NUCAMA12I HANDOUTS

THERAPEUTIC ENVIRONMENT

Therapeutic Environment is a planned physical and emotional surrounding that promotes healing, comfort, safety, and well-being of patients.

It helps the patient to:

- Recover quickly
- Maintain physical health
- Support mental and social well-being

Objectives

To promote comfort and rest

1. To help in recovery and healing
2. To prevent infection and hazards
3. To meet physical, social, and emotional needs
4. To provide safety and security
5. To create a positive and peaceful atmosphere

Physical Factors

These are environmental conditions that affect the patient physically.

1. Lighting

- Adequate lighting for observation and procedures
- Natural light improves mood and health
- Avoid glare or direct light to patient's eyes

2. Temperature

- Must be comfortable
- Extreme heat or cold causes discomfort
- Use fans, heaters, or blankets when needed

3. Ventilation

- Fresh air is necessary for proper breathing
- Removes foul odor
- Use windows or exhaust systems for air circulation

4. Humidity

- Ideal range: **40–60%**
- Too dry → throat irritation
- Too humid → promotes bacterial growth

5. Noise Control

- Keep ward quiet
- Avoid loud talking, banging doors, noisy equipment
- Silence promotes rest and recovery

6. Pest Control

- Prevent flies, mosquitoes, rats, cockroaches
- Proper waste disposal
- Maintain cleanliness

Safety Factors

- Keep bedside area clean and clutter-free
- Use side rails for weak or unconscious patients
- Keep emergency equipment ready (oxygen, suction)
- Label medicines and chemicals properly
- Ensure proper floor grip to prevent falls
- Follow fire and electrical safety rules

Psychosocial & Aesthetic Factors

These support emotional and mental well-being.

1. Emotional Support

- Be kind, understanding, and empathetic
- Reduce fear, stress, and anxiety

2. Privacy

- Use curtains or screens during procedures
- Maintain confidentiality

3. Communication

- Speak politely
- Listen actively
- Provide reassurance

4. Aesthetic Environment

- Keep ward clean, bright, and well-arranged
- Promote a cheerful atmosphere

5. Visitors and Family Support

- Allow visits according to hospital policy
- Reduces loneliness

6. Spiritual Care

- Respect religious beliefs
- Allow prayer or meditation

7. Social Interaction

- Encourage friendly patient interaction
- Prevent isolation

8. Mental Support

- Use positive words
- Build hope and confidence

lRole of the Nurse in Maintaining a Therapeutic Environment

The nurse should:

- Maintain cleanliness and safety
- Adjust lighting, ventilation, and temperature
- Maintain silence and privacy
- Show empathy and good communication
- Practice infection control (handwashing, waste disposal)
- Encourage emotional and family support

DUSTING AND CLEANING

Dusting and cleaning is the process of removing dust using water and

mechanical action, with or without detergent.

Assessment

Before starting:

- Assess the need for cleaning
- Check availability of equipment

Objectives

1. To provide a clean and comfortable environment
2. To prevent spread of pathogenic microorganisms
3. For aesthetic purposes

General Considerations

- Use **dry dust cloth** for polished furniture
- For glass:
    - Use damp newspaper or glass wiper with detergent spray
    - Rinse with water
- Use a brush for grooves and seams
- Friction helps remove contaminated materials

Equipment Needed

- Basin with soapy water
- Basin with clean water
- Two dust cloths
- Newspaper
- Waste receptacle

BODY MECHANICS

Body Mechanics – the coordinated effort of muscles, bones, and the nervous system to maintain balance, posture, and alignment during moving, transferring, and positioning patients.

Proper body mechanics:

- Prevents musculoskeletal injuries
- Conserves energy
- Promotes safe and effective movement
- Protects both patient and nurse

Body Alignment – placing one body part in line with another (vertical or horizontal line).

✔ Promotes balance
✔ Decreases musculoskeletal strain
✔ Reduces risk of falls and injury

Principles of Body Mechanics

1. Maintain a stable **center of gravity**
2. Maintain a wide **base of support**
3. Maintain proper **line of gravity**
4. Maintain correct **body alignment**

Rules of Proper Body Mechanics

1. Maintain a broad base of support (feet 8–10 inches apart)
2. Bend at hips and knees, keep back straight
3. Use strongest muscles (hips and thighs, NOT back)

4. Push, slide, or pull instead of lifting
5. Keep objects close to the body
6. Avoid twisting – pivot with feet
7. Avoid prolonged bending
8. Maintain good posture while sitting

Proper Body Mechanics in Daily Activities

When Standing

- Feet 12 inches apart
- Do not lock knees
- Shoulders down, chest out, back straight

When Lifting

- One foot slightly in front
- Bend hips and knees
- Keep back straight
- Lift using legs, not back
- Hold object close to waist level

When Sitting

- Back straight with lumbar support
- Change positions frequently
- Monitor at eye level
- Use headset if needed

Back-Saving Techniques

- Keep object close
- Knees bent
- Neutral spine
- Avoid twisting
- Pivot instead of rotating
- Do not combine bending and twisting

Common Causes of Injury

- Improper body mechanics
- Twisting trunk
- Slippery floors
- Inappropriate shoes
- Being in a hurry
- Not asking for help

Helpful Equipment for Transfer

- Sliding board
- Walker
- Grab bars
- Trapeze bar
- Hydraulic/ceiling lift

⚠ Special Considerations:

