other and support with a small pillow. If the head is not turned or the patient is not on a special bed with a removable piece at the head, the patient will not be able to breathe.

The **knee-chest position** is a variation of the prone position (Figure 18-8). The patient is face down on the bed with the head turned to one side. The chest, elbows, and knees rest on the bed, and the thighs are perpendicular to the bed. The lower legs rest flat on the bed. This is used for rectal examinations and as a method to restore the uterus to a normal position. Do not leave the patient alone in the knee-chest position because the patient may become dizzy, faint, or fall. A patient with arthritis or joint abnormalities may not be able to assume this position.

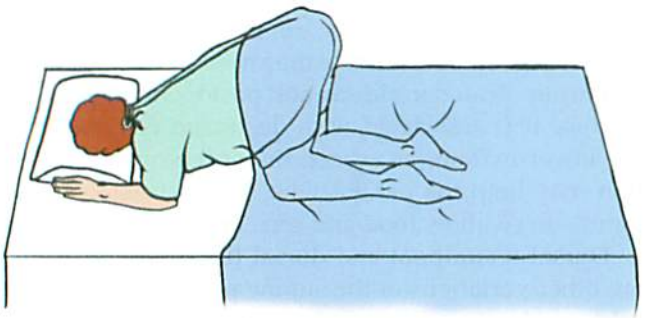


FIGURE 18-8 Knee-chest position.

Skill 18-1 describes how to place the patient in many of the above positions.

**Positioning Devices.** Devices used for positioning include pillows, boots or splints, footboards, cushioned boots or high-top sneakers, a trapeze bar (Figure 18-9, *A*), sandbags, hand rolls, trochanter rolls (Figure 18-9, *B*), side rails, and bed boards. Use pillows to support the body or extremities and elevate body parts. Boots or splints help to maintain dorsiflexion of the feet and may help to prevent heel pressure. Footboards and high-top sneakers are other devices used to maintain foot dorsiflexion. Trochanter rolls prevent external rotation of the hips and legs when a patient is lying in a supine position. Sandbags immobilize an extremity, provide support, and maintain correct body alignment. Hand rolls and splints for the hands and wrists help to prevent contractures of the hands, promote thumb adduction, keep the fingers slightly flexed, and prevent dorsiflexion of the wrist. A trapeze bar allows a patient to adjust position by raising the trunk and buttocks off the bed. The patient may use it to move up in bed, transfer from bed to wheelchair, and strengthen upper extremities. Side rails assist the patient in changing position and turning in bed. Bed boards are boards that are placed under the home mattress to give more support to the mattress and thereby improve vertebral alignment.

### *Moving Patients Up in Bed*

Patients need different amounts of help moving in bed. After proper instruction, many are able to reposition and move themselves up in bed independently. Other patients are able to provide assistance after they are told what is expected of them. Totally dependent patients rely on the nursing staff for this procedure. Before moving a patient up in bed, one of the most important steps is to determine how much help will be

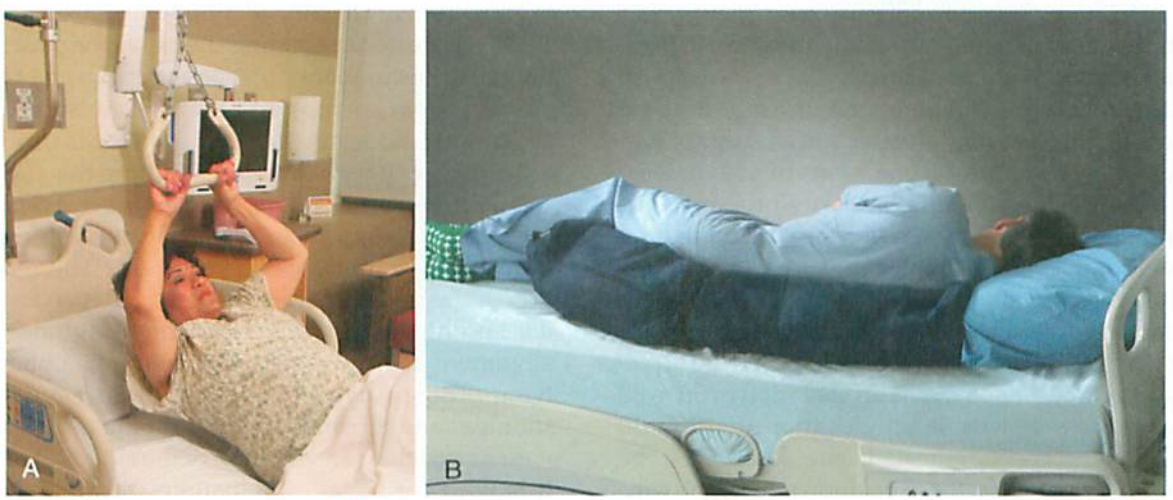



FIGURE 18-9 Positioning devices. **A,** Trapeze bar. **B,** Trochanter roll.

*Text continued on p. 268*

## Skill 18-1 Positioning the Patient

Correct positioning of patients is essential for maintaining proper alignment. Many patients, because of injury, disease, helplessness, or therapeutic devices, need assistance with repositioning. Change the position of the patient in bed at least every 2 hours. Obtain help to prevent injury to yourself and the patient.

### Supplies

Positioning devices as needed for each position:

- Pillows
- Boots
- Trochanter rolls
- Hand rolls
- Trapeze bar
- Splints
- Side rails
- Sandbags
- Bed board
- Footboard or high-top sneakers

*Review and carry out the Standard Steps in Appendix D.*

### ACTION *(RATIONALE)*

### Assessment (Data Collection)

1. Assess for any restrictions to placing patient in particular positions. *(Provides baseline data and indicates positions that are contraindicated.)*

### Planning

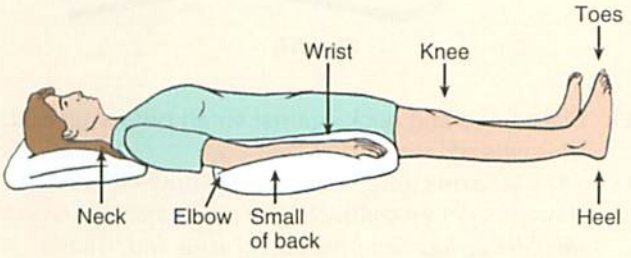
2. Gather positioning supplies. *(Provides easy access to equipment.)*
3. Explain what the patient is expected to do. *(Decreases fear and prepares patient to assist when possible.)*
4. Raise level of bed to a comfortable working height, and raise far side rail. *(Promotes safety and reduces back strain.)*
5. Remove positioning devices before beginning. *(Readies patient for move.)*
6. Get help if necessary. *(Promotes safety.)*
7. Provide privacy during the position change. *(Demonstrates respect and reduces embarrassment.)*

### Implementation

8. Perform hand hygiene. *(Reduces transfer of microorganisms.)*
9. Move patient to head of bed (see Skill 18-2). *(Prepares patient to be repositioned properly in the bed.)*

#### Supine Position

10. Place patient on back with bed in flat position, if not contraindicated. *(Promotes working with gravity.)*
11. Place a pillow under the patient's head, neck, and upper shoulders. *(Prevents flexion contractures of neck.)*




Step **11** Body alignment.

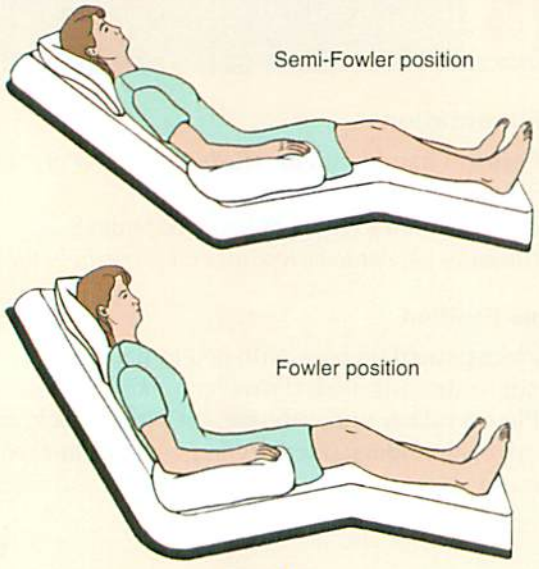
12. If needed, place sandbags or trochanter rolls parallel to the lateral aspect of the thighs. *(Prevents external rotation of the hips.)*
13. Use heel pads or a small pillow or rolled towel under the ankles to lift the heels off the mattress. *(Decreases chance of pressure ulcer formation.)*
14. Maintain upper arms parallel with body and place pillows under pronated forearms. *(Prevents extension of elbows and decreases internal shoulder rotation.)*
15. Place hand rolls or towels in patient's hands if needed to maintain correct slightly flexed position. *(Promotes thumb adduction and finger flexion.)*

#### Fowler and Semi-Fowler Positions

16. For Fowler, elevate head of bed 60 to 90 degrees. For semi-Fowler, elevate head of bed 30 to 45 degrees. *(Promotes comfort and provides patient with social and recreational opportunities. May assist with breathing, eating, and swallowing for patient with problems in these areas.)*

*Continued*

## Skill 18-1 Positioning the Patient—cont'd

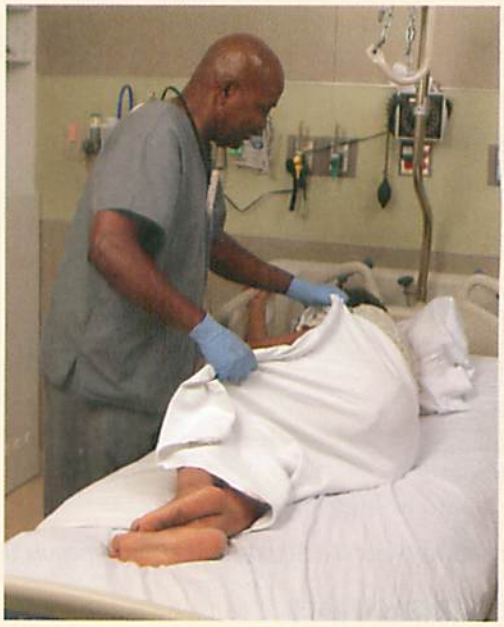



Step **16**

17. Place head and neck against small pillow on bed. *(Prevents cervical flexion.)*
18. Support arms and hands with pillows if needed. *(Prevents flexion contracture of hands and wrists and shoulder dislocation from pull of arms and hands.)*
19. Place small pillow or towel roll under thighs. *(Provides comfort without hyperextension of the knees or occlusion of popliteal artery.)*
20. Protect heels by using a small pillow, rolled towel, foam boots, or heel pads under patient's ankles. *(Decreases the chance of pressure ulcer formation.)*

