



*** Hospital ward
management**

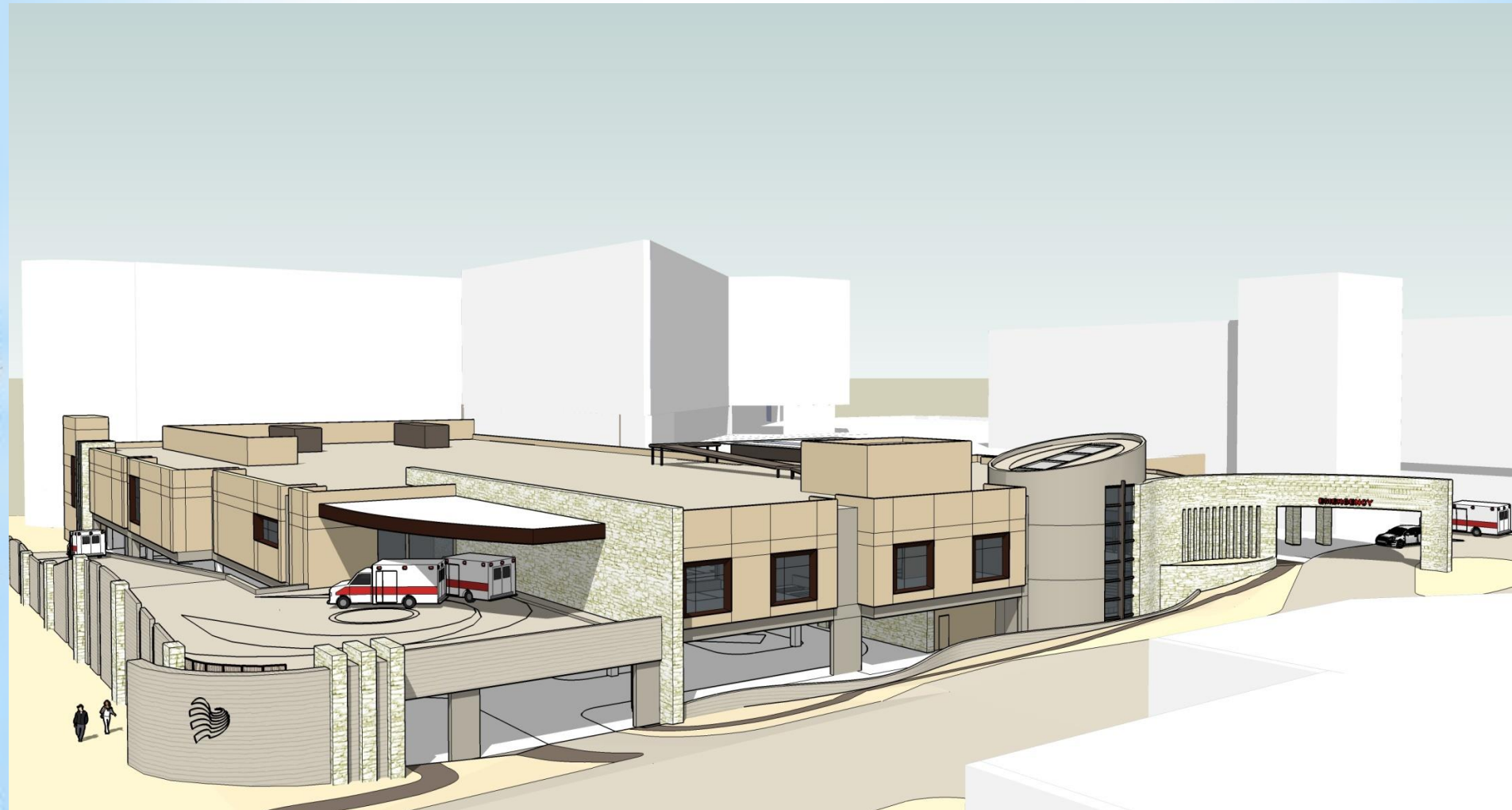
Lecture in patient care for 2 course students

Eugenia Golubkina, assistant of professor

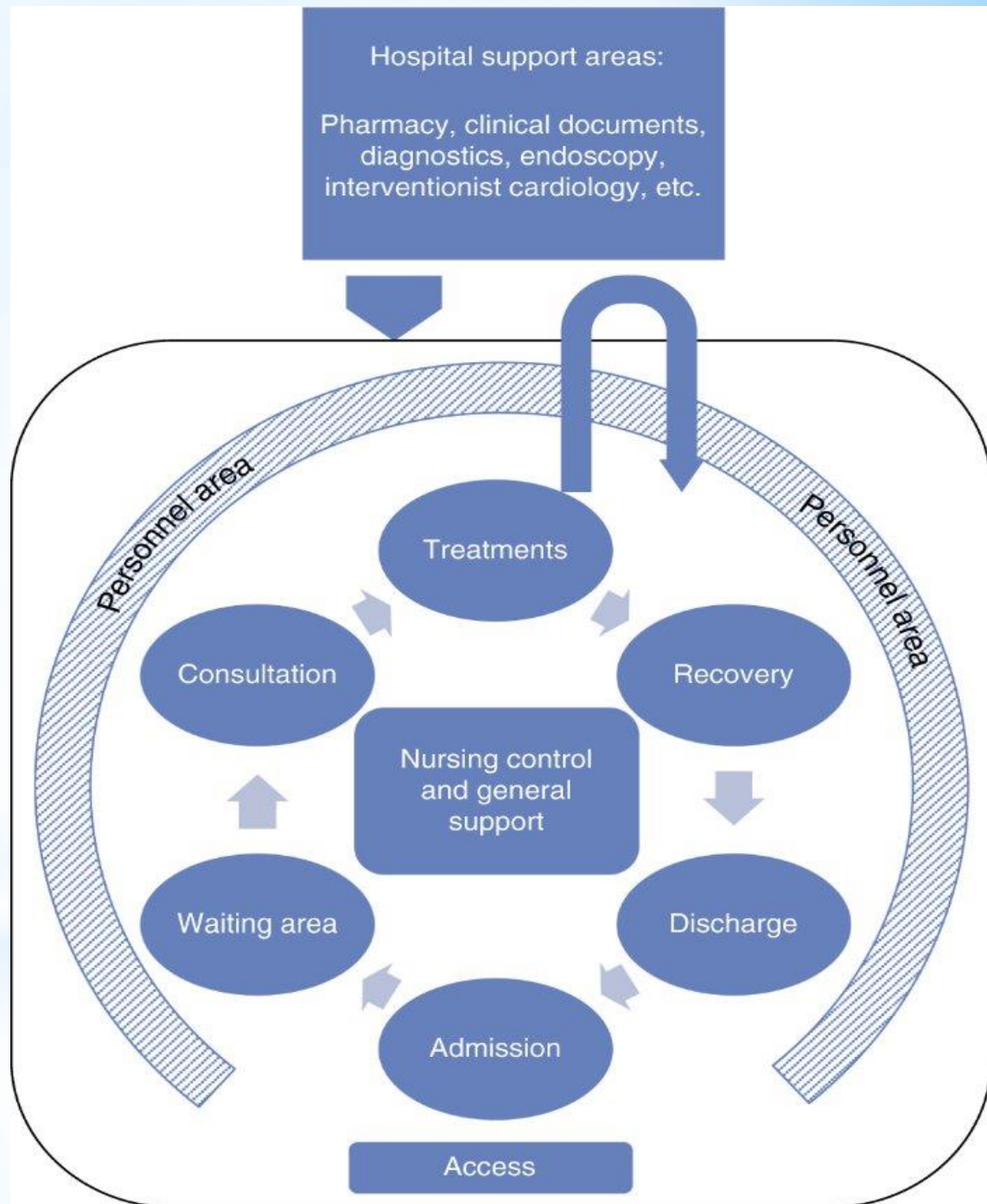
Department of Internal Medicine

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* Hospital is a health care institution for patients who require bed rest, constant care and treatment.



*Structure of the hospital



*Hospital admission

Admission - entering a health care institution for nursing care and medical and/or surgical treatment.

Hospital admission involves staying at a hospital for at least one night or more.

An individual may be admitted to the hospital for a positive experience, such as having a baby, or because they are undergoing an elective surgery or procedure, or because they are being admitted through the emergency department.

* Admission Checklist: Complete within 24 hours of admission

- Put on the patient an identification band
- Apply allergy band (if necessary)
- Initial patient assessment/nursing history
- Allergy History and Allergy Record
- Medication History/Medication Reconciliation
- Braden scale
- ARO screening
- Pediculosis and scabies screening
- Sanitary-hygienic procedures (bathing, changing clothes)

* Admitting procedures

- At the time of admission, the registered Nurse (RN) performs complete assessment of the patient.
- Enter patient's name, medical record number and age at the upper left corner of the form.
- Enter also: patient's address, house and office phone number, date of birth, place of employment, occupation.
- Enter date and time of admission, medical diagnosis and chief complaint in the appropriate spaces in the form.
- Document the source of information (patient, family, caregiver or health care person or significant person).
- Check and document if patient has previous hospitalization and write patient history including past major illnesses.

* Admitting procedures

- Indicate if patient was admitted from ER (emergency room), home, clinic, or other and accompanied by whom.
- Take patients vital signs (temperature, pulse, respiration), height, weight .
- Evaluate and document the location and the severity of the pain using the pain scale.
- Document if patient has history of allergy, if yes, check, whether its due to medication, food or others.
- Document patient brought medicine to the hospital. If yes, check whether it was send to pharmacy.
- Document if patient and family has valuables brought to the hospital . If yes , check it was sent to admission office.

* Admitting procedures

- At the time of arrival to the room, patient and family will be given orientation to the unit, an explanation to the patient's rights and responsibilities.
- Check the activities of daily living and need of mobility aid.
- Document emergency contact information, or the names and telephone numbers of those individuals (family members or others) the hospital should contact if the person being admitted needs emergency care or their condition worsens significantly

* Admitting procedures

- Admission physical assessment shall be done within 24 hours of admission. (*One nurse can start it (e.g. middle of the night admissions) and nurse on next shift can complete*)
- Must be completed before transferring patient from one unit to another
- All data collected are entered on the Nursing Admission Assessment Sheet and available to all those involved in the care of the patient.
- The RN assigned to the patient is responsible to ensure that the form is completed within the time frame specified.
- Documentation should be in permanent ink (blue or black).
- The nurse should write her/his name, RN and signature.

