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COLLEGE OF NURSING
World Health Organization Collaborating Center for Nursing Leadership and Development
Commission on Higher Education Center of Excellence
Sotejo Hall, Pedro Gil St., Ermita, Manila

N11 – NURSING FOUNDATION II

TITLE:	**Assisting a Client to Ambulate**
DEFINITION/ DESCRIPTION:	To prepare and assist safely a client for ambulation
PURPOSES:	To provide a safe condition for the client to walk with whatever support is needed
EQUIPMENT:	• Assistive devices required for safe ambulation of client (e.g., gait or transfer belt, walker, cane, sit-to-stand assist device, lift with ambulation sling) • Wheelchair for following client, or chairs along the route if the client needs to rest. • Portable oxygen tank if the client needs it.
ASSESSMENT:	• Length of time in bed and the amount and type of activity the client was last able to tolerate • Baseline vital signs • Range of motion of joints needed for ambulating (e.g., hips, knees, ankles) • Muscle strength of lower extremities • Need for ambulation aids (e.g., cane, walker, crutches, lift with ambulation sling) • Client's intake of medications (e.g., opioids, sedatives, tranquilizers, and antihistamines) that may cause drowsiness, dizziness, weakness, and orthostatic hypotension, seriously hindering the client's ability to walk safely • Presence of joint inflammation, fractures, muscle weakness, or other conditions that impair physical mobility • Ability to understand directions • Level of comfort • Weight-bearing status
PLANNING	Implement pain relief measures so that they are effective. The amount of assistance needed while ambulating will depend on the client's condition (e.g., age, health status, length of inactivity, and emotional readiness). Review any previous experiences with ambulation and the success of such efforts. Plan the length of the walk with the client, considering the nursing or primary care practitioner's orders and the medical condition of the client. Be prepared to shorten the walk according to the client's activity tolerance.

IMPLEMENTATION		
A. Preparation		
	PROCEDURE	**RATIONALE**
1.	Be certain that others are available to assist you if needed. Also, plan the route of ambulation that has the fewest hazards and a clear path for ambulation.	
B. Performance		
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client how you are going to assist, why ambulation is necessary, and how to participate. Discuss how this activity relates to the overall plan of care. Stress that the client must keep the nurse informed as to how the activity is being tolerated as it progresses.	To ensure the right medication is administered.
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.	
3.	Ensure that the client is appropriately dressed to walk and has shoes or slippers with nonskid soles.	
4.	Prepare the client for ambulation. Have the client sit up in bed for at least 1 minute prior to preparing to dangle legs. Assist the client to sit on the edge of the bed and allow dangling for at least 1 minute Assess the client carefully for signs and symptoms of orthostatic hypotension (dizziness, light-headedness, or a sudden increase in heart rate) prior to leaving the bedside. Carefully attend to any IV tubing, catheters, or drainage bags. Keep urinary drainage bags below level of the client's bladder. If the client is a high safety risk (e.g., cannot follow commands, medical instability, lack of experience with assistive device, neurologic deficits), use a lift with ambulation sling and 1 to 2 caregivers. If the client is a high safety risk and has upper extremity strength and is able to grasp with at least one hand, use a lift with ambulation sling or a sit-to-stand lift with ambulation capability and 1 to 2 caregivers.	Allowing for gradual adjustment can minimize drops in blood pressure (and fainting) that occur with shifts in position from lying to sitting and sitting to standing. To prevent backflow of urine into bladder and risk of infection.
5.	Ensure client safety while assisting the client to ambulate. • Encourage the client to ambulate independently if he or she is able, but walk beside the client's weak side, if appropriate. If the client has a lightweight IV pole because of infusing fluids, he or	

