Nursing Procedures

Fourth Edition

- Bedside care
- Equipment
- Nursing alerts
- Complications
- Documentation

LIPPINCOTT WILLIAMS & WILKINS

NURSING PROCEDURES

Fourth Edition

LIPPINCOTT WILLIAMS & WILKINS
A **Wolters Kluwer** Company
Philadelphia • Baltimore • New York • London
Buenos Aires • Hong Kong • Sydney • Tokyo

Staff

Executive Publisher
Judith A. Schilling McCann, RN, MSN

Editorial Director
H. Nancy Holmes

Clinical Director
Joan M. Robinson, RN, MSN

Senior Art Director
Arlene Putterman

Editorial Project Manager
Jennifer P. Kowalak

Editor
Elizabeth Jacqueline Mills

Clinical Editors
Joanne M. Bartelmo, RN, MSN;
Melissa M. Devlin, PharmD (drug information editor);
Mary Perrong, RN, CRNP, MSN, APRN,BC, CPAN

Copy Editors
Kimberly Bilotta (supervisor), Tom DeZego,
Carolyn Peterson, Irene Pontarelli, Dorothy P. Terry,
Bill Wine, Pamela Wingrod

Designers
Debra Moloshok (book design),
Kris Magyaritz (cover graphics)

Digital Composition Services
Diane Paluba (manager), Joyce Rossi Biletz,
Donna S. Morris

Manufacturing
Patricia K. Dorshaw (director), Beth Janae Orr

Editorial Assistants
Megan L. Aldinger, Tara L. Carter-Bell, Linda K. Ruhf

Librarian
Wani Z. Larsen

Indexer
Barbara Hodgson

NP4-D N O S A J J M A M F
06 05 04 10 9 8 7 6 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Nursing procedures.— 4th ed.
p. ; cm.
Includes bibliographical references and index.
1. Nursing. I. Lippincott Williams & Wilkins.
[DNLM: 1. Nursing Care. WY 100 N9755 2004]
RT41.N886 2004
610.73—dc22
ISBN 1-58255-281-9 (alk. paper) 2003022622

Advisory board

Contributors

Marguerite S. Ambrose, RN, DNSc, APRN, BC
Faculty
Department of Nursing
Immaculata (Pa.) University

Margaret E. Barnes, RN, MSN
Staff RN
Samaritan Regional Health System
Ashland, Ohio

Dorothy L. Borton, RN, BSN, CIC
Infection Control Practitioner
Albert Einstein Healthcare Network
Philadelphia

Darlene Nebel Cantu, RNC, MSN
Director
Baptist Health System School of Professional Nursing
San Antonio, Tex.

Diane M. Ellis, RN, MSN, CCRN, CS
Healthcare Consultant
Philadelphia

Colleen M. Fries, RN, MSN, CRNP, CCRN
Family Nurse Practitioner
Newtown (Pa.) Primary Care
Trauma Clinical Resource Nurse
Abington (Pa.) Memorial Hospital

Linda Fuhrman, RN, MSN, ANP, ANCC
Nurse Practitioner
San Francisco Veterans Administration Medical Center

Sandra Hamilton, RN, BSN, MEd, CRNI
Western Regional Coordinator of Pharmacy Nursing Services
Kindred Pharmacy Services
Las Vegas

Allan Hinton, RN, BSP
Clinical Application Coordinator
Tuscalossa (Ala.) Veterans Affairs Medical Center

JoAnne Konick-McMahan, RN, MSN, CCRN
Advance Practice Nurse
University of Pennsylvania School of Nursing
Philadelphia

Catherine Todd Magel, RN, EdD, BC
Assistant Professor
Villanova (Pa.) University College of Nursing

Ellen J. Mangin, RN, MSN, CWOCN, CRNP, CS
Nurse Practitioner
Rydal (Pa.) Park

Gladys Purvis, RN, MSN, CCRN
Clinical Leader
Abington (Pa.) Memorial Hospital

Nancy V. Runta, RN,C, MSN, CCRN
Magnet Coordinator
Grand View Hospital
Sellersville, Pa.

Lisa A. Salamon, RNC, MSN, CNS, ET
Clinical Nurse Specialist
Cleveland Clinic Foundation

Cynthia C. Small, RN, MSN, APRN,BC, FNP
Nursing Instructor
Lake Michigan College
Benton Harbor, Mich.

Douglas M. Turner, RN, MSN, CNS, CRNA, PhD(C)
Lead Instructor
Forsyth Technical Community College
Winston-Salem, N.C.

We extend special thanks to the following people, who contributed to the previous edition.

Melody C. Antoon, RN, MSN

Vicki L. Buchfa, RN, MS

Sherry Buffington, RN, CCRN, CLA (ASCP)

Kathleen C. Byington, RN, MSN, CS

Ellie Z. Franges, RN, MSN, CS, CCRN

Florence Jones, RN, MSN

Christine A. Kogel, RN, BSN

Charles F. Krozek, RN, MN

Kathleen M. Malloch, RN, BSN, MBA, PhD-C

Rebecca M. McCaskey, RN,C, MEd

Karen M.J. McCleave, RN, PhD, CIC, CFNP

Cheryl Milford, RN, MS, MBA, CCRN

Mary Beth Modic, RN,C, MSN

Lois Ann Piano, RN,C, MSN

Frances W. Quinless, RN, PhD

Janet Holman Rhorer, RN, MSN, EdD

Daniele A. Shollenberger, RN, MSN

Sarah E. Whitaker, RN,C, MSN

Myrtle Taylor Williams, RN, DNSc

Foreword

Congratulations on your selection of *Nursing Procedures,* Fourth Edition, as part of your professional reference library! In these times of rapidly changing technology and increasingly proactive patients, it's essential to have available reference materials that provide critical information to help us in practice and to help answer patients' questions. Nursing students and novice and experienced practitioners will find this book extremely useful as a practical guide to the many tasks of patient care.