### Side-Lying Position

21. Place patient on back on flat bed, if not contraindicated, or with bed as low as patient can tolerate. Move patient slightly to far side of bed, starting with the head, torso, and then feet; align the body correctly. *(Promotes easy access and working with gravity. Body will be centered in the bed when in new position.)*
22. Stand on side of bed to which you will turn the patient. *(Pulling requires less effort than pushing.)*
23. Flex the patient's far knee across the near thigh. *(Supports and prevents injury to joints.)*
24. Ask patient to raise the near arm above the head. Place one hand on patient's far shoulder and the other hand on patient's far hip and roll patient toward you with a smooth motion, or use a lift sheet to smoothly turn patient onto her side. *(Supports and prevents injury to joints.)*



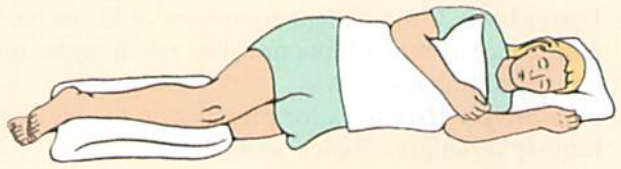
Step **24**

25. Fold pillow lengthwise; tuck upper edge under patient; roll the pillow against the patient's back, rolling it toward the mattress. Place a lengthwise pillow between the flexed knees from knee to foot. *(Supports and promotes alignment. Prevents pressure ulcer formation. Prevents patient from rolling back to prior position.)*

### Side-Lying Oblique Position

26. Move shoulder blade against the bed forward, toward you. *(Disperses weight so it is not centered on shoulder.)*
27. Flex the arm next to the mattress; raise hand so that it is even with top of patient's head. *(Places less pressure on the shoulder and promotes comfort and flexibility of the elbow.)*

## Skill 18-1 Positioning the Patient—cont'd

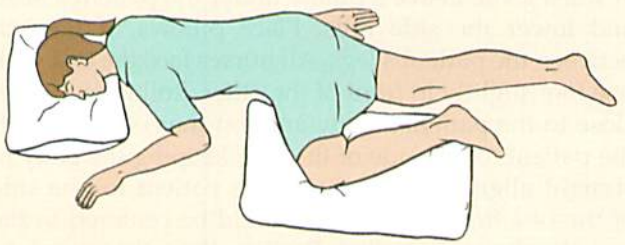


Step **27**

28. Support other arm with pillow placed level with the shoulder. *(Promotes chest expansion and decreases adduction and internal rotation of shoulder.)*
29. Reach under hip area and pull the hip slightly forward. *(Decreases pressure on the hip by placing the body at an oblique angle.)*
30. Slightly flex knees and support upper leg from thigh to ankle with pillow(s) folded lengthwise. *(Supports the leg joints and decreases adduction and internal rotation of hip and thigh. Decreases pressure on bony prominences.)*

### Sims Position

31. Position patient in complete side-lying position, but move the patient slightly to the far side of the bed that her back is facing. Roll patient forward partly on abdomen. *(Patient will be centered in bed when repositioned. Rolling patient partly onto abdomen promotes even weight distribution.)*

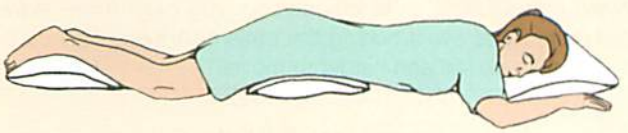


Step **31**

32. Slightly flex arm next to mattress behind patient. *(Prevents extension of elbow. Promotes comfort, and weight is not focused on shoulder joint.)*
33. Support flexed uppermost arm and leg with pillows so that the hand is level with the shoulder. *(Promotes chest expansion; decreases adduction and internal rotation of shoulder.)*

### Prone Position

34. Lower head of bed to a flat position, place patient in supine position, and move to opposite side of the bed. *(Promotes working with gravity.)*
35. Put a small pillow on the patient's abdomen, below the diaphragm. *(Positions pillow for support after turn. Aids respirations by decreasing pressure on the diaphragm. Decreases hyperextension of lumbar vertebrae.)*
36. Place patient's arms close to the body with elbow extended and hand under the hip. *(Maintains alignment for turning.)*
37. Roll patient toward you and place on abdomen (pillow is between patient's abdomen and the bed). Patient should be centered in bed. *(Maintains alignment.)*



Step **37**

38. Place a small pillow under patient's head; turn head to one side, and be sure ear is flat against the pillow. *(Decreases flexion of neck.)*
39. Support flexed arms at shoulder level. *(Decreases risk of joint dislocation.)*
40. Place a pillow under the lower legs. *(Promotes dorsiflexion of ankles and knee flexion.)*

### Completing Care

41. Lower the bed and restore the unit. Perform hand hygiene. *(Makes patient comfortable and promotes safety. Performing hand hygiene reduces transfer of microorganisms.)*

### Evaluation

42. Observe the newly positioned patient. Is the patient in proper alignment? Are positioning devices correctly placed? Is the patient comfortable? Check Special Considerations for common trouble areas with each position. *(Detects whether patient is in proper body alignment and position.)*

*Continued*

## Skill 18-1 Positioning the Patient—cont'd

### Documentation

43. Document on the flow sheet or in the nurse's notes, depending on agency policy. Note date, time, position, and positioning devices used. *(Provides for consistency among personnel and validates actions provided.)*

#### Documentation Example

3/6 0800 Placed in supine position. Correct alignment maintained with pillows, hand rolls, and foot splints.

_____
*(Nurse's signature)*

### Special Considerations

- Wear gloves when moving or positioning a patient if you will be touching blood, body fluid, secretions, excretions, broken skin, mucous membranes, or contaminated items.
- For a patient who has edema or is dehydrated, turn and reposition more frequently than every 2 hours to avoid skin breakdown.

#### Elder Care Points

When repositioning an elderly person, you must move slowly and carefully to avoid hurting the patient. Arthritis may cause the joints to be stiff and harder to move.

After positioning a patient, check the following areas to prevent possible problems.

#### Supine Position

- Feet: Maintain the feet in dorsiflexion; you may need to use a positioning device to decrease the chance of footdrop.
- Lower back: If the patient complains of lower back pain, place a small pillow or rolled towel under the patient's lumbar spine.
- Pressure points: Check for pressure on the occiput, lumbar vertebrae, elbows, and heels.

#### Fowler and Semi-Fowler Positions

- Circulation: Check to see that the lower extremities have palpable pulses, verifying that the popliteal artery is not occluded.
- Pressure points: Check for pressure on the scapula, sacrum, elbows, and heels.

#### Side-Lying Position

- Neck: Avoid lateral flexion.
- Pressure points: Check for pressure on the ankles, knees, trochanter, ileum, and ear.

#### Sims Position

- Hip and shoulder: Support properly to prevent internal rotation and adduction.
- Pressure points: Check for pressure on the clavicle, humerus, ileum, knees, and ankles.

#### Prone Position

- Feet: Position in dorsiflexion. Sustained extension with plantar flexion is undesirable.
- Pressure points: Check for pressure on the ear, chin, hips, and knees.

### Critical Thinking Questions

1. If you use a pillow, you do not need to check for pressure points in that area. Is the statement true or false? Why?
2. What are some of the advantages of having a trapeze on a bed when the patient has a broken leg?

needed. If lift equipment is available, use it. When manually lifting, if there is any doubt about whether a patient is too heavy or immobile to be moved by you, enlist at least one other person's help. Skill 18-2 describes how to move patients up in bed.

One of the techniques to move patients in bed is called **logrolling.** Logrolling is turning the patient as a single unit while maintaining straight body alignment at all times. Logrolling is often used for patients with injuries or surgery to the spine and for those who must avoid twisting. The linens for an occupied bed are often changed by using the logrolling turn. Logrolling can be done either with or without a lift sheet. If a lift sheet is used, two or three people are needed to accomplish the move, depending on the patient's size (Figure 18-10). It takes at least three people to logroll a patient without a lift sheet (Figure 18-11).

When using a lift sheet, you and preferably two assistants stand on opposite sides of a locked, flat bed at waist level. Leave a pillow under the patient's head and lower the side rails. Place pillows, if needed, between the patient's legs. All nurses face the bed with one foot slightly in front of the other. Roll the lift sheet close to the patient's body and, on the count of 3, lift the patient to one side of the bed, keeping the body in straight alignment. By lifting the patient to one side of the bed first, the patient should be centered in the bed after being logrolled. Position the tallest nurse on the far side of the bed, at the middle portion of the patient. The other two nurses are positioned one at the

## Skill 18-2 Moving the Patient Up in Bed

Many healthy patients can reposition themselves in bed independently after proper instruction. Others, because of injury, disease, weakness, or therapeutic devices, may be able to help somewhat or will be totally dependent on you. It is always easier for two people to assist any patient in moving up in bed. If the patient is large or heavy, use lift equipment or a slide board (also known as transfer board) if available instead of manually lifting. Check the agency policy.

### Supplies

- Lift sheet or slide board for the patient who is dependent or requires assistance

*Review and carry out the Standard Steps in Appendix D.*

### ACTION *(RATIONALE)*

### Assessment (Data Collection)

1. Assess alignment, muscle strength, activity tolerance, and mobility. *(Indicates how much patient can assist.)*

### Planning

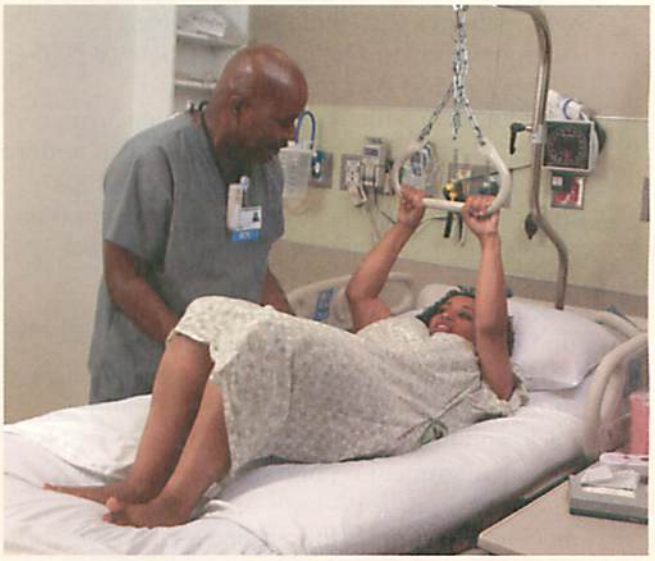
2. Gather positioning supplies and lift sheet if needed. *(Promotes easy access to equipment.)*
3. Explain what you wish the patient to do. *(Prepares patient and decreases fear.)*
4. Raise level of bed to a comfortable working height. *(Promotes proper body mechanics and reduces back strain.)*
5. Remove positioning devices for patient's current position. *(Removes obstacles.)*
6. Get help if possible or needed. *(Promotes safety.)*
7. Provide privacy during the position change. *(Protects the right to privacy and reduces embarrassment.)*

### Implementation

8. Perform hand hygiene. *(Reduces transfer of microorganisms.)*
9. Lock bed wheels and lower rail, if up, on side closest to you. *(Prevents bed from rolling and provides access.)*
10. Place pillow upright against headboard. *(Prevents the patient from striking head against the headboard.)*

#### For the Patient Who Can Assist

11. Place the patient on back. Ask the patient to flex both knees, reach back with one or both arms, and grab the side rails (or hold trapeze bar if present), place chin on chest, then push down on the bed with both feet, lift the buttocks off the bed, and push upward. *(Allows the patient control while promoting exercise and independence. The chin on the chest prevents neck strain and decreases friction on the back of the head.)*



Step **11** Moving patient up in bed.