IMPLEMENTATION		
	she may find that holding onto the pole while ambulating helps with balance. If the pole or other equipment is cumbersome in any way, the nurse must push it to match the client's pace, securing any assistance necessary in order to move smoothly with the client. • Remain physically close to the client in case assistance is needed at any point. • If it is the client's first time out of bed following surgery, injury, or an extended period of immobility, or if the client • is weak or unstable, have an assistant follow you and the client with a wheelchair in the event that it is needed quickly. • Encourage the client to assume a normal walking stance and gait as much as possible. Ask the client to straighten • the back and raise the head so that the eyes are looking forward in a normal horizontal plane.	Clients who are unsure of their ability to ambulate tend to look down at their feet, which makes them more likely to fall.
6.	Protect the client who begins to fall while ambulating. • If a client begins to experience the signs and symptoms of orthostatic hypotension or extreme weakness, quickly assist the client into a nearby wheelchair or other chair, and the client to lower the head between the knees. • Stay with the client. • When the weakness subsides, assist the client back to bed. • Never catch a falling client. A caregiver probably cannot stop a client from falling. Quickly remove obstacles out of the way that may injure the client Do not manually lift a client from the floor. Variation: Two Nurses • Place a gait or transfer belt around the client's waist. Each nurse grasps the side handle with the near hand and the lower aspect of the client's upper arm with the other hand. • Walk in unison with the client, using a smooth, even gait, at the same speed and with steps the same size as the client's.	A client who faints while in this position could fall head first out of the chair. This gives the client a greater feeling of security.
7.	• Document distance and duration of ambulation and assistive devices, if used, in the client record using forms or	

IMPLEMENTATION		
	checklists supplemented by narrative notes when appropriate. • Include description of the client's gait (including body alignment) when walking; pace; activity tolerance when walking (e.g., pulse rate, facial color, any shortness of breath, feelings of dizziness, or weakness); degree of support required; and respiratory rate and blood pressure after initial ambulation to compare with baseline data.	
EVALUATION		
	• Establish a plan for continued ambulation based on expected or normal ability for the client.	

REFERENCES:

Berman, A., Snyder, S. and Frandsen, G. (2016). *Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice* (10th ed.). New Jersey: Pearson Education, Inc.

Lynn, P. (2011). *Taylor's handbook of clinical nursing skills* (1st ed.). Wolters Kluwer Health / Lippincott Williams & Wilkins.

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N11 – NURSING FOUNDATION II

TITLE:	**Assisting a Client to Sit on the Side of the Bed**
DEFINITION/ DESCRIPTION:	To safely assist client to change position from supine to sitting position.
PURPOSES:	The client assumes a sitting position on the edge of the bed before walking, moving to a chair or wheelchair, eating, or performing other activities.
EQUIPMENT:	• Assistive devices
ASSESSMENT:	Before transferring a client, assess the following: • The client's body size and weight • Ability to follow instructions • Activity tolerance • Level of comfort • The number of assistants (one to four) needed to accomplish the repositioning safely.
PLANNING	Review the client record to determine if previous nurses have recorded information about the client's ability to move. Use proper assistive equipment and additional personnel whenever needed. Ensure that the client understands instructions, and provide an interpreter as needed. Determine the number of personnel and type of equipment needed to safely perform the positional change to prevent injury to staff and client.

IMPLEMENTATION		
A. Preparation		
PROCEDURE		**RATIONALE**
1.	Determine: • Assistive devices that will be required • Limitations to movement such as an IV or an indwelling urinary catheter • Medications the client is receiving, because certain medications may hamper movement or alertness of the client • Assistance required from other healthcare personnel.	
B. Performance		
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you	

IMPLEMENTATION		
	are going to do, why it is necessary, and how to participate.	
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.	
3.	Provide for client privacy.	
4.	Position yourself and the client appropriately before performing the move. • Assist the client to a lateral position facing you, using an assistive device depending on client assistance needs. • Raise the head of the bed slowly to its highest position. • Position the client's feet and lower legs at the edge of the bed. • Stand beside the client's hips and face the far corner of the bottom of the bed (the angle in which movement will occur). Assume a broad stance, placing the foot nearest the client and head of the bed forward. Lean your trunk forward from the hips. Flex your hips, knees, and ankles.	This decreases the distance that the client needs to move to sit up on the side of the bed. This enables the client's feet to move easily off the bed during the movement, and the client is aided by gravity into a sitting position.
5.	Move the client to a sitting position, using an assistive device depending on client assistance needs. Place the arm nearest to the head of the bed under the client's shoulders and the other arm over both of the client's thighs near the knees. • Tighten your gluteal, abdominal, leg, and arm muscles. • Pivot on the balls of your feet in the desired direction facing the foot of the bed while pulling the client's feet and legs off the bed. • Keep supporting the client until the client is well balanced and comfortable. • Assess vital signs (e.g., pulse, respirations, and blood pressure) as indicated by the client's health status.	Supporting the client's shoulders prevents the client from falling backward during the movement. Supporting the client's thighs reduces friction of the thighs against the bed surface during the move and increases the force of the movement. Pivoting prevents twisting of the nurse's spine. The weight of the client's legs swinging downward increases downward movement of the lower body and helps make the client's upper body vertical. This movement may cause some clients to become light-headed or dizzy.
6.	Document all relevant information. Record: • Ability of the client to assist in moving and turning • Type of assistive device, if one was used	