- Perform mobility assessment first
- Explain procedure to patient
- Use devices only if trained

RANGE OF MOTION (ROM)

Range of Motion (ROM) – maximum movement available at a joint in three body planes:

1. **Sagittal Plane** – divides body into left & right
2. **Frontal (Coronal) Plane** – divides body into front & back

3. **Transverse Plane** – divides body into upper & lower

Importance of ROM

If joints are not moved:

- They may become stiff
- Deformity may occur
- Client may lose normal function

ROM exercises:

- Maintain joint mobility
- Prevent contractures
- Promote circulation

Purposes of ROM

- Improve circulation and lung function
- Prevent stiffness and deformity
- Delay degenerative changes
- Restore muscle function
- Improve mobility and gait
- Reduce stress
- Aid rehabilitation

Types of ROM

1. Active ROM (AROM)

- Performed independently by patient
- Nurse/therapist provides supervision

2. Passive ROM (PROM)

- Performed by nurse/therapist
- Used for paralyzed or weak patients
- Prevents stiffness

Types of Joint Movements

Flexion - Decreases angle between bones

Extension- Increases angle between bones

Hyperextension - Extension beyond normal position

Abduction - Movement away from midline

Adduction - Movement toward midline

Circumduction - Circular movement

Rotation - Bone turns on its axis

• Internal Rotation – toward midline
• External Rotation – away from midline

Supination - Palm upward

Pronation - Palm downward

Inversion - Sole inward

Eversion - Sole outward

Dorsiflexion - Toes upward

Plantar Flexion - Toes downward

Opposition - Thumb touches fingers

Lateral Flexion - Side bending of neck/trunk

Contraindications to ROM

Do NOT perform ROM:

- On swollen or inflamed joints
- When increased circulation is hazardous
- When movement causes severe pain

BEDMAKING: OCCUPIED, UNOCCUPIED BED, AND BED STRIPPING

Bed Making- a technique for changing bed linens to ensure the client's comfort throughout their stay in the hospital.

Types of bed making

1. Unoccupied
2. Occupied
3. Surgical
4. Orthopedic

UNOCCUPIED BED - a hospital bed which is made ready for admission, or the client is out of bed ambulating.

OCCUPIED BED - preparing a client's bed who is unable to leave their bed due to a medical condition.

SURGICAL BED - making a bed occupied by a client undergoing a surgical or diagnostic procedure that requires the use of anesthetic agent.

ORTHOPEDIC - making a bed occupied by a client who has fracture or other musculoskeletal disorders

Rationale for Bed making

- Maintain proper body alignment.
- Patient's safety and comfort.
- Minimize source of skin irritation, infection, and pressure sores.
- Provide sanitized bed free from possible pathogens.

Nursing Considerations

- To prevent spread of microorganisms:
    1. Handle linens carefully.
    2. Avoid shaking the linens.
    3. Place soiled linens inside the laundry hamper and not on the floor.
    4. Wash hands before and after the procedure.
- To save time and effort:

1. Make the bed completely on one side before moving to the other side.
2. Organize your work and move with moderate speed.
3. Bring all materials to the bedside.

- To prevent contamination:
  1. Hold both soiled and clean linens away from your uniform.
  2. You may use gloves when handling patient with non-intact skin or when exposed to patient's body fluids
- To prevent fatigue and keep the body stable in position:
  1. Raise the bed to a comfortable height (hip level).
  2. Bend your knees and not your back.
  3. See to it that the entire body is facing in the direction that you are moving and avoid twisting of the body.
- To prevent accidents and for easy movement:
  1. Be certain the wheels of the bed are locked.
  2. Remove attached equipment such as call light, waste bag, or personal items before starting the procedure.
  3. Side rails should be utilized properly
  4. Side rails down at the side where you are working
  5. Side rails up at the far side of the bed or where the client is on side-lying position or where you are not working
  6. Place client on a safe comfortable position when the linens are completely changed.
- To prevent skin irritation:
  1. Seams should always be toward the mattress or away from the client.
  2. The smooth surface should be in contact with the client.

BED STRIPPING

the procedure done to remove used bed linens for washing and disinfecting, and for the bed mattress to be aired out

ASSISTING PATIENT IN AMBULATION, LIFTING, AND TURNING PATIENT, AND USE OF

ASSISTIVE DEVICES

A. **ASSISTING A CLIENT TO A SITTING POSITION** - People who have been immobile for a long period of time may experience vertigo, sensation of dizziness, and orthostatic hypotension. For this reason, always begin the ambulation process by sitting the patient on the side of the bed for a few minutes with legs dangling.

B. **AMBULATING A PATIENT -** Defined as moving a patient from one place to another. Once a patient is assessed as safe to ambulate, determine if assistance from additional health providers or assistive devices is required.

C. **ASSISTING WITH THE USE OF ASSISTIVE DEVICES -** To improve the walking pattern
   - Balance or safety while mobilizing independently
   - Means of transferring weight from the upper limb to the ground, in cases where reducing weight bearing through the lower limb is desired.
   - Walking aids fall into multiple categories and include the following:
     1. Canes or Walking sticks
     2. Crutches
     3. Walkers

CANE/ WALKING STICK

- Used for improving postural stability
- Generally prescribe for people with moderate levels of mobility impairment
- Typically used when minimal stability is needed

Types of Cane

1. The standard straight legged cane
2. The tripod or crab cane, which has three feet
3. The quad cane, which has four feet and provides the most support

AMBULATION WITH CANE

- The cane must be on the opposite side of the affected leg and in tandem with it so as to simulate normal gait and to increase balance and aid in weight distribution (can support up to 25% of client's body weight).

