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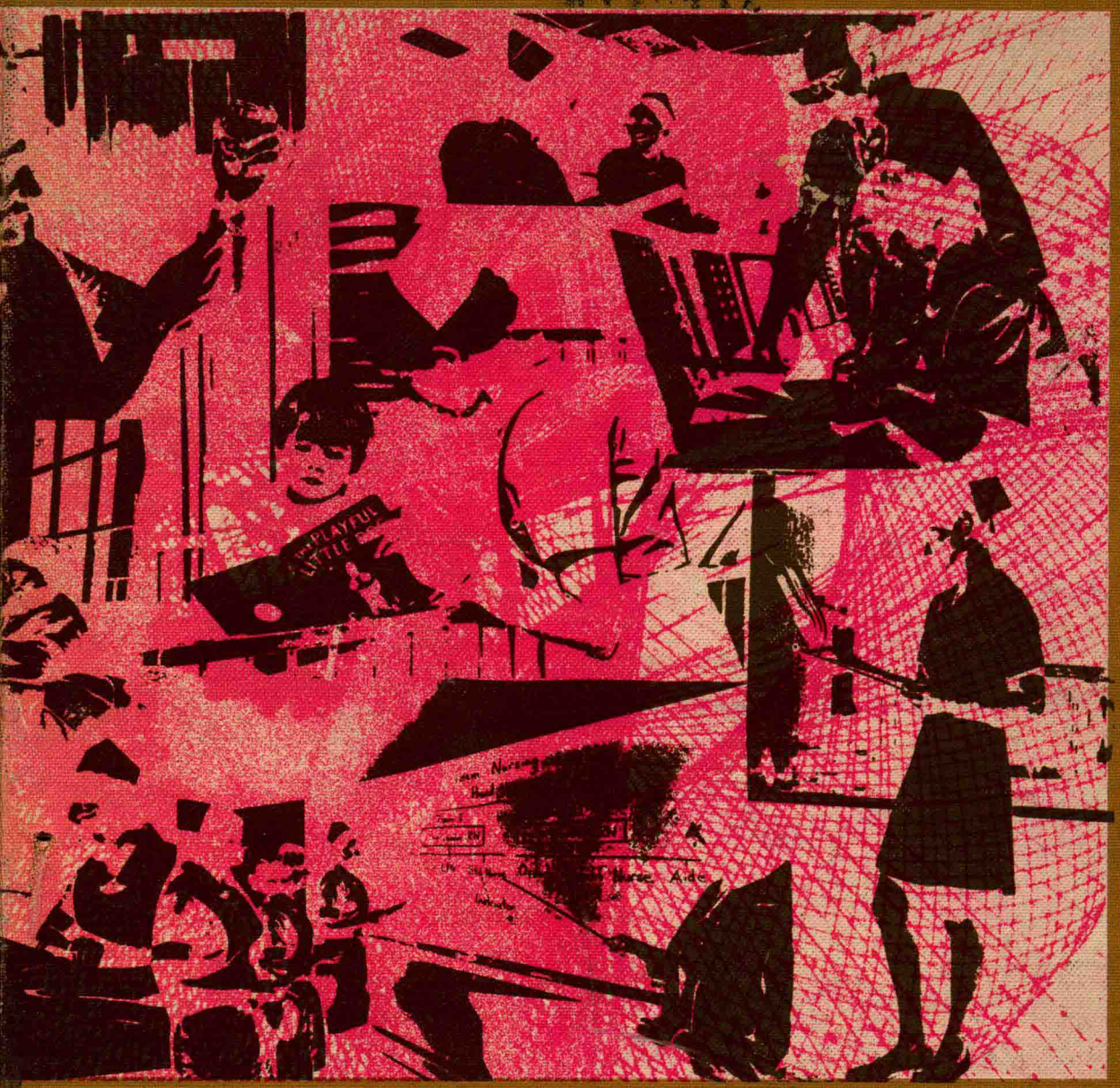