*Registration forms

New Registration

First Name :-	<input type="text"/>	Address 1 :	<input type="text"/>
Last Name :-	<input type="text"/>	Address 2 :	<input type="text"/>
Sex :-	<input type="text"/>	Address 3 :	<input type="text"/>
Relative Name :-	<input type="text"/>	Country:	<input type="text" value="India"/>
Date Of Birth :-	<input type="checkbox"/> <input type="text" value="10/08/2010"/>	State :	<input type="text" value="Madhya Pradesh"/>
Age:	<input type="text"/> <input type="text"/>	City/Town :	<input type="text" value="Bhopal"/>
Marital Status:	<input type="text"/>	Pin Code:	<input type="text"/>
Blood Group:	<input type="text" value="Not Known"/>	Phone / Mobile :	<input type="text"/>

Voluntary Blood Donor :- Yes No

*Registration forms

LONDON HEALTH SCIENCES CENTRE
LONDON, ONTARIO

NURSING ADMISSION ASSESSMENT

(SHADED AREAS FOR SHORT-STAY PATIENTS)

KEY: WNL - Within normal limits N/A - Not applicable NAP - Not a priority at this time UTA - Unable to answer * - Significant Findings

Admission Date (YYYY/MM/DD): _____ Time: _____ Planned Unplanned

Age: _____ Marital Status: _____ Languages Spoken: _____

Ht: _____ Wt: _____ Vital Signs: T _____ P _____ R _____ BP(L) _____ (S) _____

Allergies (drug, food, tape, dyes, latex, other): NKA _____

Adverse Reaction: _____

_____ Allergy band on: _____

Emergency Contact Name: _____ Relationship: _____

Phone No. Permanent. () _____ Temporary. () _____

NURSING CARE PLAN Dr. _____ Notified: Yes No

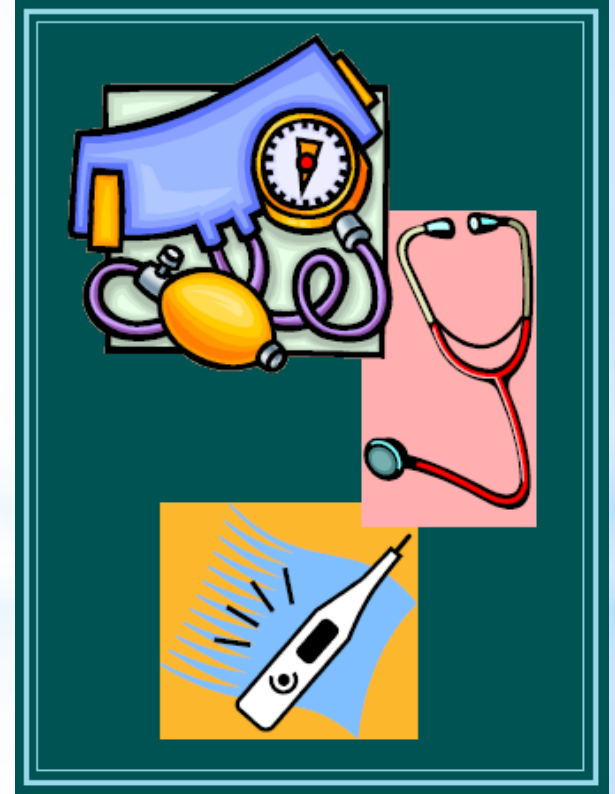
*TPR+BP = Vital signs

Abbreviations:

- Temperature - T;
- Pulse - P;
- Respirations - R;
- Blood Pressure - BP;
- Vital signs - TPR and BP.

Purpose:

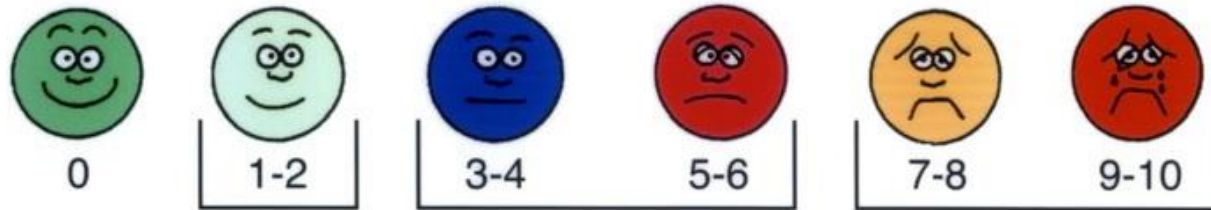
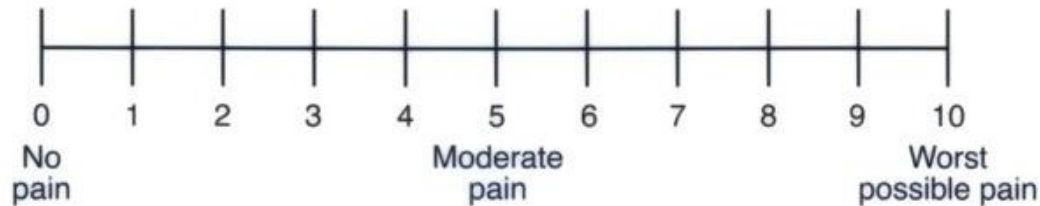
- Measured to detect any changes in normal body function
- Used to determine response to treatment



* Pain scale

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.



WONG-BAKER
FACIAL
GRIMACE SCALE

MILD

MODERATE

SEVERE

ACTIVITY
TOLERANCE
SCALE

NO
PAIN

CAN
BE
IGNORED

INTERFERES
WITH
TASKS

INTERFERES
WITH
CONCENTRATION

INTERFERES
WITH BASIC
NEEDS

BEDREST
REQUIRED

* Allergy Assessment

Ask about...

- all allergies, side effects and intolerances
- as well as reaction symptoms

Pay your attention on:

- Drug
- Environmental
- Food



* Allergy profile

Active Allergy Profile (As of 2011/09/28)

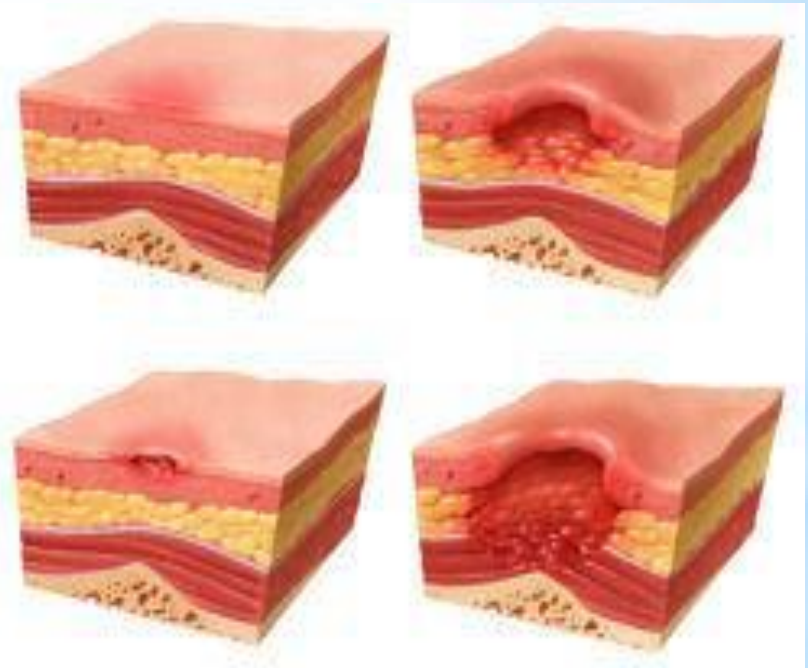
Patient: [REDACTED]
Location: LHSC-UC/U-DSU ODW
Attending Physician: Litchfield, Robert B

PIN #: [REDACTED]
DOB / Sex: [REDACTED]

Substance	Reaction Symptoms	Comments	Last Updated By
morphine	Nausea Vomiting		Kiefer, Carol Mary-Jo (RN) on 2011/09/27
Plastic tape	Rash		Kiefer, Carol Mary-Jo (RN) on 2011/09/27
No Known Food Allergies			Kiefer, Carol Mary-Jo (RN) on 2011/09/27
		(end of report)	

*Braden Scale

- A clinically validated tool that allows nurses and other medical staff to evaluate a patient's level of risk for developing pressure ulcers.
- Also determines if patient is on correct therapeutic mattress.
- Completed on admission, once a week and with any changes in patient condition.



* ARO Screening

ARO - antibiotic resistant organisms.

- All new admissions are screened for MRSA
- MRSA sites - nasal, perianal, wound (open or draining)
- Then screened every 14 days while an inpatient



* Pediculosis and scabies screening

Pediculosis - Infestation with blood-sucking lice.

Scabies - Human scabies is caused by an infestation of the skin by the human itch mite (*Sarcoptes scabiei* var. *hominis*).