1. **From Sitting to Standing**

- Position the cane on the unaffected side of the patient.
- Advise the patient to move to the edge of the seat, hold the cane handle and bear weight on the unaffected leg and cane to come up to the standing position.
- Make sure the height of the cane is appropriate (level of greater trochanter), ensure elbow flexion is 20 degree and that the cane is 2” in front of the affected leg and 6” to the side of the affected leg.

2. **Walking**
    - Instruct the patient to position the cane on the unaffected side.

Three Point Gait

- Instruct the patient to balance the body weight on the strong or unaffected limb while moving the cane forward approximately 12-18cm. Make sure the cane is close to the patient’s body.
- The client then moves the weak or affected foot forward.
- The client transfers the weight from the unaffected foot to the affected foot and cane, and then brings the unaffected foot forward to join the affected foot.
- Repeat the steps. 1 to 3 while supervising the patient closely and alertly.

Two Point Gait

- Instruct the client to balance body weight on the strong or unaffected foot.
- Instruct the client to move the cane and the weak or affected foot forward at the same time, keeping the cane close to the body to prevent leaning to the side.
- Instruct the patient to transfer their body weight forward to the cane and move the unaffected leg forward.
- Repeat steps 1 to 3 while supervising the patient closely and alertly.

3. **Standing to Sitting**

- Instruct the client to approach the chair (or bed) and turn in small circles toward the stronger side till the back is facing the chair or bed.
- Assist the client to back up to the chair until the chair can be felt against the back of the patient’s

legs.

- Instruct the client to reach for one arm rest at a time.
- The client lowers to the chair in a controlled manner.

4. Stair Climbing

- Canes can be used for stair climbing if proper instructions are followed (up with good leg, down with the affected leg).

Going up to the stairs

- The cane should be opposite the affected limb.
- At the bottom of the stairs, instruct the client to lift the strong or unaffected leg onto the first step.
- Transfer body weight to the unaffected leg on the step while lifting the cane and the affected leg onto the same step.
- Repeat steps 1 and 2.

Going down to the stairs

- The cane should be opposite the affected limb.
- At the top of the stairs, instruct patient to transfer body weight to the strong or unaffected leg while lifting the cane and the affected leg simultaneously to land on the step below it.
- Instruct the client to lift unaffected limb to land on the same step.
- Repeat step 1 and 2.

PRECAUTIONS IN USING CANE

- Check your cane frequently.
- If it looks as though it is damaged, avoid using the cane until you can replace it.
- Make sure that there are no wires or other hazards crisscrossing the floor.
- You should also not have any small rugs around as these can snag your walking cane and pull you down.
- Avoid wet patches or wait until the floor has dried until you begin walking.

CRUTCHES

- A long stick with a crosspiece at the top, used as a support under

the armpit by a person.

- Crutches are type of walking aids that serve to increase the size of an individual's base of support. It transfers weight from legs to the upper body and is often used by people who cannot use legs to support their weight.

AMBULATION WITH CRUTCH

Two Point Gait

- This gait pattern is less stable as only two points are in contact with the floor and good balance is needed too walk with 2 points of crutch gait.
- The nurse asks the client to:
  1. Move the left crutch and right foot forward together.
  2. Move the right crutch and left foot ahead together.

Three Point Gait

- This gait pattern is used when one side lower extremity is unable to bear weight. It involves three points contact with floor (two crutch point and unaffected lower extremity)
- To use this gait, the client must be able to bear the entire body weight on the unaffected leg.
- The two crutches and the unaffected leg bear weight alternately.
- The nurse ask the client to:
  1. Move both crutches and The weaker leg forward.
  2. Move the stronger leg forward.

Four Point Gait

- This gait pattern is used when there's lack of coordination, poor balance and muscle weakness in both lower extremities, as it provides a slow and stable gait pattern with three points support.
- The nurse asks the client to:
  1. Move the right crutch ahead a suitable distance, such as 10 to 15 cm.
  2. Move the left foot forward.
  3. Move the left crutch

forward

4. Move the right foot forward

Swing to Gait

- The swing gaits are used by clients with paralysis of the legs and hips.
- The nurse ask the client to:
  1. Move both crutches ahead together.
  2. Lift body weight by the arms and swing to the crutches.

Swing through Gait

- Move both crutches forward together
- Lift body weight by the arms and swing through and beyond the crutch.

PRECAUTIONS IN USING CRUTCHES

- Have someone nearby for assistance until accustomed to the crutches.
- Frequently check that all pads are securely in place.
- Check screws at least once per week.
- Clean out crutch tips to ensure they are free of dirt and stones.
- Remove small, loose rugs from walking paths.
- Beware of ice, snow, wet, or waxed floors.
- Avoid crowds, leave class early.
- Never carry anything in hands, use a backpack.

WALKER

- Has four points of contact with the ground and usually has three sides with the side closest to the patient being open.
- Provides a wider base of support than a walking stick.