Medical-Surgical Nursing

FIFTH EDITION

Medical-Surgical Nursing

■ KATHLEEN NEWTON SHAFER ■ JANET R. SAWYER
■ AUDREY M. McCLUSKEY ■ EDNA LIFGREN BECK ■ WILMA J. PHIPPS

FIFTH EDITION
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MEDICAL-SURGICAL NURSING

■ Foreword

More than a decade has passed since the first edition of *Medical-Surgical Nursing* was published. During this time some aspects of nursing have not changed at all. The nurse still deals with individuals, each of whom has basic emotional needs for security, love, and recognition and his own particular hopes, fears, and aspirations. These he carries with him as he seeks to cope with the threat of illness to his physical or emotional well-being. The nurse should have the ability to see each patient as an individual with an increasing need for personal identification as the world about him becomes ever more crowded and chaotic.

In other ways nursing has changed enormously since the first edition of this book was printed. Technical advances in medical treatment, application to the practice of medicine of scientific knowledge gained in other fields, new knowledge in physiology and biochemistry, and the development and use of new drugs have made almost commonplace some procedures and treatments only dreamed of a decade ago. The rapidity of changes in treatment demands an alertness and a flexibility in nursing care that can be based only upon complete understanding of the rationale for the treatment in a given patient. A rapidly expanding population and increasing realization of the cost of illness to the national community make the contribution by nurses to the prevention of disease in all people and to the rehabilitation of those who become ill more urgent.

Because of the many changes occurring in recent years, we, the original authors of this text, believe that a new edition should have new authorship. We believe that our book would better serve the needs of students of nursing and of their instructors if it is revised by someone who subscribes to the original viewpoint of the book, yet is more intimately associated with actual nursing practice than some of us now are. This edition, therefore, is a revision by a competent and actively practicing authority in the field. It is our hope that Miss Phipps, who has undertaken this revision, will have the satisfaction and the appreciation of her achievement that we have all enjoyed so fully. We hope also that she will be given the benefit of careful scrutiny of this book by practicing teachers that we have had in previous editions and, with this, the much-appreciated corrections, criticism, and suggestions for future editions.

■ Kathleen Newton Shafer ■ Janet R. Sawyer ■ Audrey M. McCluskey ■ Edna Lifgren Beck

■ Preface

When *Medical-Surgical Nursing* was initially published, it was the first combined medical-surgical nursing book in the field. Since that time, it has gained a wide readership among nursing students and practicing nurses who are interested in the patient as an individual affected by a condition requiring medical or surgical treatment.

This fifth edition has been brought up to date in order to reflect the many changes occurring in medical practice and, therefore, in nursing care. Some chapters have been revised extensively, while others have required few changes. To assure that this revision faithfully reflects current practice, several persons have read, commented upon, and in some cases rewritten sections of the book. I am indebted to them and to the original authors, whose comments and suggestions are incorporated in this edition. In all the changes an attempt was made to preserve those qualities of the book that have been valued by nurses using the previous editions.

With gratitude I acknowledge the assistance of the following nurse colleagues in Chicago and Cleveland who assisted with this revision:

Janet Anderson, R.N., M.S.	Rosemarie King, R.N., M.S.N.	Mildred Perlia, R.N., M.S.N.
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■ Wilma J. Phipps

†Deceased.

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Section 2 Nursing related to specific medical and surgical care

Section 1 Trends and problems influencing patient care

1 ■ The patient and the nurse—understanding, interaction, and intervention

Understanding of self and others and the use of self in interaction with others toward a therapeutic goal (the maintenance and restoration of health in people) is basic to all nursing care. In this chapter we can only highlight a few concepts that affect relationships with people. The nurse should deepen her understanding by reading and discussing articles and books devoted to such topics as mental health, cultural patterns, emotional responses to illness, and interpersonal relationships.

Nurse-patient interaction begins when the nurse and the patient first encounter each other, but this interaction may be colored by past experiences and preconceptions. The nurse learns to take appropriate nursing action spontaneously. However, through definitive assessment of the patient's emotional, social, cultural, and physical needs, the nurse learns to take planned, purposeful action to help the patient toward the therapeutic goal. With careful analysis, interpretation, validation, and evaluation of her own and the patient's responses, ideally, the nurse proceeds step by step with the patient toward both short-term and long-term goals of care. There is almost limitless reading material on these aspects of patient care. The starred readings at the end of this chapter are only suggestive.