#### For the Patient Who Needs Assistance (1 or 2 Nurses)

12. a. Place the patient on back. Face the head of the bed and, with a broad stance, place one foot in front of the other with the back foot closest to the bed. *(Prevents twisting and strain of back. Provides a good base of support.)*
    b. Unless contraindicated, ask the patient to flex both knees, or flex them for the patient. *(Decreases resistance of dragging legs.)*
    c. Place the patient's arms across the chest. *(Decreases resistance of dragging arms.)*
    d. Place one hand and forearm under the patient's shoulder, support neck, and place the other hand and forearm under the patient's upper thighs. If you have help, each person holds the patient in this way on opposite sides of the bed. *(Supports the patient's heaviest parts. Having two people decreases effort needed.)*
    e. With rocking motion of your hips and legs, and on the count of 3, shift your body weight forward, moving patient toward the head of the bed. Push with your arms as the patient lifts buttocks and pushes with both feet. *(Coordinates movement; helps to overcome forces of inertia.)*

*Continued*

## Skill 18-2 Moving the Patient Up in Bed—cont'd

### For the Immobile Patient (1 Nurse)

13. a. Place patient supine. *(Promotes working with gravity.)*
    b. Stand diagonally next to the patient's legs in a broad stance with one foot in front of the other and the back foot closest to the bed; slide your arms under the legs. *(Prevents strain or twisting of back and provides a good base of support.)*
    c. Flex your knees and hips so your arms are level with patient's legs. Slide patient's legs diagonally toward head of bed. *(Allows a pulling motion, and legs are easier to move.)*
    d. Stand next to patient's hips; place one arm under patient's thighs and the other arm under patient's lower back. Slide the patient's hips diagonally toward head of bed. *(Maintains body alignment for you and aligns patient's hips and feet.)*
    e. Place your arm nearest the head of the bed under patient's neck; support head and patient's other shoulder. Place your other arm under patient's chest. Slide trunk, shoulders, neck, and head toward head of bed. Patient is now in alignment on one side of the bed. *(Supports the patient's body weight during movement. Patient is aligned on one side of the bed.)*
    f. Raise side rail. Switch sides of bed and repeat as necessary until patient reaches desired place in bed. *(Promotes safety and moves patient while maintaining alignment.)*
    g. Center patient in bed, moving the body in the three sections. *(Maintains alignment.)*

### For the Immobile Patient (2 Nurses with a Lift Sheet)

14. a. Obtain a lift sheet. *(Less effort is needed to move patient on a sheet than to move with hands.)*
    b. With patient on her side, place the lift sheet under patient by rolling up the edge of the sheet close to the patient and placing it firmly against the patient. *(Allows sheet to be pulled easily out from under the patient once turned. Supports the heaviest part of the patient.)*
    c. Roll the patient back to the other side over the lift sheet. Pull sheet through. Place patient on back; with a nurse on each side of the bed, roll or fan-fold the sheet close to each side of the patient. *(Decreases risk of injury. If the patient is large, more than two nurses may be needed to safely transfer the patient.)*
    d. Each nurse places one foot slightly in front of the other, about shoulders' width apart, to form a broad base of support. *(Improves balance.)*
    e. With your hips and knees slightly flexed and back straight, grasp the sides of the rolled or folded sheet as close as possible to patient. On the count of 3, lift patient to the head of the bed. *(Enables you to shift body weight in direction of movement, decreasing force needed to lift patient. Maintains proper body movement, decreasing chance of injury.)*

### Completing Care

15. Smooth out lift sheet under patient. Position patient in desired position, raise side rails, lower bed, and replace call bell. *(Maintains alignment and promotes safety.)*
16. Restore the unit and perform hand hygiene. *(Promotes comfort and safety. Performing hand hygiene reduces transfer of microorganisms.)*

## Evaluation

17. Observe patient's level of comfort, position, body alignment, and potential pressure points. *(Maintains support to body and decreases risk of injury.)*

## Documentation

18. Repositioning for comfort and body alignment is charted on the flow sheet or in the nurse's notes according to agency policy. Note date, time, procedure, and position. *(Documents position changes and validates they have been done.)*

### Documentation Example

3/6 0900 Feet over end of mattress; moved to head of bed with assistance; repositioned supine for comfort; placed in proper alignment. Bed down, call bell within reach.

_____
*(Nurse's signature)*

## Critical Thinking Questions

1. Explain how positioning yourself correctly when moving a patient up in bed aids the process.
2. Describe complications, other than development of a pressure ulcer, that can occur from improper alignment and positioning.

FIGURE 18-10 Logrolling a patient using a lift sheet.

FIGURE 18-11 Logrolling a patient without a lift sheet.

shoulders and neck and one at the legs and feet of the patient so that they can control movement of these parts. The nurse on the far side of the bed grasps the lift sheet. Again, hold the sheet as close to the patient's body as possible, and on the count of 3 roll the patient in one smooth, coordinated, even motion with the body in straight alignment. Rearrange the pillow under the patient's head and place any other positioning devices before lowering the bed and putting the call bell within the patient's reach.

Logrolling without a lift sheet is accomplished in a similar manner. Evenly space three nurses along one side of a locked, flat bed at waist level. One nurse supports and rolls the head, neck, and shoulder region; one supports and rolls the waist and hips; and the third supports and rolls the thighs and lower legs.

### *Therapeutic Exercise*

Physical therapy is often ordered for the patient who is immobilized for an extended period. The physician indicates the patient's problems, and the therapist performs an evaluation and then designs an exercise program to help the patient maintain or regain function and to prevent further musculoskeletal problems from occurring. If a physical therapist is not available, you must assist your patient in performing these exercises.

**Box 18-2 Principles Guiding Range-of-Motion (ROM) Exercise**

- Move the body part to stretch the muscles and keep the joint flexible, but avoid movement to the point of discomfort.
- Perform ROM exercises of the joints of helpless or immobile patients at least twice a day, or more often if tolerated.
- Support the limb above and below the joint when performing passive exercises of arms and legs.
- Perform each movement a minimum of three to five times.
- Involve patients in planning their exercise program, and encourage active performance of the exercises if allowed and capability returns.

The family or significant other can also be shown how to assist the patient with exercise.

**Full range-of-motion (ROM) exercises should be performed either actively or passively several times a day.** Active ROM exercises are used for the patient who independently performs activities of daily living but for some reason is immobilized or limited in activity or is unable to move one extremity due to injury or surgery. Passive ROM exercises are performed on the patient who cannot actively move. This patient cannot contract muscles, so muscle strengthening cannot be accomplished. All muscles over a joint are maximally stretched to achieve or maintain flexibility of the joint. This is accomplished by moving the muscles to the point of slight resistance but not beyond. To prevent joint injury in performing passive ROM exercises, support the limb to be exercised above and below the joint. Principles related to carrying out ROM exercises for patients are listed in Box 18-2. Skill 18-3 describes how to provide passive ROM exercises.

**Clinical Cues**

Watch the patient's face as you perform passive ROM exercises so that you will know if you are causing pain. If the patient is expressing pain, you are moving the joint too far.

### *Lifting and Transferring*

Lifting and transferring patients also require the use of proper body mechanics and positioning principles. Some patients may be independent or need minimal assistance to ambulate. Others may need to be transferred to a chair, wheelchair, or stretcher.

Before transferring a patient to a wheelchair, have her dangle her legs over the side of the bed first (Figure 18-12). **Dangling** is the term used for the patient position of sitting on the side of the bed with the legs and feet over the side. **The feet are either on the floor or supported on a footstool.** Dangling is often the first step before sitting in a chair or ambulating. The purpose of this is to gradually accustom the body to the position

*Text continued on p. 276*

## Skill 18-3 Passive Range-of-Motion (ROM) Exercises

Many patients are paralyzed or have limited mobility of the extremities. To prevent joints from becoming rigid and immovable and to prevent contractures, it is necessary to provide motion to the joints on a regularly scheduled basis. Each exercise is repeated three to five times per session. The remainder of the patient is kept draped while one extremity is exercised.

### Supplies

- Blanket or top sheet

*Review and carry out the Standard Steps in Appendix D.*

### ACTION *(RATIONALE)*

### Assessment (Data Collection)

1. Check the orders for any contraindication to performance of ROM. *(Avoids injuring the patient with ROM exercise.)*
2. Assess the patient for areas of weakness or paralysis. *(Indicates which joints need passive ROM and which can be actively exercised.)*

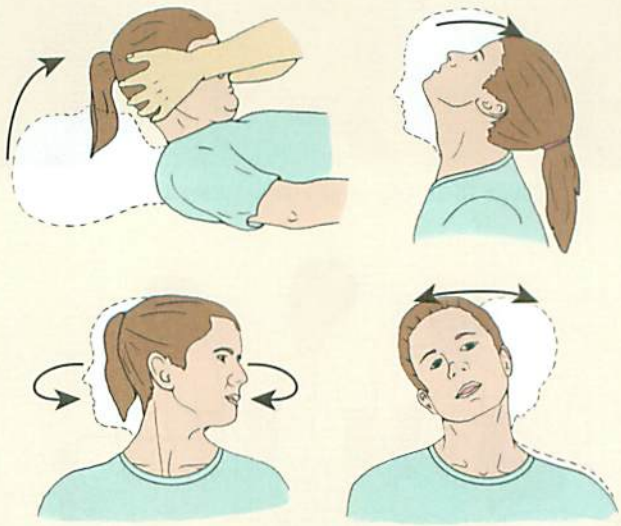
### Planning

3. Be certain wheels of bed are locked and that the bed is raised to working height. *(Prepares area for the procedure and prevents injury.)*

### Implementation

4. Place patient in supine position, remove the pillow, and drape patient with sheet or blanket. *(Positions patient for the procedure. A drape provides privacy for the patient.)*
5. Perform passive ROM of the head and neck:
   - Support the head with your hands, and bring the head forward until the chin touches the chest.
   - Extend the neck by elevating the chin and having the patient look upward. Return the head to the neutral position.
   - Support the head with your hands, and turn it to face the right shoulder and then to the left shoulder. Pause in a neutral position.
   - Bend the head laterally to the right shoulder and then to the left. Return the pillow under the head.