- Walkers are mechanical devices for ambulatory clients who need more support than a cane provides.

AMBULATION WITH WALKER

- Move the walker ahead about 15 cm while your body weight is borne by both legs.
- Then move the right foot up to the walker while your body weight is borne by the left leg and both arms.
- Move the left foot up to the right foot while your body weight is borne by the right leg and both arms.

PRECAUTION IN USING WALKERS

- Take small steps.
- Keep the walker close to your body.
- Wear non-skid slippers, socks, or shoes.
- Remove rugs from the floor.
- Keep your head up while walking to maximize your balance.
- Keep both hands-on walkers.

TRANSFERRING PATIENT FROM BED TO WHEELCHAIR, BED TO STRETCHER AND BED TO BEDSIDE COMMODE

PATIENT TRANSFER

- A TRANSFER IS THE SAFE MOVEMENT OF THE PATIENT FROM ONE PLACE TO ANOTHER LIKE FROM BED TO WHEELCHAIR AND BY THE USE OF ASSISTIVE DEVICES.
- THE NURSE MUST TEACH THE PATIENT AND ASK FOR HIS/HER PARTICIPATION FOR SUCCESSFUL RESULTS.
- THERE ARE MANY METHODS OF TRANSFER. THE NURSE SHOULD CHOOSE AN APPROPRIATE TECHNIQUE FOR THE PATIENT BY TAKING INTO CONSIDERATIONS HIS/HER DISABILITIES AND ABILITIES.
- IT IS VERY HELPFUL IF THE NURSE DEMONSTRATES THE TECHNIQUE FIRST BEFORE THE TRANSFER.
- DURING THE TRANSFER, THE NURSE COACHES AND ASSISTS THE PATIENT.

Level of Transfer

INDEPENDENT TRANSFERS: The patient consistently performs all aspects of the transfer, including setup, in a safe manner and without assistance.

ASSISTED TRANSFERS: The patient actively participates, but also

requires assistance by a care provider.

DEPENDENT TRANSFERS: The patient does not participate actively, or only very minimally and the care provider perform all aspects of the transfer.

TRANSFER ASSIST DEVICES
Primarily used to:

- Provide safer means of moving and transferring a person from one place to another.
- Facilitate independence and maintain the dignity of the person being moved or transferred.
- Eliminate or minimize risk factors that can lead to care provider or patient injury.
- If possible, patients should be encouraged to move themselves. Those with good balance and upper body strength may be able to maintain or regain independence through the use of certain transfer assist devices.
- Transfer assist devices may reduce the amount of force exerted by care providers and improve their posture when moving partially or totally dependent patterns.
- Transfer assist devices do not reduce the weight of a patient and should not be used to lift, carry, or support the whole or a large part of a patient's body weight.
- A safer means of moving the patient such as a mechanical lift, may be required.
- Safety for both patient and care provider must always be considered.

1. **Draw sheets**

- Draw or slide sheets are made of low-friction fabrics or gel-filled plastics that enable an individual to slide over a surface instead of being dragged or lifted.
- These sheets come in a

variety of widths and lengths and may be used in pairs, singly, or folded.

- Draw sheet has the slippery surface only on one side and can be kept under the patient.

2. Slider Sheets

- Slider or roller sheets are tubular sliding sheets made of specialized fabrics with low-friction inner surfaces that glide over themselves.
- Slider sheets may be flat or padded and can be placed under draw sheets or incontinence pads.
- Shorter Slider Sheets: primarily used for pivoting and repositioning tasks such as sitting a patient up on the side of the bed or repositioning a patient up in bed.
- Long Slider Sheets: intended for transferring supine patients from one surface to another, such as from bed to stretcher.

3. **Transfer Belts**

- Transfer belts do not reduce the patient's weight in any way, and must not be used for lifting patients.
- Transfer belts come in a variety of sizes and shapes. They fasten with a buckle, a clasp, or Velcro, and they usually have handles.

4. Slide/Transfer Board

- Slide/transfer board or smooth movers are made of wood or plastic and can be used in conjunction with roller sheets or slide sheets.
- Some boards are rollers, while others have fabric or vinyl coverings designed to further reduce friction.
- Slide/transfer boards are used to reduce friction and bridge gaps when sliding patients between two

horizontal surfaces, such as from a bed to a stretcher.

- These boards are suitable only for those patients who can power themselves by sliding or rolling along the board with guidance from a knowledgeable care provider

5. Smaller Slide/ Transfer Board

- Smaller slide/transfer boards are designed for seated lateral transfers.
- They are often tapered at each end and can be used to bridge a gap, such as when transferring between a bed and a wheelchair or commode.
- Patients with good enough use of their arms and legs to move themselves.

6. Turning Discs

- Turning or pivot discs come in various sizes and may be flexible or solid.
- They consist of two circular discs that rotate against each other.
- The inner surfaces are made of low-friction material, while the outer surfaces are typically high-friction material.
- Turning discs are often used with a transfer board or transfer belts.

7. Flexible Turning Discs

- Flexible turning discs conform to the contours of a surface and are most useful for pivoting seated patients (ex: when transferring patients into vehicles).
- The inner surfaces are typically low-friction plastic or other synthetic material. The top is often made of quilted or padded fabric for comfort.

8. Solid Turning Discs

- Solid turning discs are more durable and are used for

pivoting patients who are weight-bearing and can stand.