UNDERSTANDING AND INTERACTION

The concept of patient

"The patient is a person" and "patients are people" are phrases used frequently in the nurse's education. These or similar phrases serve to remind the nurse that the patient, whoever he may be, is a human being with hopes and desires, likes and dislikes, strengths and weaknesses. The patient may be a man or a woman, a boy or girl, an infant or an elderly person. *Who* he is and *his place* are important. They are of paramount importance to him and they should be a most important consideration in his care.

Being a patient places the person in a unique setting. The number of places where patient care is offered today are numerous and differ greatly. The person who becomes a patient is often described as "one who is under the care of a physician or in a hospital." Patients also receive care in the physician's office, the outpatient service of a hospital, in their own homes, in nursing homes, and in other institutions. Regardless of where care is given, each experience has special meaning to the patient. Perhaps for most people, institutional care has the greatest significance. The fact that the person is away from his home, family, friends, and usual way of life, even for only a short time, and is faced with threat of disease or illness and unpleasant experiences may tax his resources in understanding and in adaptation.

The individual who becomes a patient in a hospital takes on a different status and is surrounded by circumstances quite unlike his usual ones. His total environment becomes different from the familiar. He is requested to wear clothing he normally wears only for sleep. His living quarters are only a room or cubicle that is little more than a place to rest. He may have private bathing or toilet facilities, but most likely he will share a community-type room. A public lounge may be available to him and his family, or there may be only a bench in the corridor. His family, perhaps some friends, hospital personnel, and fellow patients complete the group of people who will be his close associates during his hospitalization. The latter two groups of people are determined for him by circumstances rather than by his choice.

A patient in the hospital is the recipient of sug-

■ STUDY QUESTIONS

1. Keep a record for a week of each patient for whom you care. Include the patient's age, his nationality, his place of birth, the language spoken in his home, his education, his place in his family, and his religion. Consider whether or not any of these influenced the nursing care you gave.

2. How has knowledge of the patient's background, as listed above, influenced your teaching of a patient during his preparation for leaving the hospital?

3. What are some of the ways in which anxiety may be expressed? ■ List some questions that patients and members of their families have asked you that indicate anxiety.

gestion, direction, explanation, and treatment. He is observed, tested, exposed to situations over which he may have little or no control and is given a variety of medications and treatments. He may have surgery. As he recovers from illness or completes a diagnostic survey, he usually is given a final checkup, and then he may be declared well enough to resume life at home or he may go to another institution for further care. On the other hand, the hospitalization may be his last life experience.

The patient's response to illness may be quite different from his response to hospitalization. Illness outside a hospital may be accepted and the patient may experience physical and emotional discomfort with little outward expression. With hospitalization, his response to illness may be intensified, or his reaction may be one of relief with a lessening of his reaction to illness. The significance of the hospital or hospital care to each patient needs careful consideration. Hospital surroundings, atmosphere, and ways of doing things are very familiar to personnel and to some patients. Most patients, however, are not familiar with them and need help in adjusting to the experience.

The patient's concept of the nurse

The nurse should be aware that each patient has a mental image of the nurse and that wide variations exist. The same factors influencing his behavioral responses to illness and care will influence his concept and expectations of the nurse.

The image the patient has of the nurse may speed or delay his acceptance of her and of what she helps him to do. For example, his mental image of the nurse may be that of a woman in a white uniform, cap, shoes, and stockings. When a public health nurse comes to his home to continue his care and he is confronted with a nurse in a different colored uniform and accessories, it is not uncommon for him to ask if she *is* a nurse or whether she is the same as the "other" nurses.