* Lice

The three species of human lice are found on different parts of the body:

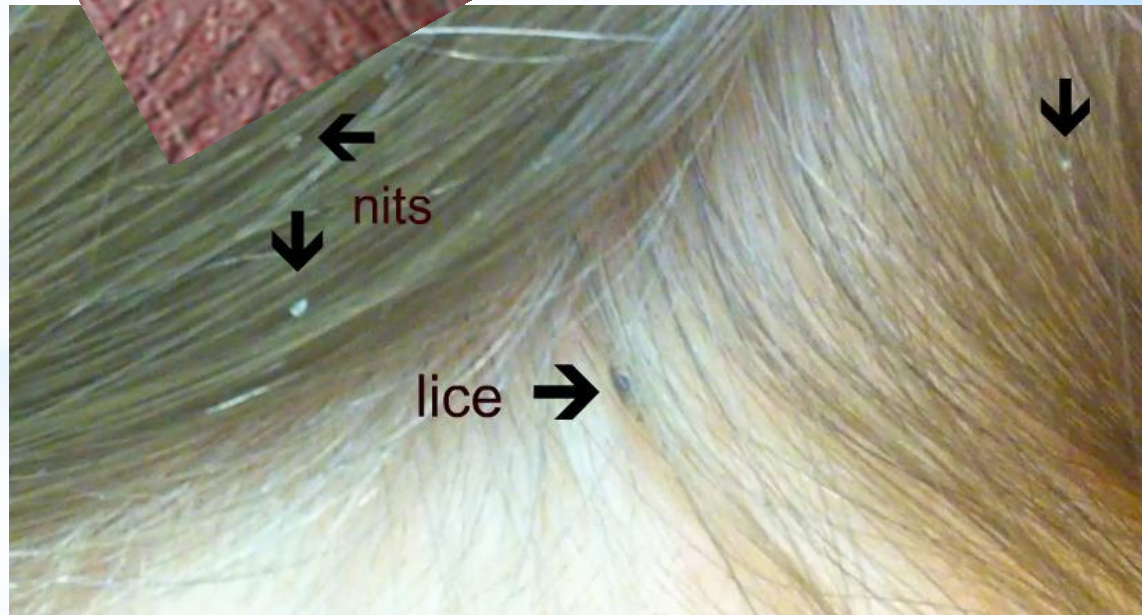
- *the head louse* occurs on the scalp and is most common in children on the back of the head and behind the ears;
- *the pubic louse or crab louse* is mainly found on hair in the pubic region but it may spread to other hairy areas of the body and, rarely, the head;
- *the body louse* occurs in clothing where it makes direct contact with the body; it is similar to the head louse but slightly bigger.

Body lice are known to transmit disease (epidemic typhus, trench fever, and epidemic relapsing fever).

Secondary bacterial infection of the skin resulting from scratching can occur with any lice infestation.

* Pediculosis

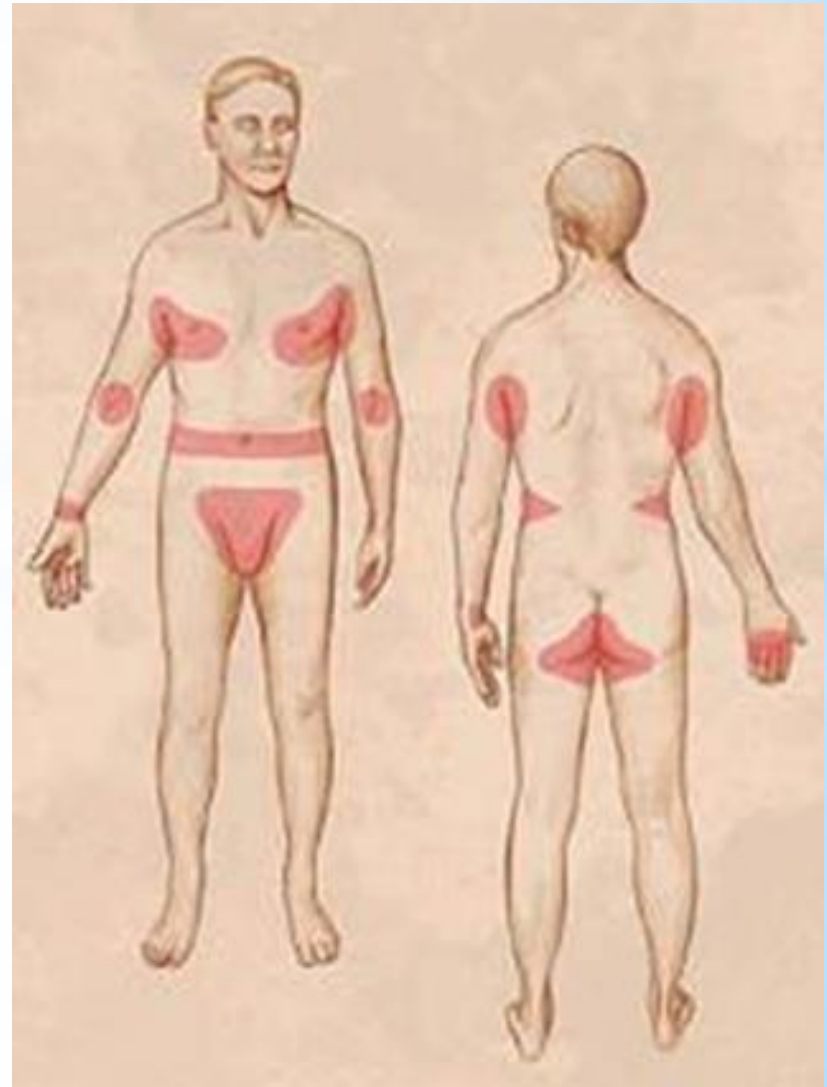
- Presence of live louse or nit
- The person habitually scratches
- There are scratches on the skin, and
- There are hemorrhagic spots in the skin where the lice have sucked blood



*Scabies: common sites

Common sites for scabies rash are:

- between fingers
- wrists
- auxiliary areas
- chest area
- the umbilical area
- genitalia
- buttocks
- ankles



* Scabies

- Skin lesions: papules, vesicles, pustules, nodules
- burrows
- scratching, secondary infection, eczema

Definite diagnosis - a definite diagnosis is made by taking skin scrapings from burrows and identifying the mites, their eggs or faeces by microscopy



* If diagnosis is positive..

Diagnosis is based on clinical findings such as mite attached to the hair base and the presence of nits.

If a patient is positively identified as being infected with pediculosis or scabies, the following steps need to be instituted:

- Isolate confirmed and suspected cases under contact precautions and exclude from social activities until 24 hours after treatment .
- Patient should be placed in a clean room with a clean bedding and dressed in clean clothes.
- Cohort staff so only one group cares/attends the ill residents.
- Do not transfer patients without notifying the accepting facility of the diagnosis of pediculosis/scabies

* If diagnosis is positive..

Environmental measures:

- Machine wash and dry bedding and clothing of patients using the hot water and hot dryer cycles.
- Items that cannot be laundered or dry cleaned should be placed in sealed plastic bags for 7 days.
- Routine cleaning and vacuuming should provide adequate environmental control.

Non-drug treatment of pediculosis:

- Nits can be removed manually with fine-toothed combs or forceps.
- All contaminated clothes and linens should be decontaminated or removed from body contact.
- Shaving the hairs of the pubis removes the nits & the ectoparasites.

Hairclipper after shaving should be treated with 70% ethanol.

* Drug treatment of pediculosis

Drug	Usage	Dosage forms	Notes
Permethrin (Nix)	applied to the affected area, and rinsed after 10 minutes	lotion, 1%	<i>First line therapy</i>
Lindane	applied to the affected area, and washed after 4 minutes	shampoo, 1%	C/I: pregnant and lactating women, children <2 years of age
Malathion	applied to the scalp and left for 8-12 hours before rinsing	Lotion, 0,5%	C/I: pregnant and lactating women, children <2 years of age It's flammable!
Benzyl benzoate	applied to the infected area	lotion, 25%	for children: 12.5%

*Treatment of scabies

- Day 1 (p.m.) clip nails → bathe or shower → apply 5% Permethrin cream to all skin areas from the neck down and under nails
- Day 2 (a.m.) bathe or shower to remove the cream and note that itching may continue for weeks
- Day 14 and Day 28: reexamine and retreat if there are persistent or recurrent lesions

Lindane (lotion, 1%) - second line therapy

The lotion is left for 12 to 24 hours, followed by a thorough washing.

C/I: pregnant and lactating women, children <2 years of age

Combined therapy:

esdepalletrin (esbiol)+piperonyl butoxide=**Spregal-spray**

applied on skin for 12 hours (C/I in lactation, caution in pregnancy)

* Hygienic bath/shower

Indications: admission of patients to the hospital in satisfactory condition.

Contraindications: severe conditions of the patient -

- hypertensive crisis,
- acute myocardial infarction,
- acute ischemic stroke,
- active tuberculosis,
- all types of bleeding,
- burns,
- fever,
- psychosis
- acute abdomen.

* Hygienic bath/shower

Equipment:

- Disinfectant for cleansing the tub
- Clean gloves;
- Soap and washcloth or sponge
- Hospital towel
- Clean gown or pajama
- Suitable bathtub/shower
- Disposable floor mat
- Thermometer



* Hygienic bath: procedure

- Take supplies to bath or shower area, put on gloves;
- Bathtubs should be cleaned before and after use with disinfectants (ex: 2% solution of chloramine B);
- Put the rubber mat in the tub or shower;
- Rinse the tub with cold water to prevent development of steam;
- Fill the $\frac{1}{2}$ of the bathtub with warm water;
- Measure the water temperature in tub: it should be 35-37°C or adjust shower temperature;
- Ensure patient understands and consents to procedure;
- Caution patients about the possible discomfort (palpitations, shortness of breath, etc.) and ask the patient to inform about it.

* Hygienic bath: procedure

- Assist the patient to undress and to seat in tub if necessary (water should reach the level of the xiphoid process) or to get in the shower area.
- Assist the patient if needed: first wash the head, then the trunk, upper and lower limbs, groin and perineum.
- The duration of the bath is 20-25 minutes.
- Help the patient to get out of the bathtub or shower area.
- Dry the patient with towel and assist to dress if needed.
- Empty and clean the tub;

The presence of a nurse during bathing procedure is required, with a deterioration in health condition of the patient (the appearance of chest pain, palpitations, dizziness, pale skin and other symptoms) nurse should stop procedure, provide first aid and inform the doctor on charge.

* If the patient has contraindication for hygienic bath..

If the patient has contraindications for hygienic bath nurse can use technique of sponge bath.

The method lies in washing the patient with wet sponge or washcloth without immersing the body of a patient in the water.



*Weight and height measurement

The patient's weight, compared with the height, gives information about his/her nutritional status and changes in the medical condition.