- Solid turning discs are usually made of wood or moulded plastic and may contain bearings.
- Patients who are weight bearing and can balance when standing may be guided to a standing position and swivelled around without having to adjust their feet.

LIFTING/GASPING A PATIENT UP IN BED

GRASP THE DRAW SHEET

- Put the head of the bed down and adjust the top of the bed to the waist or hip level of the shorter person.
- Grasp the draw sheet, pointing one foot in the direction you're moving the patient.
- Lean in the direction of the move, using your legs and body weight.
- On the count of three, lift and pull the patient up.
- Patients can also bend their knees, push down with their feet, and pull up with a trapeze to help.

TURNING PATIENT IN BED

CROSS ARMS

- Put the side rails and head of the bed down; adjust the top of the bed to waist or hip level.
- Cross the patient's arms on his or her chest; bend the leg farther away from you.

TURN THE PATIENT

- Put one hand behind the patient's far shoulder.
- Put your other hand behind the patient's hip.
- Turn the patient, supporting the patient's leg with your knee.

MOVING PATIENT FROM BED TO WHEELCHAIR

SIT THE PATIENT UP

- Position and lock the wheelchair close to the bed.
- Remove the armrest nearest the bed and swing away both leg rests.
- Help the patient turn over.
- Put an arm under the patient's neck with your hand supporting the shoulder blade; put your other hand under the knees.
- Swing legs over the edge of the bed, helping the patient to sit up.

STAND THE PATIENT UP

- Have the patient scoot to the edge of the bed.
- Put your arms around the patient's chest and clasp your hands behind his/her back. You may also use a transfer belt to provide a firm handhold.
- Support the leg farthest from the wheelchair between your legs, lean back, shift your weight, and lift.

PIVOT TOWARDS THE WHEELCHAIR

- Have the patient pivot towards the wheelchair, as you continue to clasp your hands around the patient.
- A helper can support the wheelchair or patient from behind.

SIT THE PATIENT DOWN

- As the patient bends towards you, bend your knees and lower the patient into the back of the wheelchair.
- A helper may position the patient's buttocks and support the wheelchair.

MOVING PATIENT FROM BED TO STRETCHER

PREPARE TO MOVE

- Put the head of the bed down and adjust the height of the bed.
- Move the patient's legs closer

to the edge of the bed.

- Instruct the patient to cross arms across chest and explain the move to the patient.

PULL TO THE EDGE OF THE BED

- Grasp the draw sheet on both sides of the bed.
- On the count of three, lean back and shift your weight, sliding the patient to the edge of the bed. The helper holds the sheet, keeping it from slipping.

POSITION THE STRETCHER

- Have the helper "cradle" the patient in the draw sheet while you retrieve a stretcher.
- Adjust the bed to be slightly higher than the stretcher. Then, position the stretcher, locking it in place.
- Move the patient's legs onto the stretcher.

SLIDE ONTO THE STRETCHER

- Have the helper kneel on the bed, holding on to the draw sheet.
- On the count of three, grasp the drawsheet and slide the patient onto the stretcher.

ASSISTING PATIENT FROM BED TO BEDSIDE COMMODE

GOAL - The patient is able to void with assistance.

PROCEDURE:

1. Close the curtains around the bed and close the door to the room if possible to provide privacy.
2. Explain the procedure to the patient. Assess the patient's ability to assist with the procedure as well as personal hygiene preferences.
3. Place the commode close to, and parallel with, the bed. Raise or remove the seat cover.
4. Assist the patient to a standing position and then help the patient pivot to

the commode. While bracing one commode leg with your foot, ask the patient to place his/her hands one at a time on the armrests. Assist the patient to lower himself/herself slowly onto the commode rest.

5. Cover the patient with a blanket. Place the call bell and toilet tissue within easy reach. Leave the patient if it's safe to do so.

ASSISTING PATIENT OFF THE COMMODE:

1. Perform hand hygiene. Put on gloves and additional PPE as indicated.
2. Assist the patient to a standing position. If the patient needs assistance with hygiene, wrap toilet tissue around your hand several times and wipe the patient clean. Using one stroke from the pubic area toward the anal area. Discard tissue in an appropriate waste receptacle according to hospital policy, and continue with additional tissue until the patient is clean.
3. Do not place toilet tissue in the commode if a specimen is required or if output is being recorded. Replace or lower the seat cover.
4. Remove your gloves. Return the patient to the bed or chair. If the patient returns to bed, raise side rails, as appropriate. Ensure that the patient is covered and the call bell is readily within reach.
5. Offer patient supplies to wash and dry his/her hands, assisting as necessary.

6. Put on clean gloves. Empty and clean the commode, measuring urine in a graduated container, as necessary.
7. Remove gloves and additional PPE, if used. Perform hand hygiene and document the output.

HAIR SHAMPOO/ BED SHAMPOO

IT IS WASHING OF HAIR AND SCALP OF PATIENT ON BED

ASSESSMENT:

- Review general physical assessment findings.
- Elicit information regarding loss of hair, tenderness of scalp, or itching.
- Determine the client's ability to perform their own hair care.
- IF is unable to care for its own hair, find out who usually assists the patient.
- Assess the usual hair care routine, products, and appliances used.
- Assess the method for providing hair care, for example: on the bed, in a wheel chair.
- Determine patient teaching needs regarding hair care.
- Observe the patient's hair and scalp noting the following: Texture, color, degree of thickness and hair distribution, degree of gloss or shine, dryness or oiliness, area of irritation, rash or scaliness on the scalp or surrounding skin, matting or snarls and lice.