The patient's concept of the nurse frequently is based upon the general public's idea, particularly if the patient has had no previous contact with nurses. The nurse is commonly held in a position of respect by the public. She is often thought of as a person who is good, immaculately groomed, efficient, and kind. She is thought of as one who "does for the sick." When the nurse attempts to teach the patient to do things for himself, as he will need to do in readjustment to daily living, he may feel that she is trying to get out of doing her work or that she does not appreciate the fact that he is sick. Unfortunately, in the past much of the "caring" in nurse-patient relationships has been conveyed through doing *for* the patient rather than *with* the patient.

The public frequently turns to nurses for answers to questions regarding health, but the nurse is seldom considered a teacher. When the nurse attempts to teach the patient and family about measures to prevent illness and to maintain health, she may elicit little interest from them. Thus, if continuing nursing care consists primarily of health supervision in the home, the patient and his family may feel that the nurse is not needed. If she must give some treatment, assist with some physical exercises, or carry out some other function that gives concrete evidence of "doing," then her contribution may be recognized by them. When nurses make arrangements for patient care, particularly in the change from care in the hospital to care in the home, these factors should be borne in mind.

Some patients may have had traumatic experiences that lead them to distrust and reject the nurse. Others may have listened to harrowing experiences of their friends and assume that their association with nurses will not be pleasant. The nurse should try to help the patient correct this distortion by encouraging him to relate to her as an individual.

Psychologic factors may affect the patient's response to the nurse. When any person becomes ill and dependent upon others, he regresses to some extent. Just having to be in a hospital and having to abide by the regulations places the patient in a dependent position. Some patients unconsciously respond to the nurse as they did to their mothers during childhood. This may be demonstrated by docile obedience, eagerness for approval, playing childish tricks to see if they can "get away with anything," or by a number of other ways. Their behavioral expressions will depend upon what they learned as appropriate responses. Others may identify the nurse with a domineering mother from whom they may be seeking emancipation or with an unwanted mother-in-law. They may respond with stubborn and contradictory behavior that the nurse must try to understand.

The patient may have come from a cultural background in which women are considered inferior to men, one in which women unquestionably wait upon men. For example, a man who had recently come to this country antagonized all the members of a nursing staff by ordering them about and by refusing to help himself at all. His convalescence was being delayed by his firm conviction that the women about him, the nurses, must "do for him" on all occasions. An alert nurse noticed that he also ordered his wife about during visiting hours and that she accepted this in a satisfied fashion. Only then did the nurses realize the meaning of his behavior. In this particular instance the situation was remedied by working through the doctor, whose opinions, suggestions, and judgments

were accepted readily by the patient. Thus, the nurses learned from this insight into the patient's behavior and no longer needed to feel resentful.

Interpretation of all we see is based on our own experiences and learning. Therefore, it is not strange that the nurse is seen in a different light by each person she encounters. Accepting this, she needs to work toward responding to each patient individually, respecting his differences and placing her emphasis on common elements. In this way she will give the most effective care.

The nurse's concept of the patient

The nurse-patient relationship is a term commonly used to identify the complex interaction between the patient and the nurse. Every nurse needs to understand this relationship, for upon it will rest her success in helping the patient and in achieving personal satisfaction.

Each one of us is uniquely different from any other individual. The nurse needs to be aware of her own biases and prejudices. She needs to work toward meeting each person with an open mind. To be successful in working with patients as individuals, the nurse needs to accept each as he is without attaching conditions to the acceptance. The patient then does not need to be burdened with trying to earn the nurse's approval, and it also is easier for the nurse to work with the patient and his family with genuine sincerity, sensitivity, and understanding. The nurse who attempts to convey outwardly one response when inwardly she is responding in another way only confuses the patient, and relationships remain superficial.

The nurse may encounter many situations that require acceptance of things that cannot be changed. She cares for patients with incurable illnesses that may result in immediate death or that may become chronic. Some patients may require disfiguring surgery. Some may have deformities or communicable diseases with attendant social stigma. The nurse needs to develop the ability to accept things that cannot be changed and to respect the opinions of others in the determination of what can be or should be changed within reasonable limits.