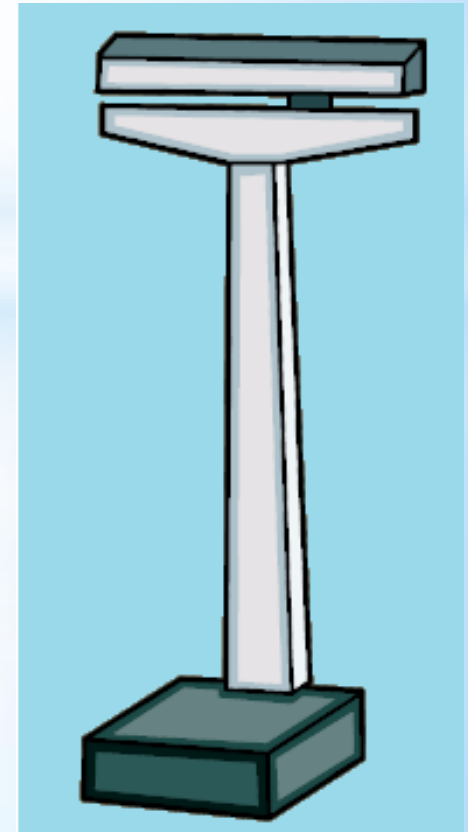
It is also used by doctor to prescribe medications.

Height measurements

- Feet
- Inches
- Centimeters

Weight measurements

- Pounds
- Ounces
- Kilograms



* Measurement of weight

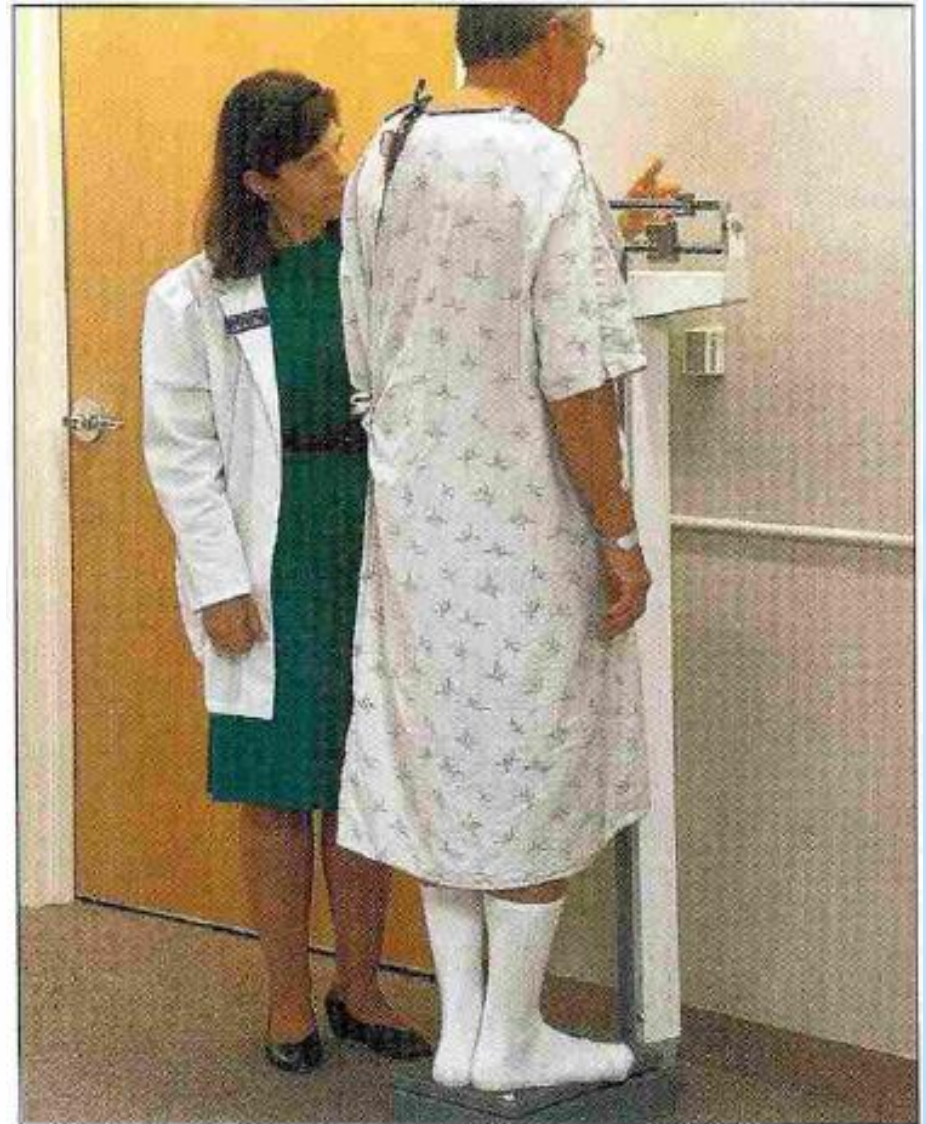
Equipment:

- Balance beam scale (for patients who are able to stand without assistance)
- Bed scale (for patients who are confined to bed or who are unable to stand) or Bed scale (built into the bed)
- Floor scale (for patients in wheelchairs)

*Types of scales

Balance beam scale

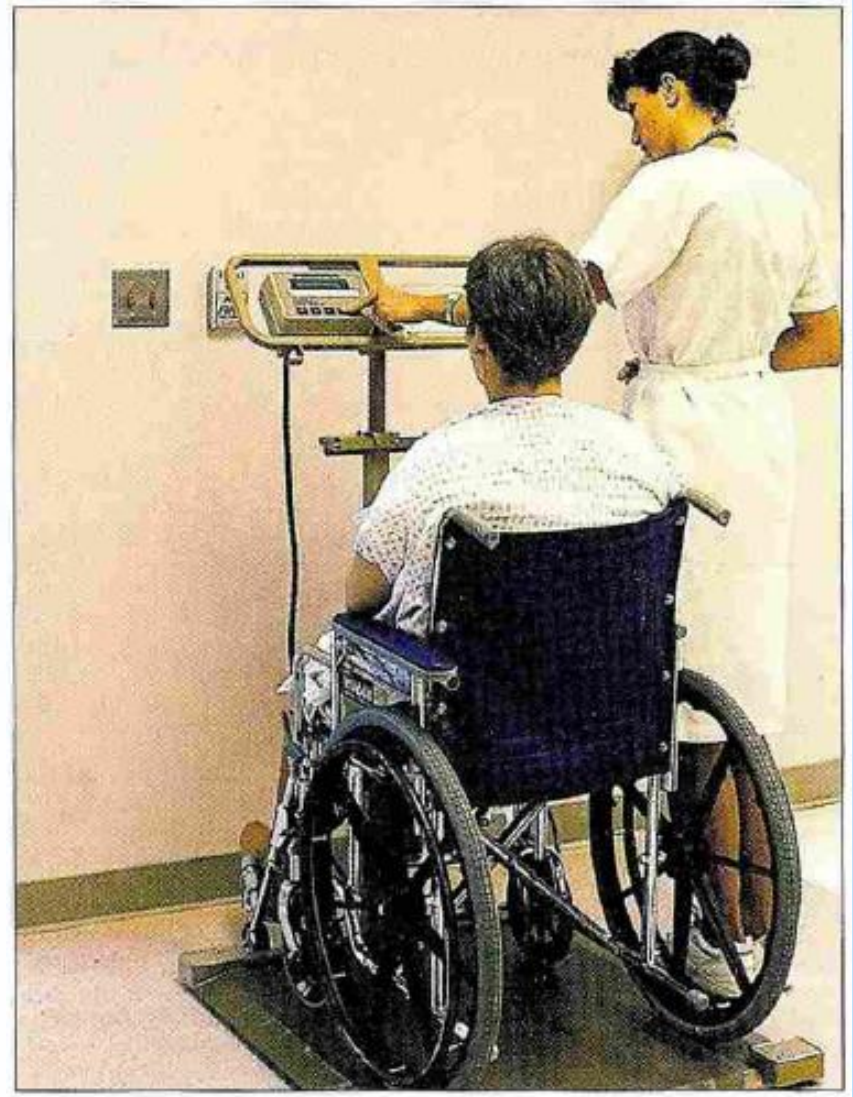
- Balance scale so that weight is accurate
- Place a clean paper towel on scale and ask patient to remove shoes.
- Assist patient to stand on scale.
- Move weights until the weight bar is level or balanced.
- Record weight on appropriate record.



*Types of scales

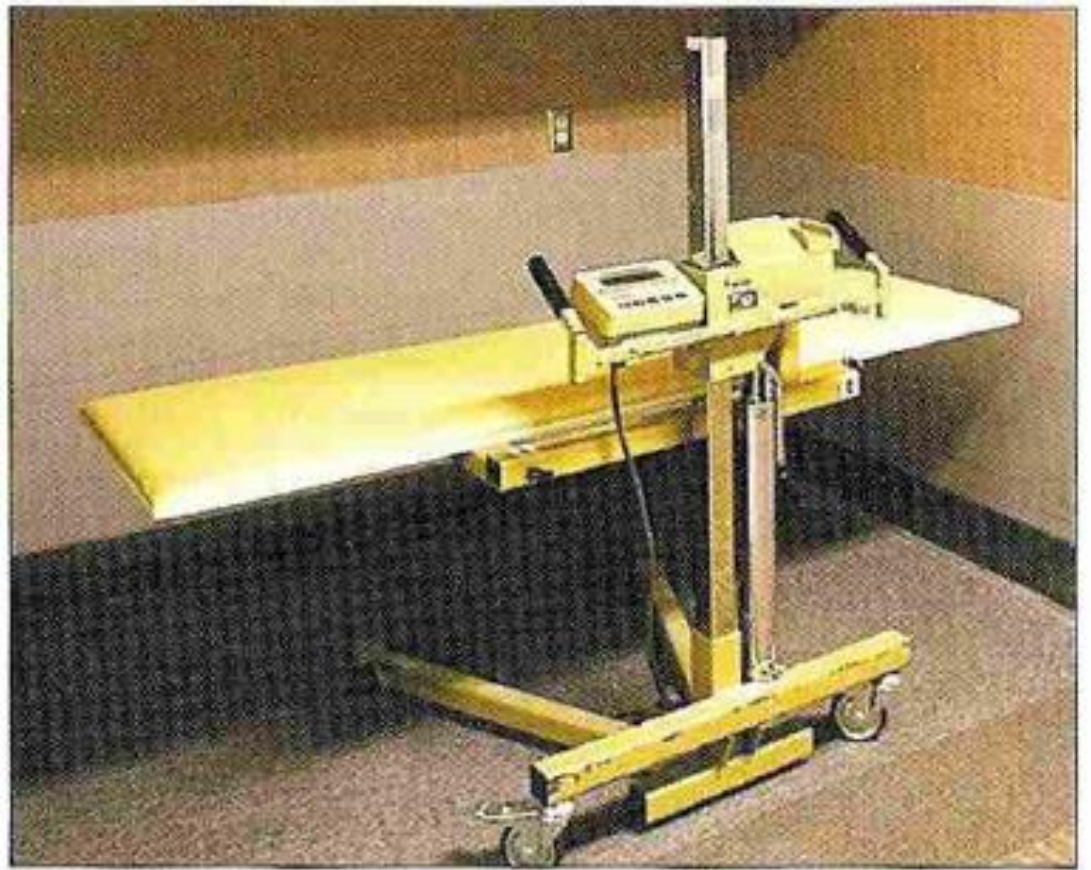
Floor scale

Scales accommodate wheelchairs for weighing patients.