IMPLEMENTATION		
	• Response of the client to moving and turning (e.g., anxiety, • discomfort, dizziness).	
EVALUATION		
	• Check the skin integrity of the pressure areas from the previous position. Relate findings to previous assessment data if available. • Conduct follow-up assessment for previous and new skin breakdown areas. • Check for proper alignment after the position change. Do a visual check and ask the client for a comfort assessment. • Determine that all required safety precautions (e.g., side rails) are in place. • Determine client's tolerance of the activity (e.g., vital signs before and after dangling), particularly the first time the client changes position. • Report significant changes to the primary care practitioner.	

REFERENCES:

Berman, A., Snyder, S. and Frandsen, G. (2016). Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice (10th ed.). New Jersey: Pearson Education, Inc.

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N11 – NURSING FOUNDATION II

TITLE:	**Educating Clients on the Use of Ambulation Aids**
DEFINITION/ DESCRIPTION:	To teach clients on how to use ambulation aids safely and correctly.
PURPOSES:	To promote client mobility through safe and correct use of ambulation aids and identification of precautions need to observe.
EQUIPMENT:	• Shoes with nonslip soles • Gait belt • PPE as needed • Prescribe ambulation aids (crutches, cane, walker)
ASSESSMENT:	• Baseline vital signs • Range of motion of joints needed for ambulating (e.g., hips, knees, ankles) • Muscle strength of lower extremities • Need for ambulation aids (e.g., cane, walker, crutches, lift with ambulation sling) • Client's intake of medications (e.g., opioids, sedatives, tranquilizers, and antihistamines) that may cause drowsiness, dizziness, weakness, and orthostatic hypotension, seriously hindering the client's ability to walk safely • Presence of joint inflammation, fractures, muscle weakness, or other conditions that impair physical mobility • Ability to understand directions • Level of comfort • Weight-bearing status
PLANNING	Selection of the proper ambulation device and gait pattern is essential for the client's safety and well-being. The client may need an ambulation aid to compensate for impaired balance, decreased strength, pain during weight bearing, or an affected leg.

IMPLEMENTATION		
A. Preparation		
PROCEDURE		**RATIONALE**
1.	Perform hand hygiene before client contact. Donned appropriate PPE based on the client's need for isolation precautions or the risk of exposure to bodily fluids.	To prevent transmission of microorganism that can place a client and care provider at risk of infection
B. Performance		
1.	Introduce self to the client.	To promote client engagement

IMPLEMENTATION		
2.	Verify the correct client using two identifiers.	To provide correct intervention to the right client
3.	Explain the procedure and ensured that the client agreed to treatment.	To promote client engagement in the intervention to be performed
4.	Assess the client's mobility needs. • Assess the client's cognitive status. • Assess the client's physical abilities, including strength, mobility, range of motion, visual acuity, perceptual difficulties, and balance. • Assess the client's home environment, including asking about stairs and the availability of a bathroom and bedroom on the main level.	To determine safety precautions that need to be observe and identify level of mobility that the client can perform and tolerate
5.	Determine the appropriate type of device and gait in collaboration with the practitioner. • Measured and adjusted the ambulation aid. • Placed a gait belt on the client.	To prevent client injury in the use of ambulation aids
6.	Ensure that the client was wearing shoes with nonslip soles. Freed the area of potential hazards.	To prevent client injury and fall
7.	**Four-Point Gait (Two Crutches or Two Canes)** • Instruct the client to move the right crutch or cane forward, then the left leg. • Next, instruct the client to move the left crutch or cane forward, then the right leg. ***Two-Point Gait (With Two Ambulation Aids)*** • With the client in a stationary position, instruct the client to move the right-side ambulation aid forward simultaneously with the left leg.	
	• Next, instruct the client to move the left-side ambulation aid forward simultaneously with the right leg. ***Three-Point Gait (With Two Ambulation Aids, Usually Crutches)*** • Instruct the client to advance the two ambulation aids simultaneously with the affected leg. • Next, instruct the client to step forward with the unaffected leg. ***Ambulating with a Cane or Single Crutch*** • Instruct the client to hold the cane or crutch on the side opposite the affected leg. • Next, instruct the client to move the cane	