   *(Exercises the neck and trapezius muscles. Promotes cervical spine mobility. Pillow makes patient more comfortable.)*

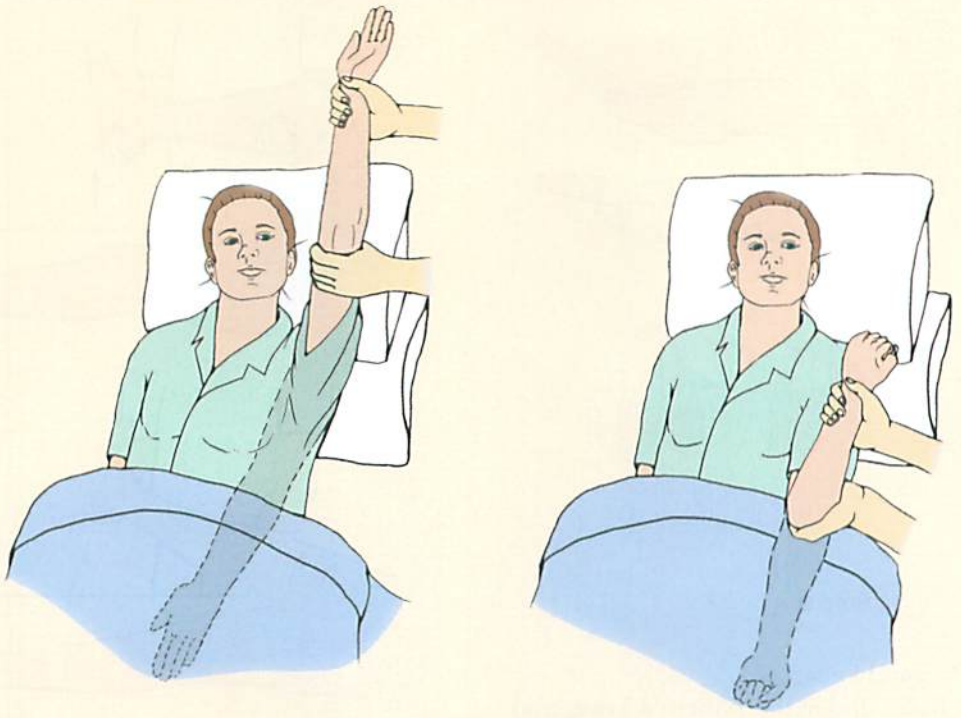


Step **5**

6. Flex and extend the shoulder and elbow:
   - Supporting the patient's elbow with one hand, grasp her wrist with your other hand. Bring her arm straight up over the head, then lower it and bend the elbow. Return the arm to the patient's side.
   - Internally rotate the shoulder. Place one hand on the patient's arm above the elbow, and grasp the patient's hand with your other hand. Lift the arm and move it across the chest toward the other side. Return the arm to the original position.
   - Externally rotate the shoulder. Move the arm out from the patient's side in abduction. Flex the elbow, and move the forearm over the head. Return the arm to the original position.

   *(Promotes joint movement and exercises the shoulder muscles.)*

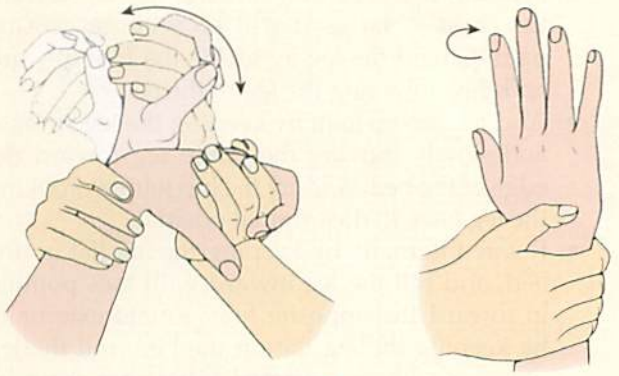
## Skill 18-3 Passive Range-of-Motion (ROM) Exercises—cont'd



Step 6

7. Elevate and depress the shoulders. With shoulders level, have the patient elevate them as if shrugging. Have the patient lower the shoulders as far as possible and then return to a level plane. *(Loosens the shoulder joints and promotes relaxation.)*
8. Flex the wrist:
   - Hold the patient's wrist with one hand and the palm of her hand with your other hand, keeping the patient's fingers straight. Hyperextend the wrist by bending it backward. Extend the wrist by straightening.
   - Flex the patient's wrist by bending the hand forward and closing the fingers to make a fist. Perform circumduction of the hand and wrist. Hold the patient's wrist with one hand and the palm of her hand with your other hand, keeping the patient's fingers straight. Bend the wrist forward, and move it in a circular motion.
   - Rotate the wrist and hand. Grasp the patient's wrist in both of your hands. Rotate the wrist by turning the palm toward the patient's face for supination and then toward the feet for pronation.

   *(Exercises the wrist. Circumduction promotes joint flexibility and prevents contractures. Rotation promotes joint flexibility and movement.)*



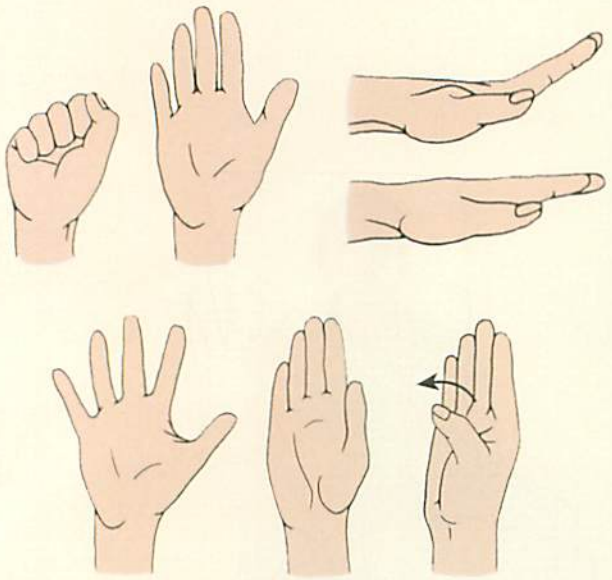
Step 8

9. Exercise the thumb and fingers:
   - Hold the patient's hand with one hand, and grasp her thumb with your other hand. Avoid pressing on the nail bed. Flex the thumb and then the fingers by bending them onto the palm.
   - Extend the fingers by returning them to their original position. Abduct the fingers by spreading them.
   - Adduct the fingers by returning them to a closed position. Circumduct the fingers and thumb by moving them in a circular motion.
   - Oppose the patient's thumb by touching it to each of her fingers in turn.

   *(Promotes opposition of thumb and grasp for other fingers needed to perform activities of daily living.)*

*Continued*

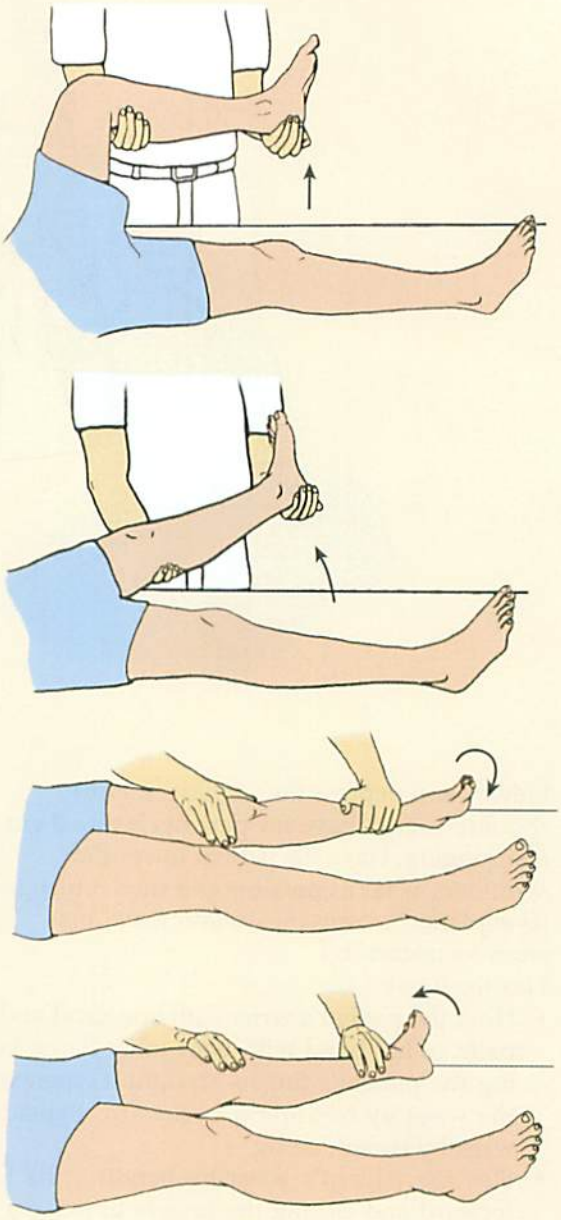
## Skill 18-3 Passive Range-of-Motion (ROM) Exercises—cont'd



Step 9

10. Exercise the hip and knee:
    - Place one hand under the patient's knee, and cup the heel in your other hand. Flex the leg by bending the knee and moving the leg toward the chest as far as it will go without causing pain. Extend the leg by lifting the foot upward and then lowering the leg to the bed.
    - Abduct the hip joint by keeping the leg straight and slowly moving the entire leg toward the edge of the bed. Adduct the hip joint by moving the leg back to the original position.
    - Rotate internally by keeping the leg flat on the bed, and roll the leg inward with toes pointed in toward the opposite foot. Rotate externally by keeping the leg flat on the bed; roll the leg outward with toes pointed away from opposite foot.