*Types of scales

Bed scale is used to weigh patients who are on complete bed rest.

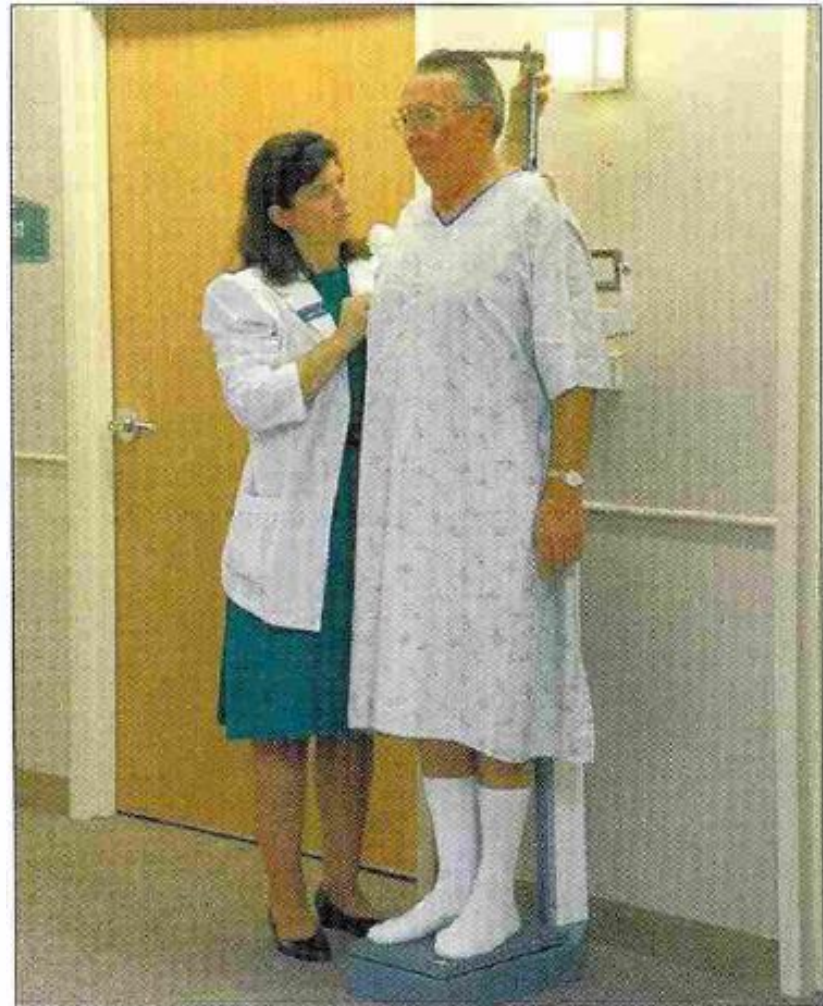


* Main rules for measurement of weight

- Check patient ID and perform hand hygiene.
- Weigh patient in the morning before breakfast. Ask patient to void before weighing.
- Use the same scale each time you weigh the patient.
- Make sure the patient wears the same type of clothing (e.g., gown or robe) for each weighing.
- If bed scale is used, account for weight of linens, etc.
- (Extraneous variables, such as linens, extra pillows, etc., result in inaccurate patient measurements.)
- Change wet gowns or heavily saturated dressings before weighing the patient.

* Procedure of height measurement

- Ask patient to face front so back is toward scale's balancing bar.
- Instruct patient to stand erect.
- Place L-shaped sliding height bar on top of patient's head.
- Read patient's height as measured.
- Record height on appropriate record.
- Discard paper towel (if used) and assist patient back to room.
- Perform hand hygiene.



* Functions of inpatient services

Hospital inpatient services basically covers 1/3 rd of the total hospital complex.

The functions of inpatient services are:

- To render nursing care to all patients
- To provide necessary equipment, essential drugs and all other stores requirements for patients care in an organized manner in the wards
- It provides opportunity for training medical, nursing and paramedical, nursing and medical staffs besides conducting research work.

* Definition

Hospital ward

- block forming a division of a hospital (or a suite of rooms) shared by patients who need a similar kind of care

Types of wards:

- General wards
- Specialized wards (maternity, pediatrics, psychiatric, geriatrics, oncology, and detoxification wards)

Constituents:

- Patient space
- Nursing space
- Corridors

* Important design factors for the ward:

- Movement space
- Number of beds in a room
- Bed spacing
- Position of nursing station
- Category of the ward
- Ancillary rooms
- Ratio of toilet accommodation

*Types of hospital wards

There are different types of ward design:

- Open ward or Nightingale Ward
- Modified Nightingale Ward
- Rig's Pattern Ward (Unilateral or Bilateral)
- T-Shaped Ward
- L-Shaped Ward
- Cruciform type of ward

*The Nightingale ward

This type of ward was designed in 1770 by Frenchman, Later it was adopted by Florence Nightingale and is known by her name.

The characteristics of Nightingale ward are :

- This is an open-plan ward containing 25-30 beds.
- Patients' beds are located in two row in a long, rectangular ward.
- It may have side rooms for utilities and perhaps one or two side rooms, that can be used for patient occupancy when patient isolation or patient privacy is important.
- Nursing Station, Doctor's room and others facility at one end. Bathroom and WC at the other end.

*The Nightingale ward



*The Nightingale ward

Advantages:

- Good visibility;
- Economical benefits (easy to construct);
- Good possibilities for ventilation.

Disadvantages:

- This is the noisiest type of ward;
- No privacy for the patients;
- High risk of cross-infections.

*Modified Nightingale Ward

Main features of the modified Nightingale ward:

- This type of ward has a nursing station in centre of ward;
- Ancillary and Auxiliary service are located at one end and utility service at other end of the ward;
- The nurse travel time has been reduced and the supervision over patients condition also improved in modified pattern of ward.

* Modified Nightingale Ward



*Rigg's Ward

It was first made in Rigg hospital in 1910 in Copenhagen.

Main features of Rigg's ward:

- Ward unit is divided into small compartments separated from each other.
- Each compartment having 4-6 or more beds arranged parallel to the longitudinal wall.
- Bed may be on one side or both sides of nursing station.
- Isolation room (1 or 2) can be kept in ward.

* Rigg's Ward



*Rigg's Ward



* Rigg's Ward

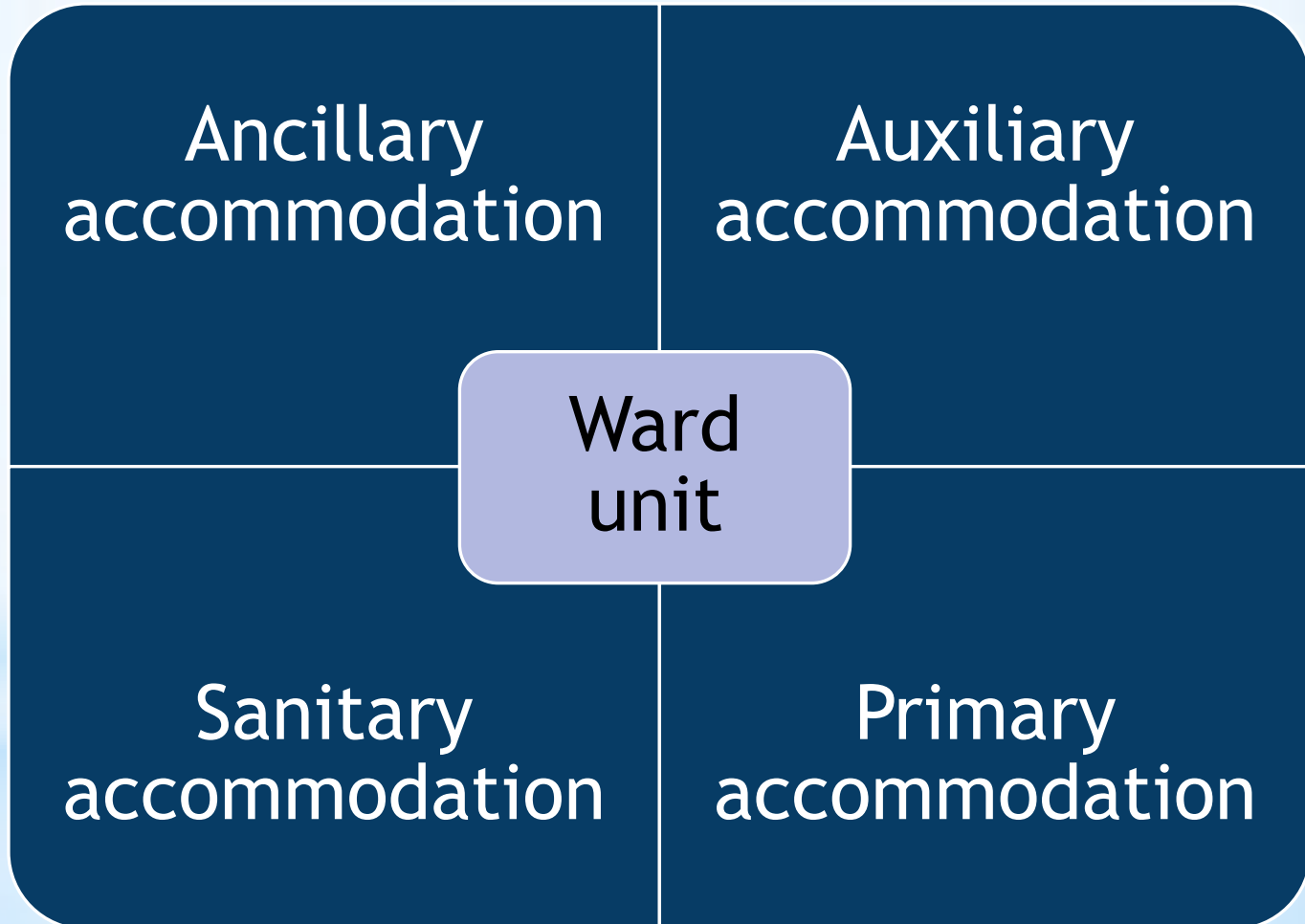
Advantages:

- Patient beds not visible to outside visitors except for visiting hours
- Gives a more clean and tidy look
- It provides as a barrier against psychological shock for other patients during emergency situations.
- More privacy

Disadvantages:

- Communication between nurses and patient becomes more difficult
- Patients deprived of direct observation from nurses
- Wards become longer, consequently nurses have to run more
- More nurses are required
- Expensive to build and maintain

*Components of ward unit



*Components of ward unit

Primary Accommodation.