IMPLEMENTATION		
	or crutch forward, followed by the affected leg and then the unaffected leg. ***Ambulating with a Walker*** • Instruct the client to advance the walker first, ensuring that all four tips touched the floor simultaneously (walkers with wheels should be slid forward slightly). • Next, instruct the client to step forward with the partial-weight-bearing leg, followed by the full-weight-bearing leg. ***Drag-to Gait (Two Crutches or a Walker)*** • Instruct the client to advance both crutches, either together or one at a time. If the client was using a walker, instructed the client to lift or drag the walker forward. • Next, instruct the client to drag both feet forward, with the feet landing behind the crutches or walker. ***Swing-to-Gait (Two Crutches or a Walker)*** • Instruct the client to advance the crutches individually or together. If the client was using a walker, instructed the client to move the walker forward slightly in front of the feet. • Next, instruct the client to swing the feet forward, ending just behind the crutches or walker.	
	Swing-Through Gait (Two Crutches) • Instruct the client to move both crutches forward simultaneously. • Next, instruct the client to extend the elbows and to swing both feet forward and slightly off of the floor, landing just behind the crutches.	

	Sitting Down or Standing Up from a Chair with Crutches
	• Teach the client how to sit down in a chair with crutches. Instruct he client to:
	  • Hold both crutches in one hand on the affected leg side.
	  • Place the unaffected leg close to the chair edge.
	  • Put the free hand on the seat bottom and sit down in the chair using the crutches, the unaffected leg, and the free hand for balance and support.
	• Teach the client how to stand up with crutches. Instruct the client to:
	  • Hold both crutches in one hand on the affected leg side.
	  • Push up using the free hand, the unaffected leg, and the hand that is	

IMPLEMENTATION		
	holding the crutches.	
	Ascending and Descending Stairs with Crutches • Warn the client that going up and down stairs with crutches could be difficult and dangerous, and that both strength and flexibility were needed. • Advise the client that a safer alternative might be to sit down and scoot up and down the stairs. • Instructed the client to ask for help, if needed, with supporting the affected leg or carrying the crutches. • *Taught the client to remember the slogan "Up with the good, down with the bad" as a reminder for which leg goes first when ascending or descending stairs.* ***Without a Handrail*** • Teach the client how to go up the stairs without a handrail. Instruct the client to: o Use the three-point gait pattern. o Keep the weight on the crutches and advance the unaffected leg up to the next step. o Shift the weight up to the unaffected leg and bring the crutches up to the same step. o Extend the hip and flex the knee on the affected side enough to clear the step with the affected leg. • Teach the client how to go down the stairs in a non-weight-bearing pattern without a handrail. Instructed the client to: o Keep the weight on the unaffected leg and extend the affected leg forward, then lower both crutches down to the next step. o Lean on the crutches and step down with the unaffected leg while bending the affected leg to maintain balance and clear the step.	
8.	Remove PPE and performed hand hygiene.	To prevent transmission of infection
9.	Document the procedure in the client's record.	To monitor and evaluate plan of care and identify client response
EVALUATION		
	• Establish a plan for continued ambulation based on expected or normal ability for the client.	

REFERENCES:

Berman, A., Snyder, S. and Frandsen, G. (2016). *Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice* (10th ed.). New Jersey: Pearson Education, Inc.