The nurse needs to learn to distinguish between her own goals, values, and standards of conduct and those of her patient. Discovery of what situations mean to the patient is one of the first steps nurses can take to truly help the patient. Every nurse should realize that although she attempts to anticipate what the patient may need, the patient may be the best interpreter of what he needs and wants, if only someone will listen. Much can be learned about the patient through observation, collection of information by other health personnel, talking to the patient's family, and talking to other nurses who take part in his care. However, the best source of information may be the patient, and he should be given every opportunity to express his own feelings about situations. If the meaning of observed patient behavior is not clear, the nurse should not make assumptions. Verifying the meaning with the patient brings the concern into the open, and together the patient and the nurse learn the meaning.

There will be situations that the nurse finds difficult to understand and that she cannot accept. She may need assistance in resolving conflict and should seek aid from persons who can help her better understand such situations and her part in them. Through this kind of discussion she then may give care to patients with greater awareness of the meaning of her own behavior and the behavior of the patient.

There can be no set rules or techniques to determine the nurse's responses to patients. Each response is made according to the individual and the situation. The following suggestions may help as guidelines:

1. Be yourself, for nothing else draws more genuine response from others.
2. Let others respond in their own way rather than trying to make them respond the way you would.
3. Reflect upon situations that are unsatisfactory or frustrating and ask yourself the following questions: Why do these situations exist? What did the patient do and say, and what did you do and say? Did you really understand what it meant to him, or were you interpreting it by your values?
4. Continue to grow intellectually, emotionally, and socially by developing broad interests both within and outside nursing.

Emotional and cultural responses to illness

In general, the patient's behavior is influenced by his previous knowledge and experience, his cultural background, his emotional makeup, and alterations in his physiologic functioning. These influences are so closely tied to each other that it is often very difficult to sift out a single reason for his behavior. However, the nurse should bear in mind that whatever the patient's behavior may be, it has a very definite meaning. It may be relatively simple or very complex. The patient may not be able to verbalize the reason for his behavior, or if he does, his interpretation may be quite different from the nurse's interpretation.

To understand his behavior, the patient's age needs to be considered along with other factors. A child will react according to his stage of emotional and physical development in addition to the factors already listed. A discussion of the stages of growth and development cannot be included here, but every nurse should re-

member that the child's reactions are different from those of the adult and are in keeping with behavioral patterns expected at particular stages of development.

The adult patient is expected to face his problems in an adult fashion. However, his behavior may illustrate that the level of emotional maturation he has attained makes this impossible under the circumstances.

Anxiety and *fear* are part of the natural reaction of every normal human being when threats to his health appear. Anxiety has been defined as a feeling of uncertainty and helplessness in the face of danger. It is caused to some extent by the nature of the human organism but can be intensified by lack of knowledge, lack of trust, and social, cultural, and economic forces bearing directly upon the affected individual. Fear of cancer, for instance, is becoming almost universal in our society. This fear can be transferred from one person to another in such a way that it has been defined as one of the most common "communicable diseases" of man. It is imperative that the nurse have some understanding of the anxieties and fears of patients.

Illness may be a new experience for the patient. He may be uncertain of what it will mean for him, of the reactions expected of him by others, and of how others will react to him. His anxiety may be the result of his present situation. He may be fearful of the many activities that directly affect him and that occur around him such as diagnostic procedures and treatments. His own incidental observations of other patients in the hospital may cause concern.

Illness often separates the patient from those he loves and those who perhaps know him best and can comfort him most. Even a short hospitalization may seem very long to the patient and his family who are accustomed to daily support from each other. Being denied this accustomed source of warmth and security increases the patient's anxiety and fear. Small children, who cannot always be given a satisfactory explanation of what may be done to them, often suffer greatly from anxiety.

The loss of financial security and the economic effects of illness may cause the patient and his family to feel threatened. This may be particularly true of the man who is head of a household. One response may be anger and hostility. If this response occurs, the patient needs acceptance of his behavior and a good listener. By listening, the nurse may help the patient to release tensions. Sometimes the social worker can help him to resolve some of his problems. In the hospital it is she who knows the most about such community resources as financial aid, housekeeping services, child-placement facilities, nursing homes, and job-placement agencies.