Consists of single bedroom or multiple bedroom for patients and a nursing station.

Ancillary accommodation.

Service for direct support of treatment (portable x-ray, Pantry, Dietician service in ward, mobile pharmacy).

Auxiliary accommodation.

Service for indirect support of treatment (Store, housekeeping, doctor's room, nurse's room, seminar - teaching room).

Sanitary accommodation.

Consists of WC, Bathroom, sluice room.

*Primary accommodation

What should be considered in designing different types of wards:

- General ward :Healthy Environment
- Pediatric/ psychiatric ward- Safety
- Geriatric ward- Safety/ comfort
- Obstetrics/Gynecology ward - Privacy
- ICU- Nursing Care
- OT-Infection control

* Sanitary-Hygienic regimen of the ward

Sanitary-hygienic and anti-epidemic regimen is the extensive complex of actions which are carried out by medical staff, and also by patients to maintain safety and cleanliness in the medical institution and prevention of developing or/and spreading of nosocomial infections.

Hygienic requirements in wards are:

- Optimal temperature in the ward should be 18-20C;
- Wiping(the floor, windows, furniture) at least 2 times a day - in the morning and evening.
- In some departments – more often, for example, in the infectious departments – 4 times a day.
- Morning wiping should be finished till 9 a.m.
- Ventilation of wards not less than four times a day.

* Hygiene requirement for the medical staff

- White coat;
- Tidy appearance;
- Short nails;
- Special hospital footwear which can be easily disinfected (for example, leather).
- Hands well washed up with soap.
- To medical sisters engaged in surgical manipulations, watches, rings, varnish on nails are forbidden.
- According to indications (the maternity, infectious department, epidemic of influenza, etc.) a mask is put on; it is necessary to change a gauze mask every 4 hours; at an opportunity, it is better to use disposable sterile masks.

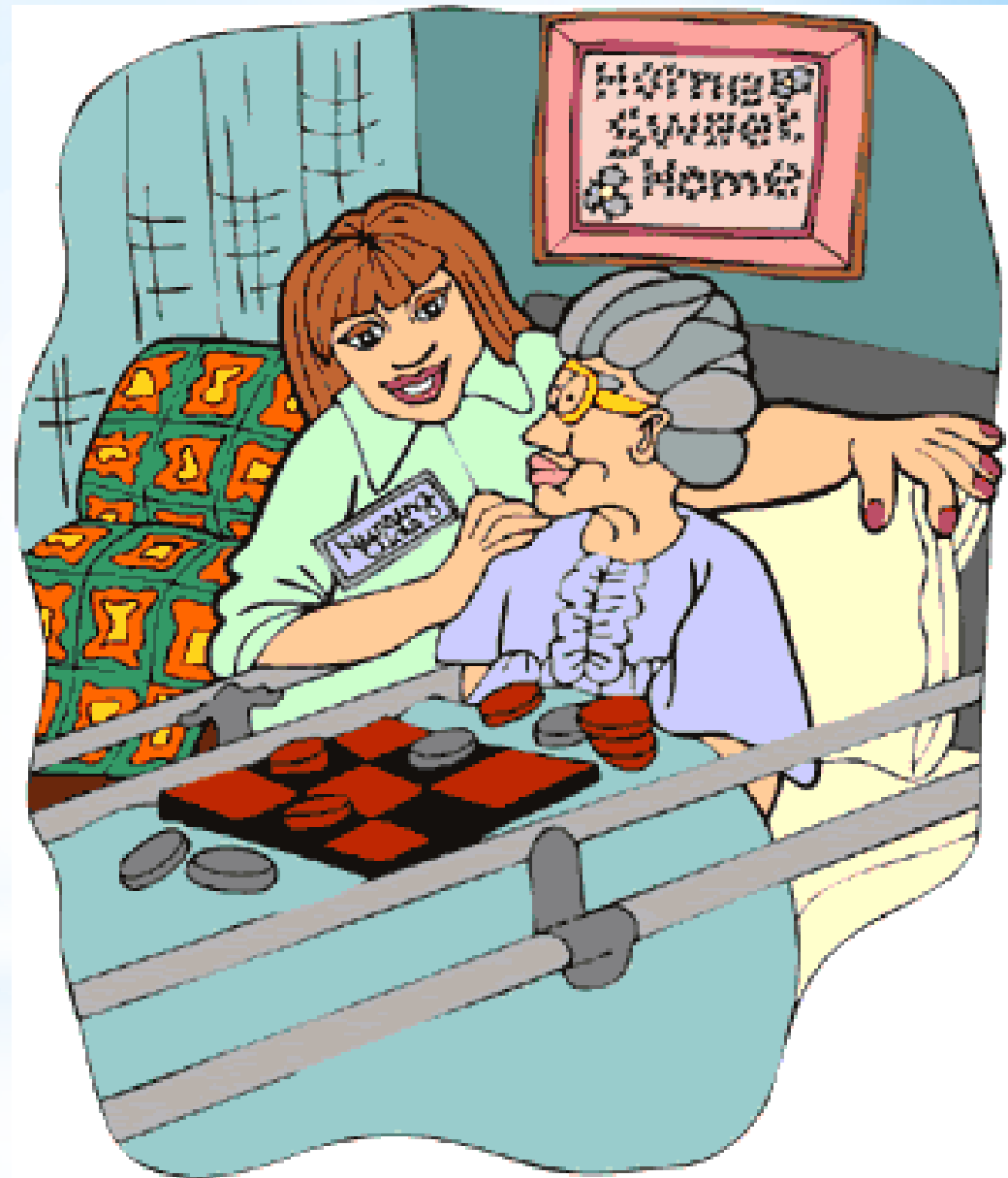
*Psycho-emotional types of nurses

There are several psycho-emotional types of nurses:

- Mother-like type;
- Sergeant-like type;
- Nervous type;
- Expert type;
- Routine type.

* Mother-like type of nurse

Working with patients
nurse is caring, shows
empathy, ability to feel
needs and emotions of a
patient.



*Sergeant-like type of nurse

Working with patients
nurse shows resoluteness,
uncompromising attitude,
instantaneously reacts on
slightest infringements of
discipline.

Patients feel themselves
nervous when she
approaches and try to put
their beds and bedside
tables in order.



*Nervous type of nurse

Such type of nurse is emotionally labile, quick-tempered, easily irritable, constantly shows hyperactive reactions on different situations, tries to draw your special attention on her problems.



*Expert type of nurse

While working with patients nurse shows extreme attention in the field of professional activity, she is proud of her importance as a nurse, sometimes she tries to act like a doctor.



**"I'm a *practical* nurse!
— I know better than
to listen to *doctors!*"**

* Routine type of nurse

While working nurse shows high level of qualification, accurate and mechanically performs her duties, but her relationships with the patient are deprived of emotion, compassion and empathy.



“Unfortunately, your insurance only allows for treatment by doctors who scored 68 or less on their medical boards.”

* Functions of ward nurse in charge



* Functions of ward nurse in charge

- Endorse patients and give attention to patients' comfort and safety; maintains safe environment for patients.
- Maintains nursing care of a patients, especially seriously ill (transfer, measurement of body temperature, BP, collecting analysis data, feeding, cleaning, moving seriously ill patients etc.)
- Carries out the doctors instructions
- Maintains proper ward management with house keeping and sanitation
- Delivers clean medical supplies to patient care units and collect used supplies, instrument sets, rubber goods, etc.
- Makes general assessment of patients in the recovery room and confers with head nurse nursing management of each patient

* Functions of ward nurse in charge

- Accompanies physician on rounds to answer questions, receives instructions and notes patients' care requirements.
- May render professional nursing care and instruct patients and members of their families in techniques and methods of home care after discharge
- Observes nursing care and visits patients to insure that nursing care is carried out as directed and treatment is administered in accordance with physician's instructions and to ascertain needs for additional or modified services.
- Cooperates with individual/group in other departments or services in carrying forward the work of the hospital as a whole.

* Functions of ward nurse in charge

- Determines and makes recommendations concerning hospital wards' facilities, equipment and surgical supplies affecting nursing care, and plans for allocation and utilization of space and equipment to ensure safe environment for patients and working personnel

* Patient's transfer

A transfer is the safe movement of the patient from one place to another, like from bed to wheelchair, from one unit to another within the one medical institution or from one medical institution to another.