    *(Promotes successful mobility when the patient is able to resume ambulation and prevents hip contracture.)*



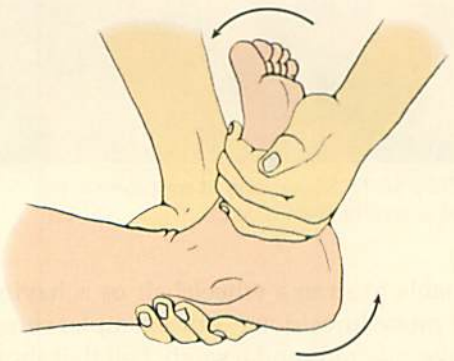
Step 10

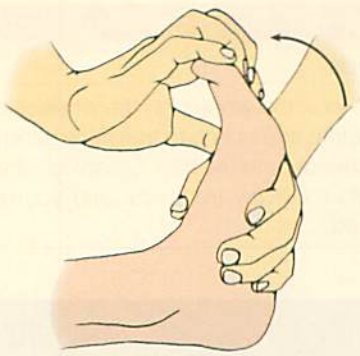
11. Exercise the ankle and foot:
    - With the patient's leg on the bed, place one hand on the ball of the foot; then place the other hand just above the ankle.
    - Circumduct by holding the ankle with one hand and turning the whole foot outward and then inward in a circular motion. Perform ankle flexion, ankle extension, and toe circumduction as you did the fingers. Avoid holding the nail beds.

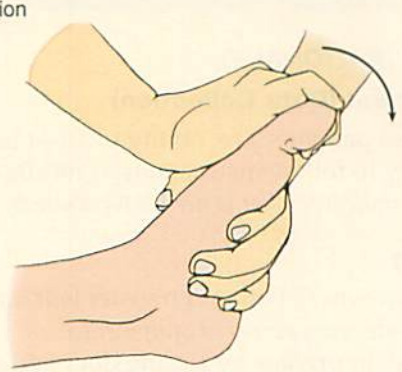
## Skill 18-3 Passive Range-of-Motion (ROM) Exercises—cont'd

- Perform dorsiflexion by pushing the foot forward toward the body and pushing down on the heel at the same time.
- Perform plantar flexion by pushing the toes away from the body while pushing down on the heel.

*(Prevents footdrop and promotes mobility when the patient is able to resume ambulation.)*




Step 11

### Evaluation

12. Ask the following questions: Was each joint exercised with three to five repetitions? Did the patient experience pain? Does any joint show diminished range of motion? *(Answers to these questions provide data to determine whether expected outcomes are being met.)*

### Documentation

13. Document the performance of ROM and any problems encountered. *(Validates that ROM was performed and records any problems encountered.)*

#### Documentation Example

3/8 0900 Passive ROM exercises carried out to all extremities, head, and neck. No evidence of contractures. Slight discomfort noted with left ankle flexion. All other motions carried out with ease.

*(Nurse's signature)*

### Special Considerations

- Encourage patients to perform active ROM on any joint they can safely move because this promotes muscle strength contraction and helps avoid muscle weakness and atrophy.
- If the patient becomes too tired with a full set of passive ROM exercises, divide the exercises into smaller sessions.

#### Elder Care Points

Elderly patients often have some arthritic joints. Ask the patient about this before beginning the exercises; medicate for pain as needed.

#### Home Care Considerations

Instruct the caregiver with the home patient on how to do the exercises, and leave a written schedule form for tracking performance.

#### Critical Thinking Questions

1. Your patient asks you why she needs to perform active ROM exercises. What would you tell her?
2. What benefits do you think will occur if you involve the patient in her exercise plan?

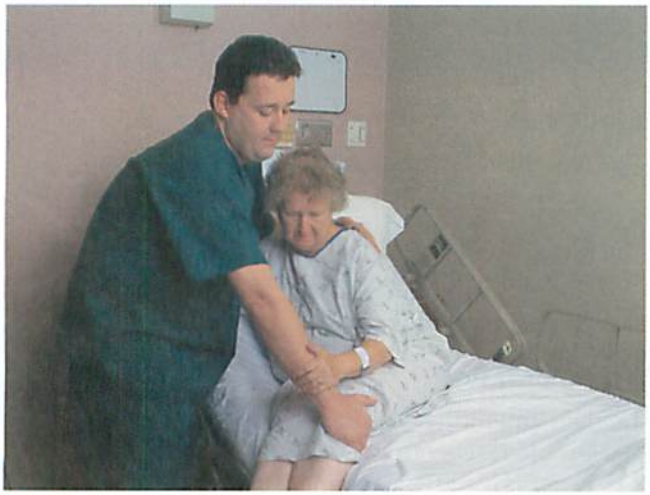


FIGURE 18-12 Assisting the patient to dangle at the side of the bed.

change. While the patient is dangling, assess the patient's balance, and monitor for orthostatic hypotension, dizziness, or nausea before getting the patient out of bed. If a patient has been on prolonged bed rest, she may be strong enough to dangle for only a few minutes and then will need to lie down again.

Wheelchairs are often used to transport an ambulatory patient to different areas for tests and procedures, or for the patient who is unable to walk or tolerate the fatigue associated with the effort. Either lift equipment or two nurses should transfer a patient to a wheelchair if the patient is unsteady, weak, or heavy (check agency policy) (Figure 18-13). Transferring a patient to a wheelchair is described in Skill 18-4.

Stretchers may also be called litters, gurneys, or carts. They are used for transporting a patient who is unable to sit in a wheelchair or is having certain tests or procedures done—for example, surgery. Stretchers have side rails and a safety belt that should be secured before moving the patient.

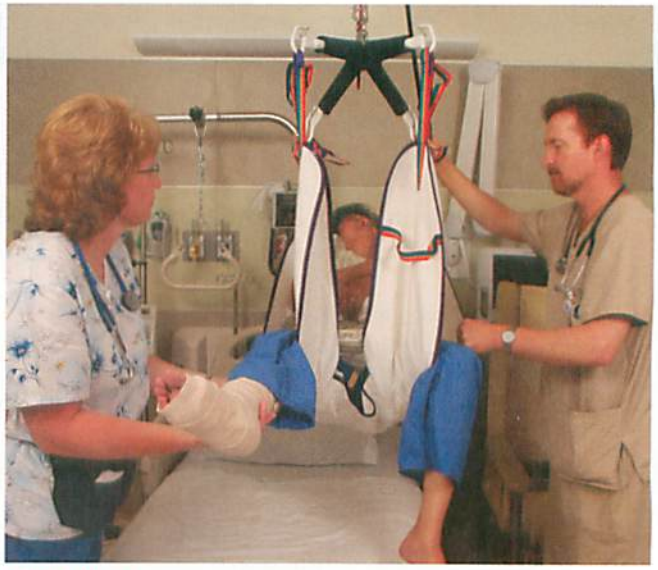


FIGURE 18-13 Nurse using lift equipment to transfer a patient from bed to chair or chair to bed.

**Safety Alert**

**Lock the Wheels**

Remember to lock the wheels on the wheelchair and the bed or stretcher before attempting to transfer a patient into a wheelchair or stretcher or onto the bed. Otherwise, the wheelchair or stretcher could roll away from you, and you and the patient could be injured.

## Skill 18-4 Transferring the Patient to a Wheelchair

A patient is often transported to another area of the facility by wheelchair. Patients may be transferred to a wheelchair to provide greater independence. A similar procedure is used to transfer a patient to a chair. If the patient is large or heavy, use lift equipment for the transfer if available. Check agency policy.

### Supplies

- Bed
- Wheelchair
- Safety jacket if patient is unstable when sitting
- Transfer belt if necessary
- Slippers or nonskid socks and robe

*Review and carry out the Standard Steps in Appendix D.*

### ACTION *(RATIONALE)*

#### Assessment (Data Collection)

1. Assess patient's size, ability to assist in move, and ability to follow instructions. *(Provides baseline data; indicates what is needed for a safe transfer.)*

#### Planning

2. Gather wheelchair and transfer belt if needed. *(Provides easy access to equipment.)*
3. Maintain privacy by closing door and/or curtain. *(Protects right to privacy and reduces embarrassment.)*
4. Get help if needed. *(Promotes safety for you and patient.)*

## Skill 18-4 Transferring the Patient to a Wheelchair—cont'd

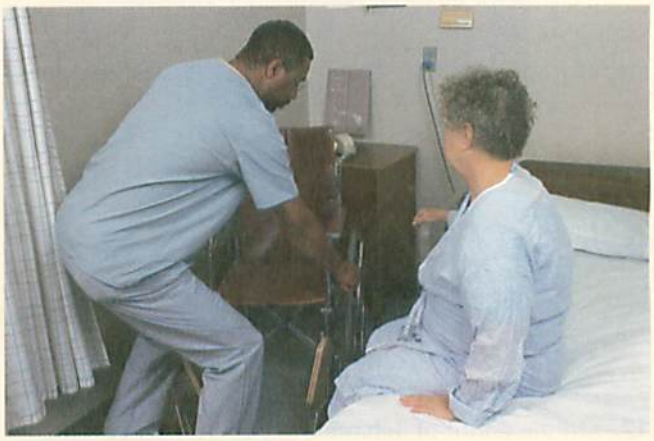
5. Explain the procedure and what the patient is to do. *(Decreases fear of the unknown and prepares patient.)*

### Implementation

6. Perform hand hygiene. *(Reduces transfer of microorganisms.)*
7. Place wheelchair parallel to the side of the bed. Lock wheelchair. *(Promotes easy reach and access. Locking wheelchair promotes safety.)*
8. Place transfer belt on patient if patient is weak or paralyzed on one side. *(Decreases the risk of a fall during transfer, and prevents pressure on patient's axillae.)*
9. Lower bed and side rail if elevated. Elevate the head of the bed to the highest level the patient can tolerate. *(Decreases the work for you and patient and promotes safety.)*
10. Help the patient turn onto side. Support the patient's shoulders with one arm, and with the other arm at the patient's thighs, help the patient sit up and move the legs over the edge of the bed. Help patient move forward on bed until feet rest on the floor, and allow the legs to dangle. *(Maintains alignment and proper body mechanics; allows patient to adjust to being upright.)*

Step **10**

11. Assist patient in donning robe. *(Provides privacy.)*
12. Place slippers or nonskid socks on patient. *(Prevents patient's feet from slipping during transfer.)*
13. Reposition wheelchair closer if necessary so the patient can stand, pivot, and sit without having to back up to chair. Place the chair so that it is closest to the patient's strongest side. *(Reduces distance the patient must travel to sit safely in the chair.)*