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N11 – NURSING FOUNDATION II

TITLE:	**Moving a Client Up in Bed**
DEFINITION/ DESCRIPTION:	To provide safe assistance to the client in moving up in bed
PURPOSES:	To assist clients who have slid down in bed from the Fowler's position to move up in bed
EQUIPMENT:	• Assistive devices such as an overhead trapeze, friction-reducing device, or a mechanical lift
ASSESSMENT:	• Client's ability to lie flat or contraindications to lie flat • Client's physical abilities to assist with the move • Client's ability to understand instructions and willingness to participate • Client's degree of comfort or discomfort when moving; if needed, administer analgesics or perform other pain relief measures prior to the move • Client's weight • The availability of equipment and other personnel to assist you.
PLANNING	Review the client record to determine if previous nurses have recorded information about the client's ability to move. Use proper assistive equipment and additional personnel whenever needed. Ensure that the client understands instructions, and provide an interpreter as needed. Determine the number of personnel and type of equipment needed to safely perform the positional change to prevent injury to staff and client.

IMPLEMENTATION

A. Preparation

	PROCEDURE	RATIONALE
1.	Determine: • Assistive devices that will be required • Limitations to movement such as an IV or an indwelling urinary catheter • Medications the client is receiving, because certain medications • may hamper movement or alertness of the client • Assistance required from other healthcare personnel.	To identify precautions and observe safety of both the client and care provider in moving up in bed the client.

B. Performance

1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going	To ensure the right medication is administered.

IMPLEMENTATION		
	to do, why it is necessary, and how to participate. Listen to any suggestions made by the client or support people.	
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.	
3.	Provide for client privacy	
4.	Adjust the bed and the client's position. Adjust the head of the bed to a flat position or as low as the client can tolerate. Raise the bed to a height appropriate for personnel safety Lock the wheels on the bed and raise the rail on the side of the bed opposite you. Remove all pillows, then place one against the head of the bed.	Moving the client upward against gravity requires more force and can cause back strain. This pillow protects the client's head from inadvertent injury against the top of the bed during the upward move.
5.	For the client who is able to reposition without assistance: Place the bed in flat or reverse Trendelenburg's position (as tolerated by the client). Stand by and instruct the client to move self. Assess if the client is able to move without causing friction to the skin. Encourage the client to reach up and grasp the upper side rails with both hands, bend knees, and push off with the feet and pull up with the arms simultaneously. Ask if a positioning device is needed (e.g., pillow).	
6.	For the client who is partially able to assist: • For a client who weighs less than 200 pounds: Use a friction-reducing device and two assistants. • For a client who weighs between 201–300 pounds: Use a friction-reducing slide sheet and four assistants OR an air transfer system and two assistants. • For a client who weighs more than 300 pounds: Use an air transfer system and two assistants OR a total transfer lift. • Ask the client to flex the hips and knees and position the feet so that they can be used effectively for pushing.	Moving a client up in bed is not a one-person task. During any client handling, if the caregiver is required to lift more than 35 lbs of a client's weight, then the client should be considered fully dependent and assistive devices should be used. This reduces risk of injury to the caregiver. Moving a client up in bed is not a one-person task. During any client handling, if the caregiver is required to lift more than 35 lb of a client's weight, then the client should be considered fully dependent and assistive devices should be used. This reduces risk of injury to the caregiver. Flexing the hips and knees keeps th entire lower leg off the bed surface, preventing friction during movement, and ensures use of the

IMPLEMENTATION		
	• Place the client's arms across the chest. Ask the client to flex the neck during the move and keep the head off the bed surface • Use the friction-reducing device and assistants to move the client up in bed. Ask the client to push on the count of three.	large muscle groups in the client's legs when pushing, thus increasing the force of movement. This keeps the arms and head off the bed surface and minimizes friction during movement.
7. 8.	• Position yourself appropriately and move the client. • Face the direction of the movement, and then assume a broad stand with the foot nearest the bed behind the forward foot and weight on the forward foot. Lean your trunk forward from the hips. Flex the hips, knees, and ankles. • Tighten your gluteal, abdominal, leg, and arm muscles and rock from the back leg to the front leg and back again. Then, shift your weight to the front leg as the client pushes with the heels so that the client moves toward the head of the bed. • For the client who is unable to assist: • Use the ceiling lift with supine sling or mobile floor-based lift and two or more caregivers. Follow manufacturer's guidelines for using the lift.	Moving a client up in bed is not a one-person task. During any client handling, if the caregiver is required to lift more than 35 lb of a client's weight, then the client should be considered to be fully dependent, and assistive devices should be used. This reduces risk of injury to the caregiver.
9.	• Ensure client comfort. • Elevate the head of the bed and provide appropriate support devices for the client's new position.	
10.	• Document all relevant information. Record: • Time and change of position moved from and position move to • Any signs of pressure areas • Use of support devices • Ability of client to assist in moving and turning	

IMPLEMENTATION		
	• Response of client to moving and turning (e.g., anxiety, discomfort, dizziness).	