Types of transfer:

Intrahospital - Within the same facility

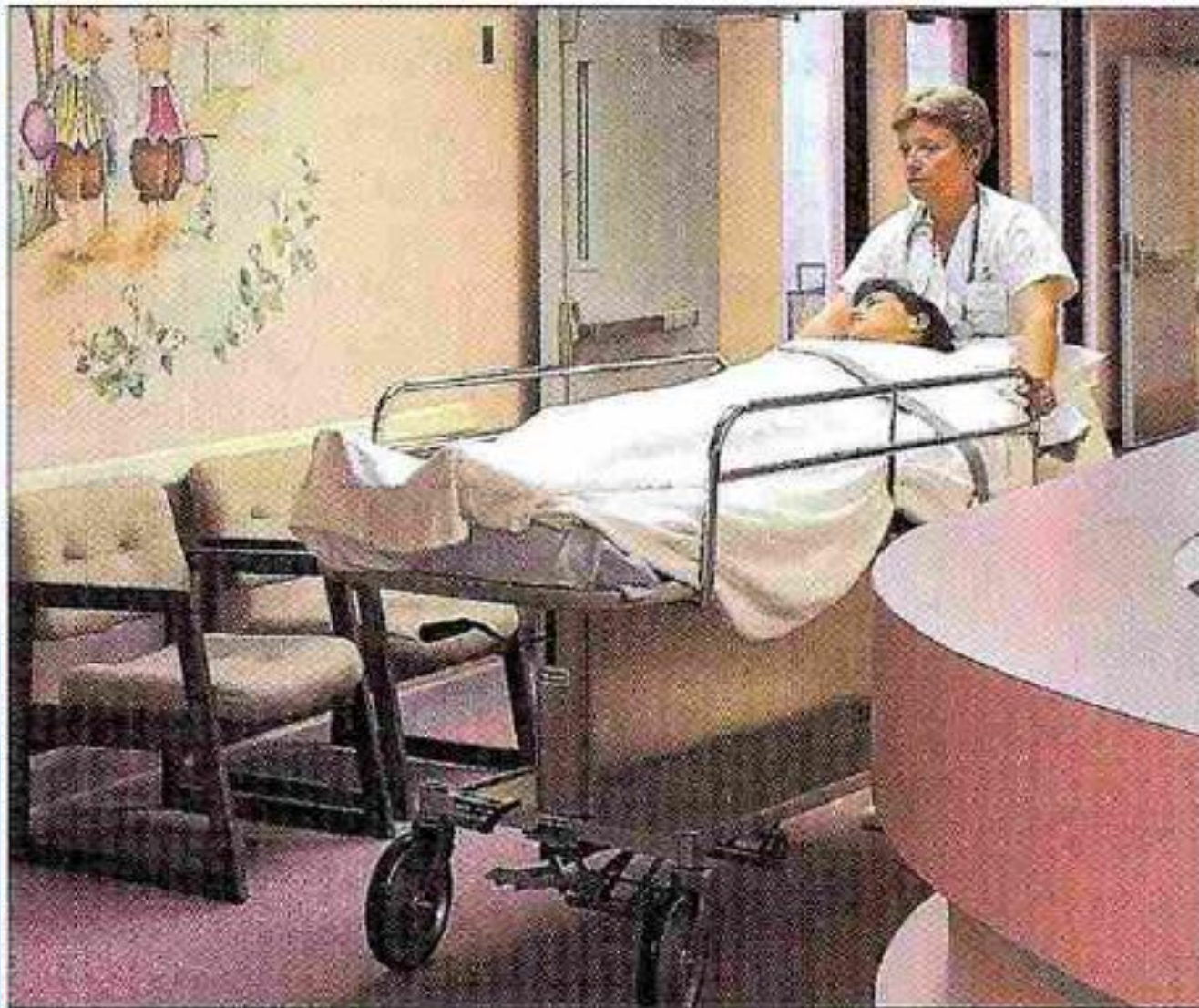
Interhospital - Within two different facilities

From hospital to home - Post Discharge/ After Referral to other type of Healthcare delivery Setups

*Intrahospital transfers

- From Admitting office to Wards
- From Emergency to Wards
- From Emergency to OT/ ICUs
- From Wards to OT/ ICUs
- From Wards to Radiology for Imaging
- From Wards to Wards
- From One ICU to other ICU

* Intrahospital transfers



* Interhospital transfers

- From one facility to other in same city
- From one facility to other in different city
- From Hospital to other healthcare delivery centre, Government Hospitals, Geriatric care, End of life care facilities, Nursing homes etc

* Interhospital transfers

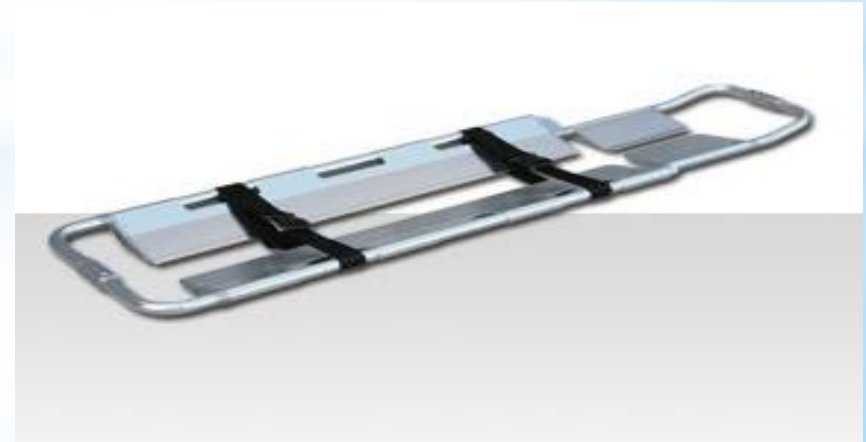


*Transferring A Patient

Equipment:

- Wheelchair or gurney
- Covering for client
- Patient's records, chart patient care plan, and valuables receipt
- Patient's MAR (medication administration record)
- Patient's personal hygiene equipment
- Special equipment (e.g., walker)
- Personal belongings

* Equipment for Patient's Transfer



*Transfer assist devices

Slider sheets



*Transfer assist devices

Slide/transfer boards



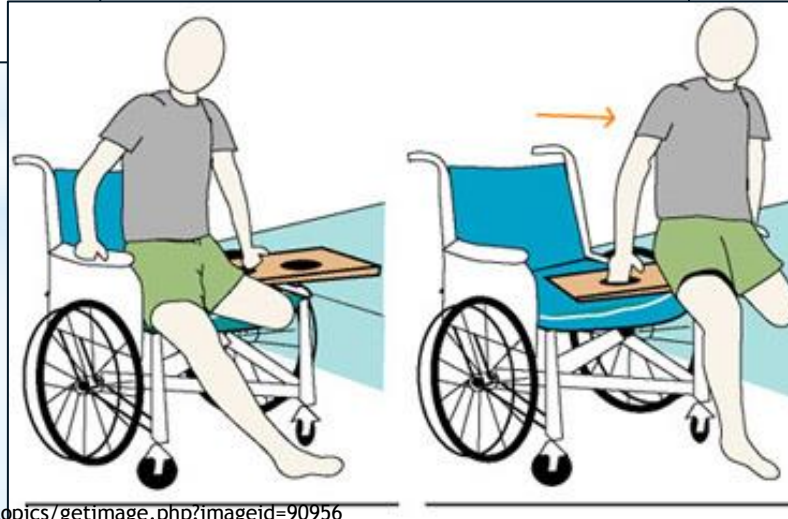
Transfer belts

Smaller slide/transfer boards: banana board



Turning or pivot discs

* Practical usage of transfer assist devices



https://segeltorp7.files.wordpress.com/2010/12/image-1-wheelchair_boardtransfer-figure-23.jpg
<http://www.vanderbilthealth.com/includes/healthtopics/getimage.php?imageid=90956>

[http://www.rehabmart.com/images_html2/ETAC-P2B%20\(PBI\)%202011/PBI-IM99836GT%20PediTurn%20Transfer%20Swivel%20Cushion_1.jpg](http://www.rehabmart.com/images_html2/ETAC-P2B%20(PBI)%202011/PBI-IM99836GT%20PediTurn%20Transfer%20Swivel%20Cushion_1.jpg)

* Positions of the patients

Supine – lying on the back
(ex - MI, head traumas, etc.)

Fowler's position – lying on the back with the head of the bed raised 30 to 90 degrees, most commonly about 45 degrees (obesity, pulmonary disease (ex. - bronchial asthma), heart disease (ex. - left heart failure))



* Positions of the patients

Prone position, the patient lies on the abdomen with the head turned to one side. (ex.-injury of the back, burn of the back)

Side-lying position- the patient lies on one side of the body with the top leg in front of the bottom leg and the hip and knee flexed. (ex - patients with vomiting, patients with dry pleurisy on affected side to decrease pain)



*Transfer procedure

- Verify physician's order if needed.
- Contact admitting office to arrange for transfer.
- Communicate with transfer unit to determine the best time for transferring client.
- Identify patient and inform patient of impending transfer.
- Gather equipment, belongings, and records.
- Obtain necessary staff assistance for transfer.
- Transfer patient to wheelchair or gurney unless patient is remaining in bed for the transfer. Use protective belts and rails as indicated.
- Cover patient to provide warmth and to avoid exposure during transfer.

*Transfer procedure

- Notify charge nurse when you arrive on the receiving unit.
- Introduce patient to new staff, who will be caring for the patient that day.
- Give complete report to staff, using the patient care plan. Give information concerning individualized care needs, patient problems, progress, when next medications or treatments are due. If necessary, give phone report to receiving nurse.
- Notify physician, admitting office, and dietary department when transfer is completed. A transfer notification must be sent to the appropriate departments.
- Notify x-ray and the laboratory if tests were scheduled or results pending.

* 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 clinician(s).

Dependent transfers

- The patient does not participate actively, or only very minimally and the clinician(s) perform all aspects of the transfer

* Sit the patient up

- Place and lock the wheelchair close to the bed. Remove armrest nearest to 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.