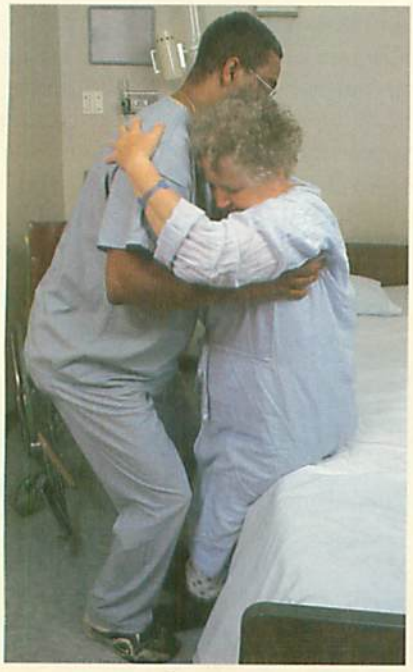


Step **13**

14. Check that both wheels are still locked on wheelchair. *(Maintains safety because unlocked wheels allow chair to back away from patient as she sits. This can lead to patient's falling and possible injury for both parties.)*
15. Help the patient stand by assuming a moderately wide stance in front of the patient; brace the patient's legs with your knees, which are slightly flexed. *(Provides base of support, maintains alignment, and prevents back injury.)*
16. Place your arms under the patient's axillae and your hands on the patient's scapula. If the patient is not able to push self off of bed, have patient place arms around your shoulders (not your neck). If the patient is able to help push up from the bed, have patient place hands on the bed. *(Brings patient close to your center of gravity and provides a point of leverage for lifting.)*

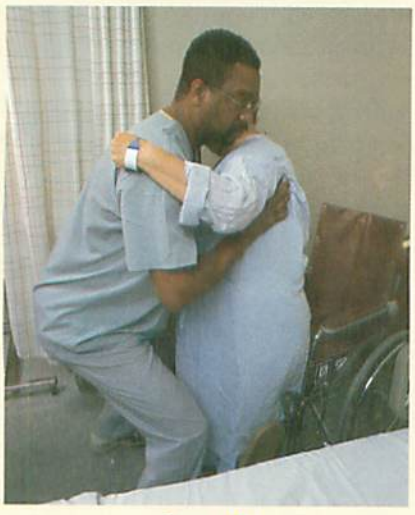
*Continued*

## Skill 18-4 Transferring the Patient to a Wheelchair—cont'd



Step **16**

17. On the count of 3, have the patient push on the bed, and lift patient upward while maintaining correct alignment in your back. Depending on your assessment of the patient's ability, a transfer belt or another nurse on the opposite side may be needed. *(Uses leverage to raise patient to a standing position. Assistance helps maintain safety.)*
18. Pivot 90 degrees so the patient's back is toward the seat of the chair. Have the patient reach back and grasp the arms of the chair, if able. Be certain patient's legs are against seat of chair, and lower the body into the chair. Flex your knees as patient lowers into the chair. *(Pivoting allows patient to sit down without twisting. Having legs against seat places the patient's weight directly over the chair, providing safe support during sitting. Flexing your knees prevents self-injury.)*



Step **18**

19. Assist the patient in placing the feet on the footrests. Avoid striking the patient's ankles while fixing the footrest. Apply a protective device if ordered. Position patient in the chair in correct alignment—hips should be back in chair. If necessary, help patient to reposition farther back in chair. Provide support for weak or paralyzed extremities. *(Maintains alignment and prevents injury.)*

### Transferring the Patient Back to the Bed (a Reversal of the Procedure)

20. Check to ensure the brakes are locked on the wheelchair. Have patient grasp both arms of the chair and push up and out of the chair to a standing position. Assist patient by placing one arm under the axilla and the other under the elbow. *(Maintains safety. Patient assists with lifting. Hands under the axilla and elbow stabilize the patient.)*
21. Help the patient pivot 90 degrees so her back is next to the bed. When the patient is able to stand unassisted, remove the robe. Have patient place hands on bed and lower to sit on bed. *(Pivoting allows patient to sit without twisting. Having patient stand aids in removal of robe because patient is not sitting on robe.)*
22. Remove slippers. Have patient lean against the elevated head of the bed, and assist in swinging legs up into bed, maintaining good body mechanics. *(Positions patient at head of bed so patient will not need to be moved up in bed.)*
23. Cover the patient, raise side rail if necessary, and place call bell within reach. *(Maintains privacy, and institutes safety measures.)*

### Evaluation

24. Assess patient's position, alignment, and comfort level. Modify as necessary. *(Maintains support of body and decreases chance of injury resulting from poor positioning or movement.)*

## Skill 18-4 Transferring the Patient to a Wheelchair—cont'd

### Documentation

25. Document, noting date, time, position, length of time patient was out of bed, and how patient tolerated the procedure. If the patient was transported to another area for a test, include this information. Note number of personnel needed to complete the transfer. *(Validates effectiveness of nursing care and activity of patient, and provides data for transferring patient.)*

#### Documentation Example

3/8 1000 Assisted out of bed to wheelchair by standing and pivoting, with assistance of one nurse. No weakness or difficulty noted during transfer. Returned to bed after 30 minutes.

_____
*(Nurse's signature)*

### Special Considerations

- When transferring a patient to a wheelchair, you may need to help the weak patient readjust position in the wheelchair. To do this, stand behind the wheelchair with your knees flexed. Place your arms under the patient's axillae and lift the patient up and back by using your leg muscles. Reposition and place call bell within patient's reach.

### Critical Thinking Questions

1. Dangling at the side of the bed is important, especially for the patient who has not been out of bed. Why?
2. Your patient had a right stroke with left-sided paresis. In transferring the patient to the wheelchair, which side of the patient should be closest to the chair? Why?

### Think Critically

Your 39-year-old patient has been on bed rest for 1 week. She has not been out of bed yet and needs to go to the x-ray department for a chest x-ray study. Do you use a wheelchair or a stretcher to send her? Why?

Moving a wheelchair or a stretcher is an exception to a principle of body mechanics discussed earlier in this chapter. Both devices are pushed rather than pulled. To pull a wheelchair or stretcher would cause back strain and twisting.

### Clinical Cues

When transferring a patient into or out of a wheelchair, check feet and arms for positions where they will not hit the parts of the chair or the bed. Position the footrests where they won't interfere with the feet during transfer. Many skin injuries occur when transferring patients into or out of wheelchairs.

#### *Transferring Devices*

Devices that may be used in lifting and transferring patients include mechanical lifts, lift or pull sheets, roller boards, slide boards, and transfer (or gait) belts. Mechanical lifts are discussed in Chapter 39. Lift sheets are often used to move and transfer a patient. Low friction sheets may be used. Transferring a patient to a stretcher is discussed in Skill 18-5. Lift sheets may be used alone or with the following devices to help maintain the patient's alignment during a transfer.

A **roller board** consists of several roller bars between fixed end bars. The bars are enclosed in a vinyl covering that allows the bars to turn when something or someone is pulled over the top of the roller board. It works similar to a conveyor belt.

To use a roller board to transfer a patient to a stretcher, turn the patient to one side and place the roller board and lift sheet underneath the patient. Return the patient to a supine position and place the stretcher against the bed with the side rail down. Lock the stretcher wheels. One or more nurses are on the far side of the bed, and you and another nurse are on the far side of the stretcher. Hold the lift sheet as close to the patient as possible. On the count of 3, pull the patient across the roller board. The nurse(s) on the far side of the bed support the patient's head and feet and help guide the patient to the stretcher. A **slide board** works similarly to a roller board except that it does not roll. It has a slippery surface that allows the patient on a lift sheet to be slid across it to a stretcher or to a wheelchair.

A **transfer belt** or **gait belt** may be used to ambulate or transfer the weak or unsteady patient. It is made of a tightly webbed canvas material and is very sturdy. Place and buckle the belt around the patient's waist before having the patient stand. Tighten it just enough to allow space for your hand to grasp it from the rear. **Insert your hand into the belt from the bottom so that, if the patient falls, you will be able to support the weight.** If you hold the belt from the top, it could slip out of your hand from the patient's weight during a fall. Skill 18-6 discusses how to assist a patient in ambulation and how to break a fall.

## Skill 18-5 Transferring the Patient to a Stretcher

Patients are transferred to a stretcher to be moved from place to place in the hospital for diagnostic tests or surgery. Care must be taken to prevent injury to the patient and yourself during this task. As with any skill, it is important to have the correct number of staff members to transfer the patient safely. Observe proper body movement and alignment to prevent injury. Three staff members or more are needed, depending on patient size. Use a roller board or slide board if available.

### Supplies

- Bed
- Stretcher
- Bath blanket or sheet
- Second bath blanket or sheet
- Roller board or slide board

*Review and carry out the Standard Steps in Appendix D.*

### ACTION *(RATIONALE)*

#### Assessment (Data Collection)

1. Assess patient's size and ability to assist in move (e.g., folding arms on chest). *(Provides baseline data and indicates the number of additional staff needed for transfer.)*

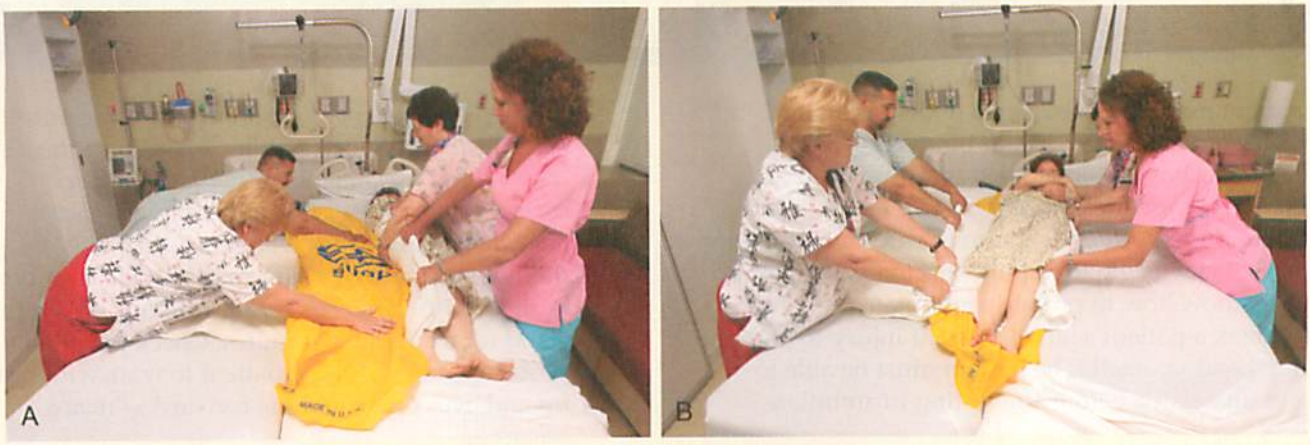
#### Planning

2. Gather stretcher and other supplies needed for the transfer. *(Promotes access to equipment for safe transfer.)*
3. Maintain patient's privacy by closing door and/or curtain. *(Protects the patient's right to privacy and reduces embarrassment.)*
4. Get other staff members needed to help with transfer. *(Provides for a safe transfer.)*
5. Explain the procedure to the patient. *(Decreases fear of the unknown and prepares patient for what will occur.)*