REFERENCES:

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N11 – NURSING FOUNDATION II

TITLE:	**Transferring Between Bed and Chair**
DEFINITION/ DESCRIPTION:	To safely transfer client between bed and chair.
PURPOSES:	The client assumes a sitting position on the edge of the bed before walking, moving to a chair or wheelchair, eating, or performing other activities.
EQUIPMENT:	• Robe or appropriate clothing • Slippers or shoes with nonskid soles • Gait or transfer belt • Chair, commode, wheelchair as appropriate to client need • Slide board, if appropriate • Lift, if appropriate
ASSESSMENT:	Before transferring a client, assess the following: • The client's body size and weight • Ability to follow instructions • Ability to bear weight (full, partial, or none) • Ability to position and reposition feet on floor • Ability to push down with arms and lean forward • Ability to grasp • Ability to achieve independent balance (sitting, standing, or • none) • Activity tolerance • Muscle strength • Joint mobility • Presence of paralysis • Level of comfort • Presence of orthostatic hypotension • The technique with which the client is familiar • The space in which the transfer will need to be maneuvered (bathrooms, for example, are usually cramped) • The number of assistants (one or two) needed to accomplish the transfer safely.
PLANNING	Review the client record to determine if previous nurses have recorded information about the client's ability to transfer. Implement pain relief measures so that they are effective when the transfer begins. The decision must be made at this time regarding the client's ability to participate. If the client can safely participate in the transfer, a gait or transfer belt or sliding board can be used; if not, a powered standing assist lift or full-body lift would be safer for the client and nurse.

IMPLEMENTATION	
A. Preparation	
PROCEDURE	**RATIONALE**

IMPLEMENTATION		
1.	• Plan what to do and how to do it. • Obtain essential equipment before starting (e.g., gait or transfer belt, wheelchair), and check that all equipment is functioning correctly. • Remove obstacles from the area so clients do not trip. Make sure there are no spills or liquids on the floor on which clients could slip. • Note any devices attached to the client (e.g., IV, urinary catheter).	
B. Performance		
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain the transfer process to the client. During the transfer, explain step by step what the client should do, for example, "Move your right foot forward."	
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.	
3.	Provide for client privacy.	
4.	Position the equipment appropriately. • Lower the bed to its lowest position so that the client's feet will rest flat on the floor. Lock the wheels of the bed. • Place the wheelchair parallel to the bed and as close to the bed as possible. Put the wheelchair on the side of the bed that allows the client to move toward his or her stronger side. Lock the wheels of the wheelchair, raise the footplates, and move the leg rests out of the way.	This decreases the distance that the client needs to move to sit up on the side of the bed.
5.	Prepare and assess the client. Assist the client to a sitting position on the side of the bed. • Assess the client for orthostatic hypotension before moving the client from the bed. • Assist the client in putting on a bathrobe and nonskid slippers or shoes. • Place a gait or transfer belt snugly around the client's waist. Check to be certain that the belt is securely fastened.	
6.	Give explicit instructions to the client. Ask the client to: Move forward and sit on the edge of the bed (or surface on which the client is sitting) with feet placed flat on the floor. Lean forward slightly from the hips.	This brings the client's center of gravity closer to the nurse's. This brings the client's center of gravity more directly over the base of support and positions the head and trunk in the direction of the movement.