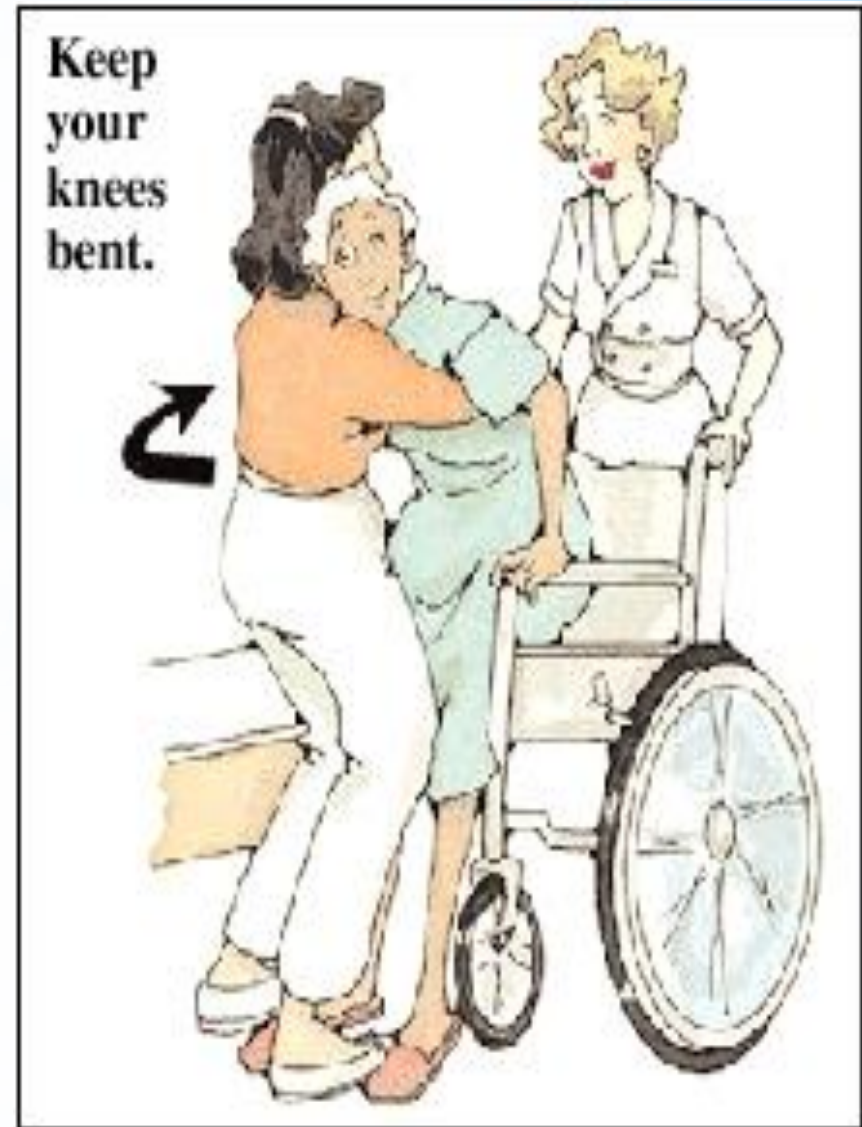
*Stand the patient up

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



* Pivot towards the chair

- Have the patient pivot toward the chair, 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 toward 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 chair.



TransferFrom Bed to Wheelchair.mp4

*Turning the patient over in bed

Cross Arms of a patient

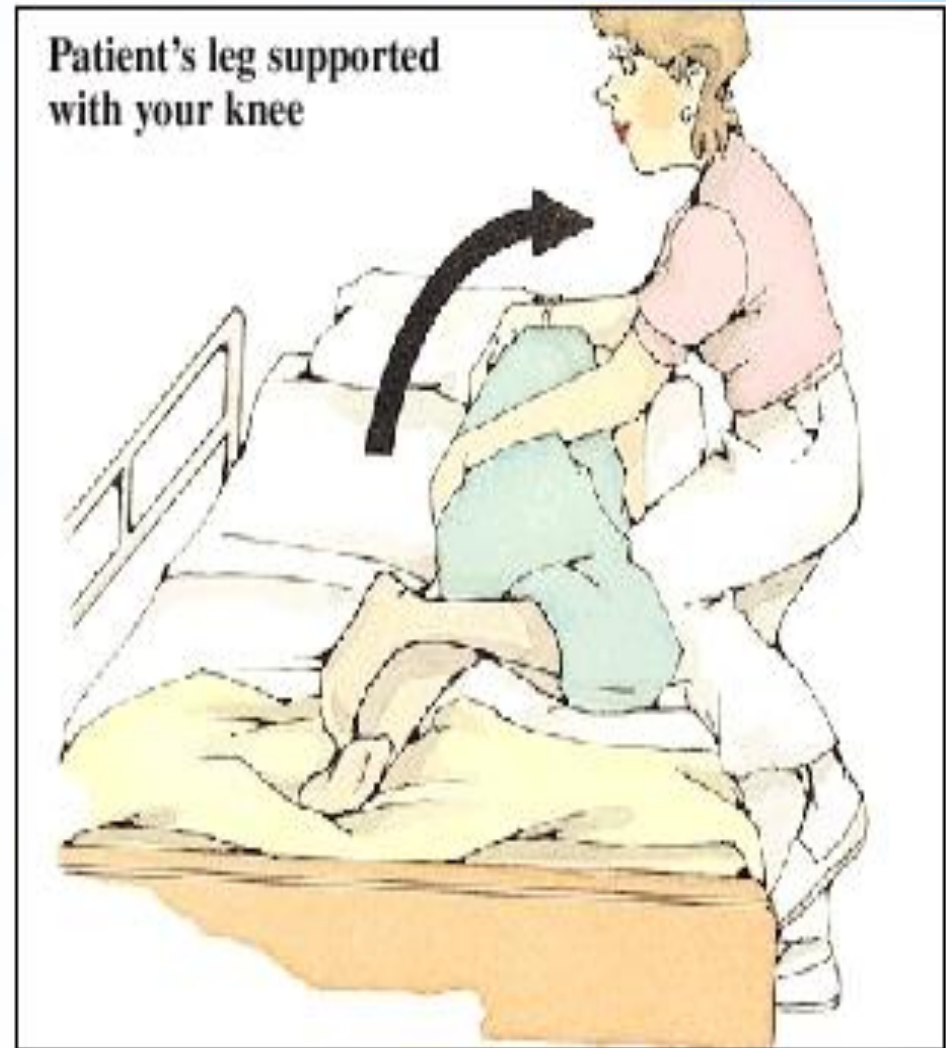
- Put the bed rail and head of the bed down; adjust the top of the bed to waist- or hip-level.
- Cross the patient's arms on his or her chest; bend the leg farther away from you.



*Turning the patient over in bed

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.
- **Remember:** Putting one knee on the bed gets you closer to the patient, so you pull more with you



* Moving patients from bed to stretcher (gurney)

The leader should have one foot forward with knees bent.

Prepare to move.

- Put the head of the bed down and adjust the bed height.
- Put a garbage bag or plastic slide board between the sheet and draw-sheet, beneath one edge of the patient's torso.
- Move the patient's legs closer to the edge of the bed.
- Instruct patient to cross arms across chest and explain move to patient.

* Moving patients from bed to stretcher (gurney)

Pull to Edge of 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.



* Moving patients from bed to stretcher (gurney)

Position 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.

* Moving patients from bed to stretcher (gurney)

Slide onto Stretcher

- Have the helper kneel on the bed, holding on to the draw-sheet.
- **On the count of three**, grasp the draw-sheet and slide the patient onto the stretcher. You may need to repeat this step.



*When a patient falls

Once the momentum has started, it's almost impossible to stop a patient from falling. By trying to do so, you can injure your back. Instead, guide the patient to the ground; then get help to move the patient back to a bed or stretcher.

Guiding the Fall

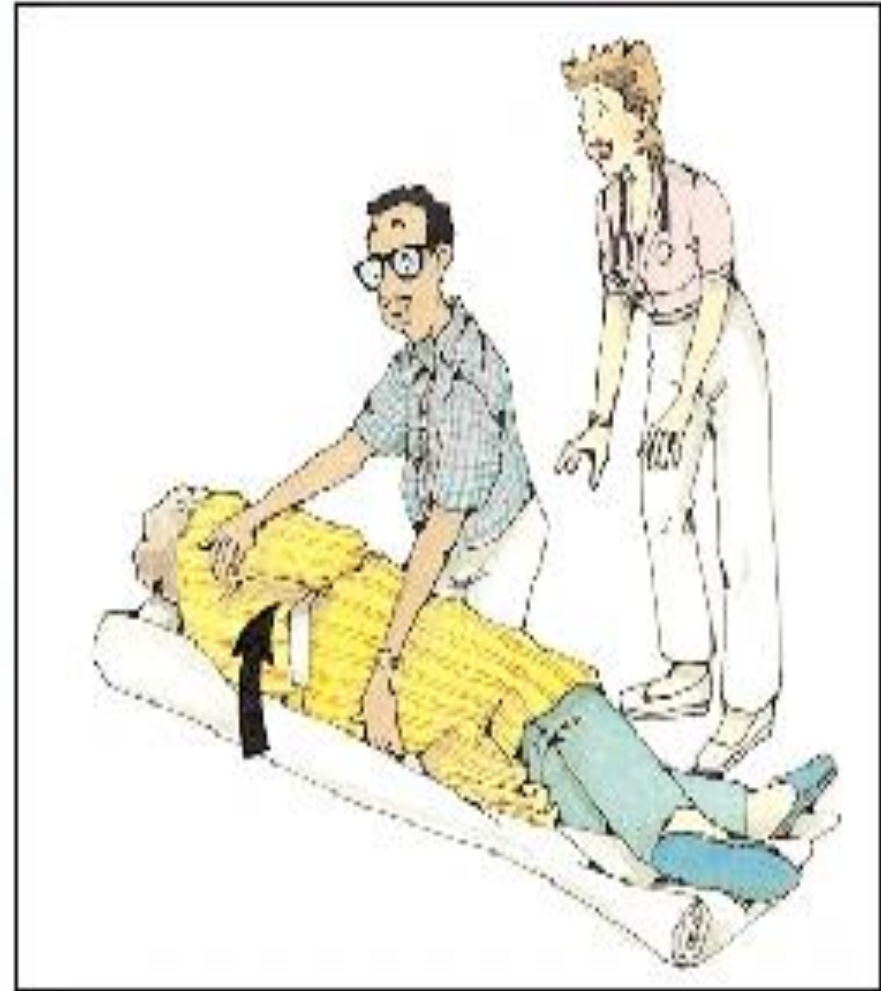
Help falling patients to the floor with as little impact as possible. If you're near a wall, gently push the patient against it to slow the fall. If you can, move close enough to "hug" the patient. Focus on protecting the patient's head as you move down to the floor. Then call for help.



* Moving the fallen patient

Roll onto Blanket

- Roll the patient onto his or her side.
- Put a blanket under the patient and roll the patient onto it.
- Position two or more people on each side of the patient.



*Lifting the fallen patient

Lift from Floor

- Kneel on one knee and grasp the blanket.
- On a count of three, lift the patient and stand up.
- Move the patient onto a bed or stretcher.

Remember: Be proactive; assess and identify a patient as a fall risk and start intervention to prevent a fall.



* Have a nice day!