#### Implementation

6. Perform hand hygiene. *(Reduces transfer of microorganisms.)*
7. Lock the wheels of the bed and raise it level with the height of the stretcher. *(Prevents the patient from falling between bed and stretcher. Level surfaces allow maintenance of proper body movement and alignment.)*
8. Fold the top covers to the foot of the bed, making certain feet are uncovered. Remove any positioning devices from bed. Cover patient with bath blanket or sheet. *(Moving covers prevents feet from becoming tangled in bed linen during transfer. Removing positioning devices prevents obstruction during transfer. Covering the patient provides privacy during transfer.)*
9. Check for any tubes (e.g., intravenous [IV], nasogastric, urinary catheter, or chest tube), and position them so they will not be pulled out or dislodged during transfer. *(Prevents patient injury and loss of access, as with an IV.)*
10. Lower the side rail of the bed on the side where the transfer will take place, and have one nurse remain at the bedside to protect the patient from falling. *(Improves access to patient and provides for safety.)*
11. Place the lift sheet and/or slide board under the patient as described in Skill 18-2. The slide board is placed beneath the lift sheet. *(Lift sheet minimizes shearing forces. Slide board makes transfer much easier.)*
12. Place patient on back; have both nurses grasp the edge of the sheet, and on the count of 3, move patient to the open edge of the bed. *(Decreases the risk of injury by using more people. If the patient is large, more than three nurses may be needed to safely transfer the patient.)*
13. Place the stretcher firmly against the open side of the bed and lock its wheels. *(Maintains safety and prevents patient from falling.)*
14. Two nurses stand with a correct stance on the far side of the stretcher. The third nurse stands or kneels on the other side of the bed to assist in guiding the patient from the bed to the stretcher. On the count of 3, the two nurses pull and the third nurse lifts and guides the patient to the stretcher. *(Pulling is easier than pushing, and it promotes a smooth transfer.)*

## Skill 18-5 Transferring the Patient to a Stretcher—cont'd




Step 14

15. Smooth out the lift sheet under the patient. Check and straighten the patient's body alignment. Fasten the safety belt securely over the patient, and raise the side rail of the stretcher. *(Provides safety.)*
16. Cover the patient for more warmth if needed, and put a pillow under the patient's head. *(Provides comfort.)*
17. Unlock the wheels, move the stretcher away from the bed, and raise the opposite stretcher rail. *(Allows patient to be moved to site of test or procedure.)*
18. Remake or straighten the patient's bed in preparation for patient's return. *(Conserves time because bed is ready for patient on return.)*

### Evaluation

19. Assess patient's position, alignment, and comfort level. Modify as necessary. *(Maintains support of body and decreases chance of injury resulting from poor positioning or mechanics.)*

### Documentation

20. Document the transfer: date, time, type of transfer, number of personnel necessary, and how patient tolerated the procedure. If the patient was transported to another area for a test, include this information. *(Notes patient transfer off unit.)*

#### Documentation Example

3/18 1330 To x-ray. Transferred from bed to stretcher by three staff members using a pull sheet without incident. Safety belt applied.

_____
*(Nurse's signature)*

### Critical Thinking Questions

1. Why are two nurses placed on the side to which the patient is being moved onto the stretcher?
2. What purpose does a roller board serve in transferring your patient to the stretcher?

## Evaluation

During evaluation, determine whether the expected outcomes and goals from the planning phase have been met. Evaluate your use of proper body mechanics. Obtain feedback from the patient and other personnel regarding positioning and transfers. Did you position the patient safely and correctly? Was the patient comfortable when you finished, or did you need to readjust the position? Did pressure areas develop on the skin? If the plan needs to be changed, document the changes for other personnel. Record the progress achieved in meeting the goals and outcomes (Nursing Care Plan 18-1 on p. 284).

Practicing the techniques of proper body mechanics and alignment will increase your confidence in being able to safely move and position any patient. Using your muscles and these techniques correctly will help protect your back. Preventing back injuries is a major concern for all health care professionals.

## Skill 18-6 Ambulating the Patient and Breaking a Fall

A patient may need assistance with ambulation because of unsteadiness from illness or trauma, weakness from prolonged bed rest, or a need to manage therapeutic equipment such as drains or intravenous (IV) lines. Sometimes during ambulation a patient may begin to fall unexpectedly. It is important to know how to properly ambulate the patient and break a patient's fall to prevent injury to both the patient and yourself. The patient must be able to stand unassisted before attempting to ambulate.

### Supplies

- Robe
- Socks
- Slippers or shoes
- Transfer or gait belt (if necessary)

*Review and carry out the Standard Steps in Appendix D.*

### ACTION *(RATIONALE)*

### Assessment (Data Collection)

1. Check the patient's written activity order. *(A written order is required to get the patient out of bed.)*
2. Assess patient's comfort level, coordination, activity tolerance, strength, and balance. *(Provides baseline data and informs you if more than one staff member will be needed.)*

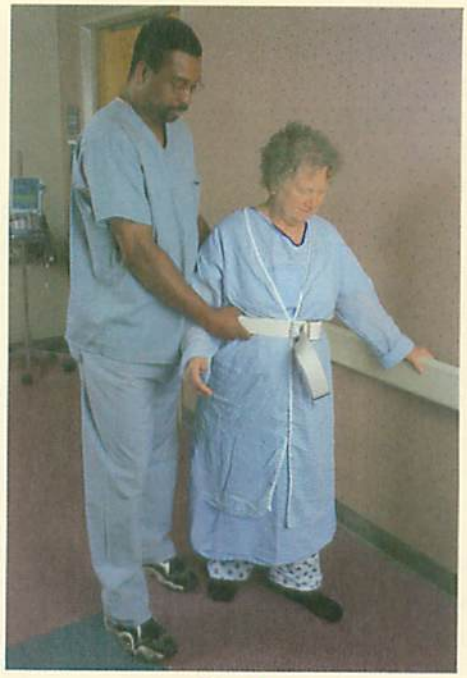
### Planning

3. Gather patient items and transfer belt if necessary. *(Provides easy access.)*
4. Get additional help if necessary. *(Promotes safety.)*
5. Explain the procedure to the patient. *(Decreases fear of the unknown and prepares patient for what will occur.)*

### Implementation

#### Ambulating the Patient

6. With the patient seated on the side of the bed with robe and socks and slippers on, place patient's feet firmly on the floor. Position yourself in front of the patient with feet apart and outside the patient's feet. Place your arms under the axillae and hands over both scapulae, and assist the patient to a standing position. (Alternative: For the weak patient, use a transfer or gait belt. Hold belt behind the patient with one hand from underneath.) Support the patient's arm/elbow on the side closest to you. Check and secure all tubes. *(Forms a support base for you and the patient and provides leverage for lifting. Maintains patient's center of gravity at midline. Transfer or gait belt enables you to support the patient's weight. Tubes must not be pulled on or trip the patient.)*
7. Move to the patient's side, and provide support as the patient balances before walking. Allow to stand for a couple of minutes. Check patient's posture, and encourage patient to walk with head up and eyes open, looking forward. *(Promotes balance.)*



Step 7

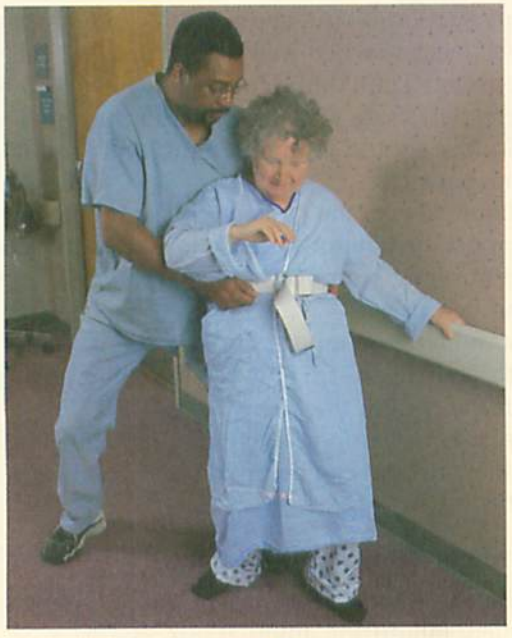
8. Walk at the patient's side. Match your gait with the patient's. The patient may hold your elbow or hand for stabilization. *(Conveys caring as well as stability, thus encouraging the patient to achieve greater mobility. Support prevents loss of balance and falling.)*

#### Breaking a Patient's Fall

During ambulation, a patient may unexpectedly stumble or begin to fall.