IMPLEMENTATION		
	Place the foot of the stronger leg beneath the edge of the bed (or sitting surface) and put the other foot forward. Place the client's hands on the bed surface (or available stable area) so that the client can push while standing. The client should not grasp your neck for support.	In this way, the client can use the stronger leg muscles to stand and power the movement. A broader base of support makes the client more stable during the transfer. This provides additional force for the movement and reduces the potential for strain on the nurse's back. Doing so can injure the nurse.
7.	Position yourself correctly. Stand directly in front of the client and to the side requiring the most support. Hold the gait or transfer belt with the nearest hand; the other hand supports the back of the client's shoulder. Lean your trunk forward from the hips. Flex your hips, knees, and ankles. Assume a broad stance, placing one foot forward and one back. Brace the client's feet with your feet to prevent the client from sliding forward or laterally. Mirror the placement of the client's feet, if possible.	This helps prevent loss of balance during the transfer.
8.	Assist the client to stand, and then move together toward the wheelchair or sitting area to which you wish to transfer the client. • On the count of three or the verbal instructions of "Ready–steady–stand" and on the count of three or the word "Stand," ask the client to push down against the mattress or side of the bed while you transfer your weight from one foot to the other (while keeping your back straight) and stand upright moving the client forward (directly toward your center of gravity) into a standing position. (If the client requires more than a very small degree of pulling, even with the assistance of two nurses, a mechanical device should be obtained and used.) • Support the client in an upright standing position for a few moments. • Together, pivot on your foot farthest from the chair, or take a few steps toward the wheelchair, bed, chair, commode, or car seat.	This allows the nurse and the client to extend the joints and provides the nurse with an opportunity to ensure that the client is stable before moving away from the bed.
9.	Assist the client to sit.	

IMPLEMENTATION		
	Move the wheelchair forward or have the client back up to the wheelchair (or desired seating area) and place the legs against the seat. Make sure the wheelchair brakes are on. Have the client reach back and feel or hold the arms of the wheelchair. Stand directly in front of the client. Place one foot forward and one back. Tighten your grasp on the gait or transfer belt, and tighten your gluteal, abdominal, leg, and arm muscles. Have the client sit down while you bend your knees and hips and lower the client onto the wheelchair seat.	Having the client place the legs against the wheelchair seat minimizes the risk of the client falling when sitting down.
10.	Ensure client safety. Ask the client to push back into the wheelchair seat. Remove the gait or transfer belt. Lower the leg rests and footplates, and place the client's feet on them, if applicable.	Sitting well back on the seat provides a broader base of support and greater stability and minimizes the risk of falling from the wheelchair. A wheelchair or bedside commode can topple forward when the client sits on the edge of the seat and leans far forward.

Variation: Transferring with a Belt and Two Nurses

Even if a client is able to partially bear weight and is cooperative, it still may be safer to transfer a client with the assistance of two nurses. If so, you should position yourselves on both sides of the client, facing the same direction as the client. Flex your hips, knees, and ankles. Grasp the client's transfer belt with the hand closest to the client, and with the other hand support the client's elbows. Coordinating your efforts, all three of you stand simultaneously, pivot, and move to the wheelchair. Reverse the process to lower the client onto the wheelchair seat.

Variation: Transferring a Client with an Injured Lower Extremity

When the client has an injured lower extremity, movement should always occur toward the client's unaffected (strong) side. For example, if the client's right leg is injured and the client is sitting on the edge of the bed preparing to transfer to a wheelchair, position the wheelchair on the client's left side. *Rationale: In this way, the client can use the unaffected leg most effectively and safely*

Variation: Using a Slide Board

For clients who cannot stand but are able to cooperate and possess sufficient upper body strength, use a slide board to help them move without nursing assistance. *Rationale: This method not only promotes the client's sense of independence but also preserves your energy.*

IMPLEMENTATION		
11.	Document relevant information: • Client's ability to bear weight and pivot • Number of staff needed for transfer and the safety • measures • and precautions used • Length of time up in chair • Client response to transfer and being up in chair or • wheelchair.	

REFERENCES:

Berman, A., Snyder, S. and Frandsen, G. (2016). Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice (10th ed.). New Jersey: Pearson Education, Inc.