The signs of anxiety, fear, and tension are variable. An indifference to his symptoms and to the tests being made may mean that the patient has not accepted the possibility that anything may be wrong. He may not be able to face reality and still maintain stability and integrity of his personality. The patient who is noisy and demanding, perhaps declaring that he is not worried, is one who, if closely observed, may reveal what he dares not verbalize. The patient who "forgets" the clinic appointment at which he is to learn the results of a test is probably fearful of these results. Other patients manifest their anxiety, consciously or unconsciously, by repeatedly asking the same question, making many complaints, or being preoccupied with bodily functions. Still others struggle with their fears alone, leaving the nurse unaware of their problems. Insomnia, anorexia, frequent urination, irritability, inability to listen or to concentrate, and detachment are signs of anxiety. Sometimes marked physical signs, such as perspiring hands, increased pulse and respiratory rates, and dilated pupils, denote anxiety and fear. Perhaps the best way a nurse can estimate her helpfulness to the anxious patient is by his progress. If he becomes more tense, she should seek expert assistance.

Cultural background is related so closely to emotional response that it must always be considered in determining the basis for the patient's behavior. This evaluation may be difficult to make and may necessitate careful observation and study. It is important that the nurse try to identify whether the patient's response is a cultural or an emotional one because her response will depend upon this knowledge.

Certain diseases may have implications that are not culturally acceptable to the patient or his family. In some societies it is a disgrace to become ill. Diseases such as epilepsy and mental illness may be carefully guarded secrets within families. Some diseases, such as venereal disease, may be associated with uncleanliness or immorality.

Various parts of the body may have significant meaning in certain cultures. Some patients may refuse to permit amputation of a limb because physical fitness and the "body beautiful" are valued highly. The modern woman in the United States may have an almost intolerable emotional reaction to a mastectomy because of the emphasis placed upon women's breasts in our culture.

The patient may be censured for displaying behavior acceptable in his own cultural group. For instance, in one culture "the picture of health contains a normal amount of disease." For this reason, early medical care or a program of prevention may meet resistance. In another culture the family usually prefers to care for the patient at home, but if hospitaliza-

tion is necessary, many relatives and friends cluster around lest the patient feel rejected in his time of need. In still another culture it is proper to go to bed with much moaning and groaning if one is ill, so that the relatives may fulfill their rightful role of beneficence. Hospital personnel frequently consider these patients "problems" rather than recognizing that such behavior is culturally determined and trying to work out acceptable adjustments. Explanation to the patient and his family of hospital policies, such as visiting hours and isolation requirements, may prevent undue anxiety in both the patient and his relatives.

Hospitalization should not deprive the patient of the right to follow his religious convictions (Fig. 1-1). To provide total patient care, the nurse must be aware of and make provision for the patient's participation in his preferred religious activities. A significant part of many religions is the observation of *dietary laws*. While most of the major religions waive such restrictions in time of illness, individuals frequently prefer to follow them. The anxiety produced in the patient who is confronted with food he feels he should not eat can usually be prevented by keeping the dietary department informed about religious persuasions.

In addition to religious restrictions on food, patients may have cultural preferences. For example, Mexican diets contain spicy foods while Swedish diets are bland and high in fat. Many illnesses necessitate major changes in eating habits and most patients accept dietary changes reluctantly. Good patient and family teaching is necessary if the medical regimen is to be successful. Some patients "just don't like the food." If there are no medical contraindications, families can be encouraged to bring in food for patients. This provides excellent opportunities for health teaching in nutrition.

Complaints about food in hospitals are very common. While sometimes legitimate, they are more often the result of patient dissatisfaction in other areas. Good nurse-patient relationships that provide for open communication may help eliminate these misplaced complaints.

FIG. 1-1
Many patients derive great comfort from a few moments of silent prayer in the chapel.

NURSING INTERVENTION

Appraisal of the patient

The nurse's general understanding of the patient and the interaction that takes place between patient and nurse form the basis for planning nursing care. Information from the patient and family supplies more of the framework from which she can begin to plan nursing care. As the nurse learns more about the patient, she is able to identify his potential. She helps the patient to maintain and use his capacities, and especially to find ways of achieving what is most important to him. There may be times when the patient is unable to recognize the strengths he has, but through understanding and building trust the nurse can help the patient to become more aware of his capabilities.