OBJECTIVES:

- To prevent irritation and damage to the hair and scalp
- To help maintain or improve the patient's existing condition of hair and scalp
- To promote blood circulation to the scalp through massage
- To distribute oil along the hair shaft
- To promote self-esteem.

SPECIAL CONSIDERATIONS:

- Be sure the procedure is ordered by the attending physician.
- See to it that the patient is comfortably placed in a diagonal position.
- Arrange the through so as to allow the free flow of water from the head.
- Protect the patient from falling and chilling.
- Check the temperature before the shampoo.
- See to it that the head is adequately protected.
- Observe principles of body

mechanics.
- Remove jewelry before the start of the procedure.

CHARTING:

1. Time treatment was given
2. Condition of the hair and scalp
3. Reaction of the patient and any abnormality noted.

EVALUATION:

1. The patient's hair and scalp are clean, comfortable, and styled according to the patient's preference.
2. Patient is comfortable and rested after shampooing.

CLEANSING BED BATH

- It is a type of bath given to a client who cannot perform his / her own personal hygiene or therapeutic regimen
- The washing of the patient on bed with soap and water

ASSESSMENT:

- Assess the patient's need for bathing and other personal hygiene.
- Check the patient's activity order. Note special precautions related to movement or exercise.
- Assess the patient's tolerance for activity, discomfort level, cognitive ability, and musculoskeletal function.
- Discuss the patient's preferences for the bathing procedure and personal articles.
- Check the patient's room for the availability of bathing articles and linens.

OBJECTIVES:

- To decrease the possibility of infection by removing excessive debris, secretions, and perspirations from the skin.
- To promote circulation
- To maintain muscle tone through active or passive movement during bathing
- To alternate points of pressure on the body by changing the patient's position during the bath
- To provide comfort for the patient
- To assess the patient's overall status, skin condition, level of mobility, and comfort

GENERAL CONSIDERATIONS:

- If the patient has an intravenous (IV) line, remove the gown from the arm without the IV first, then lower the IV container or remove it from the

pump and slide the gown covering the affected arm over the tubing and container.

- Re-hang the IV container and check the flow rate or reset the pump rate.
- Never disconnect intravenous tubing to change a gown because this causes a break in a sterile system and introduces the possibility of infection.
- To put on a gown, work first on the affected side or IV side, then on the unaffected side.
- To perform bed bath, always start from the farthest to the nearest side.
- Patients with a history of deep vein thrombosis or hypercoagulation disorder should not be washed with a long firm stroke.
- Check the temperature of the water, particularly before bathing an elderly patient because temperature sensitivity may be impaired.
- An elderly patient who does not have incontinence may not require a full bed bath with soap and water every day. If dry skin is a problem, water and skin lotion or bath oil may be used.
- Lying flat in bed during the bed bath may be contraindicated for certain patients. A position has to be modified to accommodate their needs.

KINDS OF BATH

Cleansing Baths – for hygienic purposes.

- **Complete Bed Bath** – Nurses wash the entire body of a dependent client in bed.
- **Self-Help Bed Bath** – Clients confined to bed are able to bathe themselves with help from the nurse for washing the back and perhaps the feet
- **Partial Bath** – Only the parts of the client's body that cause discomfort or odor, if neglected are washed: face, hands, axillae, perineal area, and back. Omitted are the arms, chest, abdomen, legs, and feet
- **Tub Bath** – Are preferred to bed baths, since washing and rinsing are easier in a tub.
- **Shower Bath** – Require only minimal assistance from the nurse.

Therapeutic Baths – are given for physical effects to soothe irritated skin or treat an area.

- **Saline** – 1 tsp: 1pt. Water – Cooling and cleansing effect, decreases skin irritation.
- **Oatmeal or Aveeno** – 2 cups cooked oatmeal: tub of water until the water is opalescent –

Soothes skin irritations, softens and lubricates dry, scaly skin.

- **Cornstarch** – 1 lb. cornstarch dissolve in cold water and add boiling water until thick. Add to tub bath – Soothes skin irritation.
- **Sodium Bicarbonate** – 2 tsp: 1 pint water – Cooling effect relieves skin irritation
- **Potassium Permanganate** – added to bath water – Cleans and disinfects; treat infected skin areas.

EVALUATION:

- The patient's skin is free of excessive perspiration, debris, secretions, and offensive odors.
- Body position has been changed and muscles and joints have been exercised actively and or passively during the bath.
- The patient feels comfortable and does not complain of pain, fatigue, itching, irritation, or excessively dry skin.
- The patient participates in bath procedures to the best of his ability.

ASSISTING IN SERVING AND REMOVING BEDPAN AND URINAL

Purpose: To provide elimination of bodily waste such as urine and feces in a way that will respect the patient's privacy and integrity during the entire procedure.

REGULATING IV FLUID AND COMPUTATION

HOW TO CALCULATE IV FLOW RATE?

- To calculate IV flow rates, the nurse must know the total volume of fluid to be infused and the specific time for the infusion.
- Intravenously administered fluids are prescribed most frequently based on milliliters per hour to be administered. The volume per hour prescribed is administered by setting the flow rate, which is counted in drops per minute.