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N11 – NURSING FOUNDATION II

TITLE:	**Transferring from Bed to Stretcher**
DEFINITION/ DESCRIPTION:	To demonstrate safe transferring of clients from bed to stretcher.
PURPOSES:	The stretcher, or gurney, is used to transfer supine clients from one location to another. Whenever the client is capable of accomplishing the transfer from bed to stretcher independently, either by lifting onto it or by rolling onto it, the client should be encouraged to do so. If the client cannot move onto the stretcher independently and weighs less than 200 pounds, a frictio educing device (i.e., slide sheet) or a lateral transfer board or an air transfer system should be used, and at least two caregivers are needed to assist with the transfer. Some friction-reducing devices have handles or long straps to avoid awkward stretching by the caregivers when pulling the client during the latera transfer. For clients between 201 and 300 pounds, a slide sheet or transfer board and four caregivers or an air transfer system and two caregivers should be used. For clients who weigh more than 300 pounds, two caregivers and either an air transfer system or a ceiling lift with supine sling should be used
EQUIPMENT:	• Stretcher • Transfer assistive devices
ASSESSMENT:	Before transferring a client, assess the following: • The client's body size and weight • Ability to follow instructions • Activity tolerance • Level of comfort The space in which the transfer is maneuvered • The number of assistants (one to four) needed to accomplish the transfer safely.
PLANNING	Review the client record to determine if previous nurses have recorded information about how the client tolerated similar transfers. If indicated, implement pain relief measures so that they are effective when the transfer begins.

IMPLEMENTATION		
A. Preparation		
PROCEDURE		**RATIONALE**
1.	• Obtain the necessary equipment and nursing personnel to assist in the transfer.	

IMPLEMENTATION		
	• Note any devices attached to the client.	
B. Performance		
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how to participate. Explain the transfer to the nursing personnel who are helping and specify who will give directions (one staff member needs to be in charge).	
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.	
3.	Provide for client privacy.	
4.	Adjust the client's bed in preparation for the transfer. • Lower the head of the bed until it is flat or as low as the client can tolerate. • Place the friction-reducing device under the client. • Raise the bed so that it is slightly higher (i.e., 1/2 in.) than the surface of the stretcher. • Ensure that the wheels on the bed are locked. • Place the stretcher parallel to the bed next to the client and lock the stretcher wheels. • Fill the gap that exists between the bed and the stretcher loosely with the bath blankets (optional).	It is easier for the client to move down a slant.

5.	Transfer the client securely to the stretcher.
	• If the client can transfer independently, encourage him or her to do so and stand by for safety.
	• If the client is partially able or not able to transfer:
	  • One caregiver needs to be at the side of the client's bed, between the client's shoulder and hip.
	  • The second and third caregivers should be at the side of the stretcher: one positioned between the client's shoulder and hip and the other between the client's hip and lower legs.
	• All caregivers should position their feet in a walking stance.
	• Ask the client to flex the neck during the move, if possible, and place the arms across the chest.
		This prevents injury to those body parts.

IMPLEMENTATION		
6.	• On a planned command, the caregivers at the stretcher's side pull (shifting weight to the rear foot), and the caregiver at the bedside pushes the client toward the stretcher (shifting weight to the front foot). Ensure client comfort and safety. • Make the client comfortable, unlock the stretcher wheels, and move the stretcher away from the bed. • Immediately raise the stretcher side rails or fasten the safety straps across the client.	Because the stretcher is high and narrow, the client is in danger of falling unless these safety precautions are taken.
	Variation: Using a Transfer Board The transfer board is a lacquered or smooth polyethylene board measuring 45 to 55 cm (18 to 22 in.) by 182 cm (72 in.) with handholds along its edges. Transfer mattresses are also available, as are mechanical assistive devices. It is imperative to have enough staff assisting with the transfer to prevent injury to staff as well as clients. Turn the client to a lateral position away from you, position the board close to the client's back, and roll the client onto the board. Pull the client and board across the bed to the stretcher. Safety belts may be placed over the chest, abdomen, and legs.	
7.	Document relevant information: • Equipment used • Number of personnel needed for transfer and safety measures and precautions used • Destination if reason for transfer is to transport from one location to another.	
EVALUATION		
	• Compare client capabilities such as weight bearing, pivoting ability, and strength and control during previous transfers. • Report any significant deviations from normal to the primary care practitioner. • Note use of appropriate safety measures (e.g., transfer belt, locking wheels of bed and stretcher) by AP during transfer process.	

REFERENCES:

Berman, A., Snyder, S. and Frandsen, G. (2016). Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice (10th ed.). New Jersey: Pearson Education, Inc.

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