Plans for patient care need to be kept flexible and within practical limits for the patient and his family. Written plans help to keep all nurses informed of what the patient is capable of doing and of the goal he is trying to reach. Keeping plans simple, yet up-to-date and pertinent, reduces the number of times the patient has to inform the staff about his capabilities and helps to provide a consistent approach toward his nursing care.

The following "Patient Information Guide for the Nurse" is a sample of the kind of information that can be collected by the nurse for her use as well as for the use of other professional persons giving patient care. Although traditionally the physician records the history of the patient over a period of time, the nurse learns

many details about the patient's habits, behavior, complaints, and discomforts as well as his reactions and progress during treatment. By using a guide to identify what the patient has to use and what he lacks, the nurse is better prepared to help him proceed toward recovery.

PATIENT INFORMATION GUIDE
FOR THE NURSE

I Physical, emotional, and social observations
- A Physical
  - 1 General appearance
    - (a) Body build, weight, height, posture, gait
    - (b) General day-to-day appearance
    - (c) Changes in appearance
    - (d) Appearance before illness
  - 2 Symptoms and signs
    - (a) Temperature
    - (b) Pulse
    - (c) Respiration
    - (d) Blood pressure
    - (e) Color
    - (f) Specific complaints such as pain, nausea, fatigue, dyspnea
    - (g) Usual pattern of specific complaints; e.g., in cardiac patient, time and nature of chest pain over a period of days, in relation to activity
    - (h) Intake and output
    - (i) Other physical symptoms and signs that occur in relation to self-care (see II, Self-care activities)
  - 3 Previous state of health
    - (a) Number of admissions—present hospital and others
    - (b) Contact with other health agencies—public health nursing, family service
- B Emotional and social
  - 1 Behavior
    - (a) Adjustment—to illness, roommates, staff, therapy
    - (b) Previous behavior—collection of observations made by patient and by family and/or friends
    - (c) Usual day-to-day behavior—interest, occupation, general frame of mind or spirits
    - (d) Changes in behavior—circumstances at time of change and before and after change
    - (e) Family relationships—at home, reaction to visitors, reaction to lack of visitors, family interest, family members who seem to help
  - 2 Social activities
    - (a) Usual way patient likes to spend time
    - (b) Amount of free time available and how used
    - (c) Friends or lack of friends
    - (d) Activities at home or outside home or both
  - 3 Family
    - (a) Nationality
    - (b) Birthplace
    - (c) Religion
    - (d) Place in family—mother, father
    - (e) Siblings
    - (f) Children
    - (g) Language spoken in home
  - 4 Mental ability and education
    - (a) Vocabulary
    - (b) Ability to understand explanations
    - (c) Ability to carry out functions in relation to care needed
    - (d) Ability to repeat actions, such as giving self-medication after a demonstration
    - (e) Ability to retain knowledge to be used another time
    - (f) Ability to make suggestions regarding own care
    - (g) Amount of schooling
    - (h) Kind of schooling
    - (i) I.Q.—if psychologic testing has been done
  - 5 Household
    - (a) Importance to patient
    - (b) Importance to family
    - (c) Patient satisfied or dissatisfied
    - (d) Location of home
    - (e) Physical setup of home
  - 6 Finances
    - (a) Kind of work patient has done
    - (b) Kind of work patient is doing
    - (c) Income of patient and family
    - (d) Attitude toward job—satisfaction, dissatisfaction
    - (e) Use of income—values of individual in relation to finances
    - (f) Use of public assistance or private funds—acceptance of, reaction to
    - (g) Effect of finances on health habits, purchase of prescribed medications, follow-through on prescribed diagnostic tests