THREE COMMONLY USED WAYS TO CALCULATE FLOW RATES:

- **Milliliters per hour (mL/h)** - Calculated by dividing the total infusion volume by the total infusion time in hours.
- **Number of drops per one (1) minute (gtts/min) -** Calculated by multiplying the total infusion volume by the *drop factor* and then dividing by the total infusion time in minutes.
- **Infusion time -** Total volume to infuse divided by milliliters per hour being infused.

DROP FACTORS/DRIP FACTOR: The total number of drops delivered per milliliters of solution. This rate varies by

brand and type of infusion set and is printed on the package of the infusion set.

- Generally, **macrodrops** have a drop factor of **10, 12, 15,** or **20 drops/mL**.
- **Microdrip** sets, on the other hand, have a drop factor of **60 drops/mL**.
- **Blood set =** 10 drops/ml

IV COMPUTATION FORMULAS

- **Milliliters per hour (mL/hr):**

  ml/hr = volume per cc (ml) / no. of hours

- **Drops per minute (gtts/min)**

  gtts/min = Volume in cc x gtt factor / no. of hours x 60 mins/hr

- **Infusion time**

  H (hour) = total volume to infuse (mL) / milliliters per hour being infused

HOW TO REGULATE IV FLUID?

The following factors affect the infusion rate if an infusion pump is not used:

- **Size of the catheter.** A catheter with a larger bore allows the solution to flow faster.
- **Height of the IV bag.** The higher the IV bag, the faster the infusion will flow.
- **Position of the insertion site.** A change in the position of the client's arm may decrease the flow, while elevation on a pillow may increase the flow rate. If the IV is inserted into the antecubital area, the solution can flow freely if the client extends the arm and can be obstructed if the client bends the arm at the elbow.
- Monitoring and regulating the rate of the infusion is the responsibility of the nurse.
- A slower rate is usually unnecessary for older adults or those who are at risk of fluid overload.
- A faster IV flow rate is therapeutic for patients who have lost large amounts of body fluids and those who are severely dehydrated.
- Never increased the rate of the infusion if it is running behind schedule. Check for obstructions and collaborate with primary care providers to determine the patient's ability to tolerate an increased flow rate.
- Flow rate is regulated by tightening or releasing the IV tubing clamp and counting the drops for 15 seconds then multiplying the number 4 to get drops per minute

GENERAL CONSIDERATIONS

- ***Monitor for infiltration or irritation***. Inspect the insertion for fluid infiltration. If present, stop the infusion and remove the catheter, restart the infusion at another site, and start supportive treatment by elevating or applying heat on the site.
- ***Look for signs of infiltration.*** Infiltration occurs when the IV fluid is not flowing into the client's vein but into surrounding tissues. Signs of infiltrations include swelling or

puffiness, coolness, pain at the insertion site, and tenderness in the area.

- ***Monitor for signs of phlebitis.*** Phlebitis is the inflammation of the vein. Signs include pain and tenderness, swelling and warmth in the area. If phlebitis occurs, stop infusion and restart at another site. Do not use the injured vein again.
- ***Regularly monitor IV flow rate.*** Monitor IV flow rate regularly (every hour) even if the solution is administered through an IV pump.
- ***Assess for fluid overload***. Regularly assess the patient for signs of fluid overload. Increased heart rate, increased respiration, and increased lung congestion.
- ***Risk for fluid overload.*** IV flow control devices should be used for older and pediatric patients when administering IV fluids. These age groups are at risk for complications of fluid overload.
- ***Proper documentation.*** Document all the findings on the IV flow sheet or in the computer including the total amount of fluid administered, and any adverse responses of the client.

CHANGING HOSPITAL GOWN WITH IV

HOSPITAL GOWN

- a long loose piece of clothing worn in a hospital by someone doing or having an operation.
- It can be used by bedridden individuals as clothes.

MEDICAL GOWN

- These gowns are worn by doctors, nurses, surgeons and other medical personnel to protect the wearer from fluids, germs and bacteria.
- *Non-surgical gowns*: These multipurpose gowns are worn when there is a low to moderate risk of contamination, but medical personnel still need more protection than just their scrubs.
- *Coveralls*: These are worn when a high level of protection is needed (for instance, when working with blood that could transmit hepatitis or HIV). These gowns are made of plastic or another kind of waterproof fabric that repels fluid. As the name suggests, these garments are worn over scrubs or other gowns for added protection.
- *Surgical and surgical isolation gowns*: These gowns are designed for surgery, as the name implies. Surgical gowns are used during controlled procedures when the risk of contamination and splashes is a bit lower. Protection is concentrated mostly on the cuffs up to the elbows and the front from the chest downwards.

PATIENT GOWN

- Patients also wear gowns for various medical procedures, whether it's a routine exam or an experimental surgery. These gowns are not designed for protection, but rather so that medical personnel can easily access the patient for exams or

surgery.

