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**Birzeit University**

**Faculty of Pharmacy, Nursing & health professions**

**NURS 131**

**Fundamentals of Nursing and Health Promotion 1**

**Lab Skills Manual**

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Skill 44-7🡺 Assisting a client to ambulate

**PURPOSE**

■ To provide a safe condition for the client to walk with whatever support is needed

**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., narcotics, sedatives, tranquilizers, and antihistamines) that may cause drowsiness, dizziness, weakness, and orthostatic hypotension and seriously hinder 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

**PLANNING**

**Equipment**

■ Assistive devices required for safe ambulation of client (e.g., gait/ 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

**IMPLEMENTATION**

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| **Performance steps** | **Done or not** |
| 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 he or she can 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. |  |
| 2. Perform hand hygiene and observe 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. *Rationale:* 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.  • Assist the client to stand by the side of the bed for at least 1 minute until he or she feels secure.  • Carefully attend to any IV tubing, catheters, or drainage bags. Keep urinary drainage bags below level of the client’s bladder. *Rationale:* To prevent backflow of urine into bladder and risk of infection.  • 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 1-2 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 1-2 caregivers.  • If the client is a low safety risk (e.g., able to follow commands, medically stable, and experienced with assistive device), use a gait/transfer belt for standby assist as needed and assistive devices as needed (e.g., crutches, walker, cane) and 1-2 caregivers. Make sure the belt is pulled snugly around the client’s waist and fastened securely. Grasp the belt at the client’s back, and walk behind and slightly to one side of the client. |  |
| 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 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. *Rationale:* 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 help the client to lower the head between the knees.  • Stay with the client. *Rationale:* A client who faints while in this position could fall head first out of the chair.  • When the weakness subsides, assist the client back to bed.  • If a chair is not close by, assist the client to a horizontal position on the floor before fainting occurs.  a. Assume a broad stance with one foot in front of the other. *Rationale:* A broad stance widens your base of support. Placing one foot behind the other allows you to rock backward and use the femoral muscles when supporting the client’s weight and lowering the center of gravity (see the next step), thus preventing back strain.  b. Bring the client backward so that your body supports the person. *Rationale:* Clients who faint or start to fall usually pitch slightly forward because of the momentum of ambulating. Bringing the client’s weight backward against your body allows gradual movement to the floor without injury to the client.  c. Allow the client to slide down your leg, and lower the person gently to the floor, making sure the client’s head does not hit any objects.  **Variation: Two Nurses**  • Place a gait/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. *Rationale:* 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 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. |  |