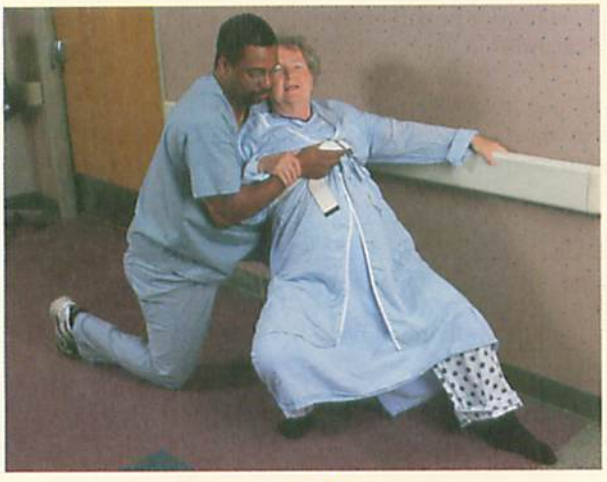
9. If the patient begins to fall, stand with your feet apart slightly behind the patient, and grasp the patient's body firmly at the waist or under the axilla. *(Provides a broad base of support.)*

## Skill 18-6 Ambulating the Patient and Breaking a Fall—cont'd



Step 9

10. Extend your near leg against the patient's leg, and slowly slide the patient down your leg to the floor, keeping your body in straight alignment. *(Slows the rate of descent, decreasing the risk of injury. Straight alignment keeps your line of gravity within your base of support.)*



Step 10

11. As the patient slides, bend your knees to lower your body while continuing to support the patient. *(Maintains weight within your center of gravity.)*

12. Call for additional help, check the vital signs, and examine the patient for any injuries incurred as a result of the fall before allowing the patient to rise. *(Prevents any further injury or discomfort to the patient.)*

#### Assisting the Patient Back to Bed After Ambulating

13. Walk to the side of the bed and have patient turn her back to the bed. Patient reaches back for the mattress with both hands for support. Reconnect tubing that was disconnected for ambulation; secure all tubing appropriately. Continue to assist the patient back to bed as described in Skill 18-4. *(Mattress provides support and security. Alignment is maintained. IV tubing, urinary catheter, drainage tubes, and suction must be re-secured and checked for patency.)*

### Evaluation

14. For ambulating: Note patient's posture during ambulation, effort, tolerance, comfort level, and the distance ambulated. *(Provides data for comparison and modification if necessary.)*
15. For breaking a fall: Note difficulty encountered, whether injury occurred, and whether physician was notified. Did patient stumble or feel dizzy? Was the patient hypotensive? *(Provides data for prevention of fall and highlights necessary modifications.)*

### Documentation

16. For ambulating: Record distance ambulated, patient's tolerance of procedure, and assistive devices or personnel necessary. *(Records effectiveness of nursing care and provides for consistency of care among personnel.)*

#### Documentation Example

3/18 1430 Assisted to ambulate the length of the hall. Walked slowly with minimal assistance. No complaint of weakness or dizziness. Back to bed, placed in a semi-Fowler position for comfort. Bed down, call bell in reach.

_____
*(Nurse's signature)*

17. For breaking a fall: Document the fall and its consequences per institutional policy. Note any perceived or patient-stated cause of fall, any injury sustained, and measures taken. *(Documents incident; presents assessment findings and care provided.)*

*Continued*

## Skill 18-6 Ambulating the Patient and Breaking a Fall—cont'd

**Documentation Example**

3/18 1030 While ambulating in hallway, patient stated became dizzy and began to fall. Fall broken and patient gradually supported in slide to the floor. Checked for injuries. No cuts, bruises, or abrasions noted. BP, 110/76; pulse, 92; respirations, 24. Complains of no discomfort, only weakness. Assisted to wheelchair and back to bed. Bed down, call bell in reach. Physician and charge nurse notified.

_____
*(Nurse's signature)*

### Special Considerations

- Assess for signs and symptoms of orthostatic hypotension when the patient is dangling at the side of the bed.
- If the patient is weak or partially paralyzed on one side, support the patient on the opposite, unaffected side, so that the assistive device (such as a cane) can be used on the affected side. Otherwise support the patient on the affected, weaker side.
- Only suction tubing and oxygen cannula should be disconnected when ambulating the patient out of the room. The IV line needs to be checked for the correct drip rate after the patient is returned to bed. All tubes should be checked for kinks and to determine patency.
- Do not overtire the patient when ambulating.
- Support the patient's head when breaking a fall.
- For minimal support, hold the patient's arm with your hand.
- For moderate support, encircle the patient's waist with your near arm and use the other arm to support the patient's near arm and hand.
- For maximal support, have another person help you so that support can be provided on each side of the patient.

### Critical Thinking Questions

1. What steps would you take to avoid having a patient fall during ambulation?
2. On which side do you support a patient who has left-sided weakness? Why?

## Nursing Care Plan 18-1 Care of the Patient at Risk for Injury

**SCENARIO** Darla Porter, age 74, a patient on your orthopedic unit, sustained a proximal fracture of the right tibia during a motor vehicle accident. Mrs. Porter has a long leg cast and a history of arthritis in her hands. You implement this plan of care.

***PROBLEM*/NURSING DIAGNOSIS** *Leg in cast*/Risk for injury related to inability to change position independently.
**Supporting Assessment Data** ***Subjective:*** States since car accident is unable to move in bed without help. ***Objective:*** Arthritis in her hands makes using a trapeze bar difficult. She is not able to shift her position independently.

| Goals/Expected Outcomes | Nursing Interventions | Selected Rationales | Evaluation |
|---|---|---|---|
| Patient will remain free of injury until able to move independently. | Inspect skin for signs and symptoms of impaired integrity q 2 hr. | Patient at risk for development of pressure ulcer because of inability to independently move. | *Has any injury occurred?* No redness, blanching, or pallor noted on skin pressure points. |
| | Encourage the patient to perform ROM exercises twice a day; assist as necessary. | ROM exercises help to maintain joint mobility. | ROM performed 1 time this shift. |
| | Inspect the musculoskeletal system for joint contractures every day. | Early detection is key for intervention, thus avoiding contractures. | No contractures noted. |
| | Reposition patient at least every 2 hours using appropriate devices such as pillows and footboard to maintain anatomic alignment. | Adjusting position at least every 2 hours helps to prevent skin breakdown. Positioning devices help maintain anatomic alignment and therefore decrease chance of injury. | Correct anatomic alignment maintained. |

Key: *ROM*, Range-of-motion.

## Nursing Care Plan 18-1 Care of the Patient at Risk for Injury—cont'd

| Goals/Expected Outcomes | Nursing Interventions | Selected Rationales | Evaluation |
|---|---|---|---|
| | Encourage the patient to cough and deep breathe every hour. | Coughing and deep breathing help prevent collection of fluid in the lungs. | Expected outcome is being met. |
| | Teach patient and family correct transfer techniques | Correct transfer techniques protect the patient and the family member from injury. | |

### Critical Thinking Questions

1. What are some other possible nursing diagnoses this patient might have? Construct a care plan for one or two of those diagnoses using some of the above information.
2. Describe the benefits of using positioning devices.

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## Key Points

- The musculoskeletal system is involved in positioning and moving patients.
- Observing proper body alignment and mechanics helps prevent injuries. Lower back strain is one of the most common injuries for health care workers.
- Get help when necessary before moving or positioning a patient.
- Observing these principles helps to prevent the hazards of improper positioning: pressure ulcers, muscle contractures, and fluid collection in the lungs.
- Pressure and shearing force are the main factors in developing pressure ulcers.
- There are three basic positions: supine, side-lying, and prone. Other positions include Fowler, semi-Fowler, low Fowler, and Sims.
- Common positioning devices include pillows, boots, splints, high-top sneakers, trochanter rolls, sandbags, trapeze bars, side rails, and bed boards.
- Logrolling is a technique in which the patient is turned as a single unit.
- A lift sheet supports a patient from the shoulders to below the buttocks and facilitates transfers.
- While the patient is dangling, monitor for orthostatic hypotension, dizziness, or nausea before getting the patient out of bed.
- Lock the wheels on stretchers and wheelchairs before transferring patients.
- Transferring devices include mechanical lifts, roller boards, slide boards, lift or pull sheets, low friction sheets, and transfer (or gait) belts.
- Pulling motions are better than pushing motions, except that wheelchairs and stretchers are pushed to maintain alignment.

## Additional Learning Resources

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- Animations
- Answer Guidelines for Think Critically boxes and Critical Thinking Questions and Activities
- Answers and Rationales for Review Questions for the NCLEX® Examination
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions for the NCLEX® Examination and more!

## Review Questions for the NCLEX® Examination

*Choose the **best** answer for each question.*

1. An elderly person may need to be reeducated on how to lift safely because: *(Select all that apply.)*
   1. muscles and bones lose strength as one ages.
   2. bone density is decreased.
   3. muscle mass is decreased and posture changed.
   4. she has forgotten how to lift things.

2. When moving the patient up in bed:
   1. place one foot in front of the other.
   2. use only those muscles absolutely necessary.
   3. pushing is better than pulling, as your weight helps.
   4. lock the knees before moving the patient.

3. Forgetting to reposition a patient in a wheelchair for more than 1 hour may lead to:
   1. the beginning of a pressure ulcer.
   2. muscle atrophy.
   3. pooling of lung secretions.
   4. skin abrasions from shearing forces.

4. When preparing to move a patient up in the bed who can assist, you would *first:*
   1. pull the bed covers down to the foot of the bed.
   2. raise the bed to a good working height.
   3. ask the patient to grab the upper guard rails.
   4. ask the patient to bend the knees and plant the feet on the mattress.

5. The oblique side-lying (lateral) position is helpful because:
   1. the patient does not need to be repositioned as often.
   2. it takes pressure off of the trochanter and shoulder.
   3. all areas of the lung will drain secretions to the bronchus.
   4. the shoulder is rolled to a forward position.

6. You have assisted your patient to the prone position. Which intervention is most important?
   1. Ask if he has any neck discomfort.
   2. Count his respirations.
   3. Offer him a magazine.
   4. Place the call bell within reach.

7. When changing the patient's position, it is most important to:
   1. use only those muscles absolutely necessary.
   2. stand with feet close together for greater strength.
   3. work at the same level or height as the patient.
   4. push rather than pull, as your weight helps.

8. You are dangling your patient in preparation for getting her out of bed. Your plan is to dangle her for 2 minutes, then transfer her to the chair. After 1 minute she complains of nausea and states that she sees "stars." What should you do?
   1. Reassure her that this will pass.
   2. Get the BP cuff from across the room.
   3. Gently lie her back down.
   4. Wait 2 more minutes, then check her BP.

9. When performing passive range-of-motion exercises:
   1. help patients who are independently performing these activities.
   2. avoid moving the joint to the point of discomfort.
   3. perform each exercise at least 15 to 20 times.
   4. support the extremity above and below the joint.

10. When a patient falls, you document in the nurse's notes:
    1. your best guess about what happened.
    2. a statement concerning how you believe the hospital was negligent.
    3. any patient-stated cause of fall.
    4. as little as possible to avoid liability.

## Critical Thinking Activities

*Read each clinical scenario and discuss the questions with your classmates.*

### Scenario A

You are to get a patient who has left-sided paresis out of bed and into a chair for the first time. The patient has been in this country only a short time. How would you go about doing this? Would you need assistance?

### Scenario B

You and three other nurses are logrolling a patient. You are 5 feet, 6 inches tall, and the other nurses are all at least 3 inches taller. How high do you position the bed to logroll the patient?

### Scenario C

Your patient became weak while walking, and you broke her fall and assisted her to the floor. What would you do next? What procedures would need to be followed?