- *Disposable*: These gowns are usually made of paper and are designed to be used once and thrown away.
- *Fabric*: These gowns are usually made from cotton, polyester or a blend of both. They can be rewashed and reused, cutting down on waste. They are also thicker than disposable gowns, which provides more coverage and makes them more comfortable.
- *Classic patient gown*: This is the classic hospital gown and the one you are most likely to have worn before. The front panel provides full coverage while the back is cut down the middle so the gown can easily be put on and taken off.
- *Wrap style*: For this type of gown, the ties are located in the front and the two front panels overlap to provide more coverage for patients.
- *IV gowns*: These gowns have slits up the shoulders to provide easy access to an IV line. The slit may simply be left hanging open or it may be lined with snaps so that the sleeves can be opened and closed as needed.

PHYSICAL EXAMINATION

- process of evaluating objective anatomic findings through the use of observation, palpation, percussion, and auscultation.
- The information obtained must be thoughtfully integrated with the patient's history and pathophysiology.

DEEP BREATHING EXERCISES
BREATHING EXERCISE

- A form of exercises that can be used for a variety of health related reasons such as: to enhance the respiratory system by improving ventilation, strengthening respiratory muscles, make breathing more efficient and for stress reduction.

2 TYPES OF BREATHING EXERCISES

1. **PURSED LIP BREATHING EXERCISES**
2. **DIAPHRAGMATIC BREATHING EXERCISE**

COUGHING EXERCISE

- They are two techniques that are commonly used

CHEST PHYSIOTHERAPY

- It is a technique used to mobilize or loose secretions in the lungs and respiratory tract.
- It consist of external mechanical maneuvers, such as chest percussion, postural drainage, vibration to augment mobilization and clearance of airway secretions, diaphragmatic

breathing with pursed lips, coughing and controlled coughing.
- Chest percussion utilizes the striking force with cupped hands over the chest wall. The striking force causes air to be trapped between the hands and chest wall.

POSTURAL DRAINAGE

- Utilizes gravity to facilitate drainage of secretions.
- Utilizes gravity to facilitate drainage of secretions.

ASSESSMENT

- Determine the normal range of patient's vital signs. Conditions requiring CPT, such as atelectasis, and pneumonia, affects vital signs.
- Determine the patient's medications. Certain medications, particularly diuretics, antihypertensive cause fluid and hemodynamics changes. These decrease patient's tolerance to positional changes and postural damage.
- Determine the patient's medical history; certain conditions such as increased ICP, spinal cord injuries and abdominal aneurysm resection, contraindicate the positional change to postural drainage.
- Thoracic trauma and chest surgeries also contraindicate percussion and vibration.

OBJECTIVES

- To mobilize and eliminate secretions.
- To re expand lung tissue.
- To promote efficient use of respiratory muscles.
- To prevent or treat atelectasis.
- To prevent pneumonia.

GENERAL CONSIDERATIONS

- For optimal effectiveness and safety, modify chest physiotherapy according to the patient's condition.
- For example, initiate or increase the flow of supplemental oxygen, if indicated. Also, suction the patient who has an ineffective cough reflex. If the patient tires quickly during therapy, shorten the sessions because fatigue leads to shallow respirations and increased hypoxia.
- Maintain adequate hydration in the patient receiving chest physiotherapy. Avoid performing postural drainage immediately before or within 1 ½ hours after meals to avoid nausea, vomiting, and aspiration of food or vomitus.
- Because chest percussion can induce bronchospasm, any adjunct treatment should precede chest physiotherapy.
- Refrain from percussing over the

spine, liver, kidneys, or spleen to avoid injury to the spine or internal organs. Also avoid performing percussion on bare skin or the female patient's breasts. Percuss over soft clothing, or place a thin towel over the chest wall.

- Remember to remove jewelry that might scratch or bruise the patient.
- Explain coughing and deep-breathing exercises preoperatively, splint the patient's incision using your hands or, if possible, teach the patient to splint it himself to minimize pain during coughing.
- Try to schedule the last session just before bedtime to help maximize the patient's oxygenation while hes's sleeping.

OXYGEN ADMINISTRATION

- is the process by which supplemented oxygen is administered in high concentration than that of atmospheric air.

PURPOSE

- To relieve dyspnea.
- To prevent hypoxemia (low level of oxygen in the blood) and hypoxia (low level of oxygen in cells).
- To increase oxygenation in tissues.

PRECAUTIONS

- Avoid naked flames near oxygen cylinder.
- Put a No Smoking sign at the entrance of the ward and near patient bed to warn others.
- Do not use oil on the oxygen cylinder. Oil can ignite if exposed to oxygen.
- Do not use electrical gadgets or any article which can cause sparks near oxygen cylinder.
- **Do not give oxygen to a hyperventilated patient.**

METHODS OF OXYGEN ADMINISTRATION

- There are many ways of administering oxygen to patients but the most common ones are:

❏ By mask
❏ By nasal cannula

NASAL CANNULA

ADVANTAGES

❖ Patients are able to talk, eat and drink with oxygen in place.
❖ Patients can vomit and let oral secretion out easily without any interruption in oxygen delivery.
❖ It delivers low concentration of oxygen.

DISADVANTAGES

- It can easily dislodge from patient nostrils.
- It causes irritation in the nostrils.
- It causes dryness in the nostrils.

MASK

ADVANTAGES

- It delivers high concentration of oxygen.
- Its quick and easy to apply.

DISADVANTAGES

- It must be removed while talking, eating, vomiting and drinking.
- It obstruct coughing.
- It blocks vomitus in unconscious patients.
- Carbon dioxide may build up in the mask.
- It causes skin irritation.

- Aspiration of vomitus is likely when mask is in place.