II Self-care activities
(Include factors such as patient's interest in doing, specifically how the activity is done, progression in doing activities)
- A Personal hygiene
  - 1 Bathing
    - (a) By patient, nurse, member of family, or combination
    - (b) Usual method—bed, tub, shower
    - (c) Frequency
  - 2 Nails
    Care of, by patient, nurse, member of family, or combination
  - 3 Hair
    - (a) Shampoo by patient, nurse, member of family, beautician, or combination
    - (b) Where shampooed and type of equipment used or needed
    - (c) Usual method
  - 4 Shaving
    - (a) By patient, nurse, member of family, barber, or combination
    - (b) Usual method and equipment used
    - (c) Frequency
- B Grooming and appearance
  - 1 General appearance
    - (a) Neat (c) Interest in
    - (b) Untidy
  - 2 Use of cosmetics
    - (a) Used by self or with help
    - (b) Interest in

3 Combing hair
(a) By self, nurse, member of family, or combination
(b) Special device necessary
4 Dressing
(a) By self, nurse, member of family, or combination
(b) Special devices used
(c) Difficulties involved, need for practice

C Eating
1 Type of food
(a) Regular
(b) Special diet
2 Appetite
3 Likes and dislikes
4 Accomplished by self, nurse, member of family, or combination
5 Special devices or setup necessary

D Elimination
1 Continent
2 Incontinent
3 Constipation
4 Amount of urinary output
5 Habit
6 Need for special training schedule and management—bladder and bowel
7 Facility used
(a) Bedpan
(b) Commode
(c) Toilet
(d) Special equipment

E Activity
1 Bed activities
Ability to turn, lift, pull, balance, attain sitting position
2 Special devices for bed activity
(a) Bars
(b) Trapeze
(c) Others
3 Ability to go from bed to chair, from bed to wheelchair, from wheelchair to chair
4 Ability to return to bed
5 Ability to stand
6 Walking and stair climbing
7 Use of any devices in standing and walking
8 Tolerance for activity
9 Amount of activity advised in comparision to that carried out
10 Activity on unit and activity off unit
11 Ability to move about in house and how
12 Ability to go outside house and how
13 Ability in managing transportation

F Rest
1 Usual habit
2 Habit on hospital unit
3 Habit since illness
4 Prescribed amount in comparison to amount taken
5 Problems of maintaining or securing rest—when and how helped

III Special teachings for future
(Need for special teaching may be in relation to any of above activities)

A Special diet—selection, purchase, and preparation of food
B Administering medication
1 Purchasing and obtaining medication and necessary equipment
2 Method

C Household activities
1 Easier ways of managing
2 Relocation of articles in home
3 Scheduling activities

D Care of other members of family by patient
E Care of patient by other members of family
F Provision for follow-up of patient and reevaluation

Maintaining the patient

■ **Physical capacities.** Although the nurse may begin with recognizing the patient's emotional strengths and weaknesses, at the same time she should be assessing carefully his physical strengths and weaknesses. The patient should be kept as active as possible within the limitations set by his diagnosis and the physician's prescribed regimen. The nurse should be particularly attentive to the maintenance of activity in the case of patients who are confined to bed or who have severely restricted activity. Patients who have partial restriction of activity and are left without encouragement to move may readily develop limitations in motion or contractures.

Patients confined to bed or allowed only limited activity will have problems of body mechanics. Helping the patient to keep as active as possible within his limitations and to keep good bodily alignment may enable him to resume usual activities sooner. The nurse should have a thorough understanding of joint motion and either should help the patient go through the full range of motion or should move each joint through its range of motion once or twice daily, or as often as necessary to preserve the ability to move freely. The daily bath and assistance with self-care activities provide excellent opportunities for helping to preserve mobility. The nurse should know the ranges of motion in a systematic fashion and should familiarize herself with their terminology (Figs. 1-2 to 1-4). As she helps the patient to preserve motion, she should teach the importance of these activities to both patient and family.

If a patient has lost an extremity (amputation) or has loss of function (paralysis), careful attention given to bed posture, changes in position, and follow-through on exercise programs will help prevent development of additional disability. Many patients who require extended periods of bed rest can be helped to maintain muscle tone by use of a footboard, foot exercises, quadriceps setting, self-care within the limits permitted, correct position, and frequent turning unless contraindicated. If there is doubt about the appropriateness of certain exercises, the physician should be consulted.