Nursing Procedures, Fourth Edition, offers an excellent blend of theoretical and practical information. More than 300 procedures are presented ranging from the basic to the complex — everything from bed making to administration of chemotherapeutic drugs. New topics include surgical site verification, impaired swallowing and aspiration precautions, pericardiocentesis, ST-segment monitoring, femoral compression, prone positioning, bispectral index monitoring, jugular venous oxygen saturation monitoring, and bladder ultrasonography.

Also new to this edition is a chapter devoted to psychiatric care, which describes 11 psychiatric care procedures and focuses on the special needs of psychiatric patients.

The first chapters of the book center on the most fundamental procedures common to nursing practice in a variety of settings. They cover physical assessment and maintenance of a safe environment for your patients; infection control; specimen collection and testing; physical treatments, including heat and cold, support devices, and wound care; and the administration of topical, enteral, parenteral, and I.V. medications. Because you may need to delegate some of these responsibilities, these first chapters can be used in orientation and in service education to ensure the skills of your personnel.

Building on the fundamental procedures, the chapters that follow cover nursing activities organized by body system, covering the critical aspects of monitoring, managing, and treating patients with alterations in these major systems. The last four chapters focus on the special procedural needs of our most medically vulnerable populations — maternal-neonatal, pediatric, geriatric, as well as mental health patients. The maternal-neonatal care chapter covers assessment and procedures of the prenatal, labor and delivery, postpartum, and neonate stages. The pediatric care chapter covers medication administration in detail with information helpful in acute care as well as home settings. The geriatric care chapter also focuses on procedures and medication administration issues that occur with elderly patients across all settings.

Each chapter follows a standardized format that makes *Nursing Procedures,* Fourth Edition, so user-friendly. A brief *Introduction* outlines what's to be covered. This is followed by *Equipment,* a listing of the necessary equipment and *Preparation of equipment,* which outlines in detail how the nurse prepares for the procedure. *Implementation* gives step-by-step guidance on how to carry out the procedure. *Special considerations* assists the nurse to troubleshoot situations that deviate from the expected so that patient comfort and safety are ensured. When appropriate, the *Home care* section describes tips on discharge planning and patient teaching should the procedure be done in the patient's home. *Complications* alerts the nurse to situations that may contraindicate the procedure, or call for a modification in the procedure. *Documentation* provides clear direction on how to complete an accurate written record concerning the procedure. Each chapter ends with a list of current references for further reading.

Throughout the book, the reader's attention is drawn to critical information through the use of graphic icons announcing *Pediatric, Elder,* and *Nursing alerts.* The pediatric and elder alerts immediately tailor the procedure to these patient populations. The nursing alert focuses the nurse on critical thinking related to the particular procedure. Additional features of the book include numerous charts, diagrams, and illustrations that make the information clear and concise.

Nursing Procedures, Fourth Edition, will be a helpful resource to you, the nurse, throughout your daily practice.

Christena Langley, RN, PhD
Assistant Professor
Assistant Dean for Undergraduate Programs
College of Nursing and Health Science
George Mason University
Fairfax, Virginia

Contents

1 ■ FUNDAMENTAL PROCEDURES

Marguerite S. Ambrose, RN, DNSc, APRN,BC
Frances W. Quinless, RN, PhD

INTRODUCTION

Patients come to hospitals and other health care facilities because they need skilled clinical observation and treatment. According to the American Hospital Association, about 37 million people undergo hospitalization each year, and for most, it's a trying experience. After all, hospitalization challenges the patient's sense of privacy and control of his life. He must relinquish at least part of his normal routine. He must rely on you and your coworkers to meet his fundamental needs. Depending on the complexity of his health problem, he and his family may also require teaching, counseling, coordination of services, development of community support systems, and help in coping with health-related changes in his life.

In many facilities, staff nurses, primary nurses, clinical nurse specialists, and nurse practitioners deliver these vital services. This chapter serves as a starting point to help you understand and perform many of these tasks confidently and effectively. It thoroughly covers all the fundamentals: admission, transfer, and discharge procedures; assessment (including a section on writing a nursing care plan); ensuring patient safety and mobility (including proper use of restraints and assistive devices); practicing correct body mechanics and patient transfer techniques; and using special orthopedic beds. The chapter also includes a comprehensive review of personal hygiene and comfort measures, nutrition, elimination, surgical care, spiritual care, and postmortem care.

Before turning to these nursing care specifics, however, review the broader aims of your care such as helping the patient cope with restricted mobility; giving him a comfortable, stimulating environment; making sure his stay is free from hazards; promoting an uneventful recovery; and helping him return to his normal life.

Dealing with restricted mobility

Whenever a patient's condition impairs or prevents mobility, your nursing goals include promoting his independence by motivating him; helping him set goals, to prevent injury and the complications of immobility; teaching him needed skills; and fostering a positive body image, especially if he faces long-term or permanent immobility.

Promoting a comfortable environment

By manipulating physical factors in the patient's environment — temperature, humidity, lighting — you can affect his comfort, condition and, at times, his response to treatment. For example, a room temperature of 68° to 72° F (20° to 22.2° C) and a relative humidity of 30% to 60%, although comfortable for most patients, may be too cold for elderly patients. Also, proper artificial or natural lighting helps duplicate the day-night cycle.

Providing sensory stimulation

Sensory stimulation (such as therapeutic touch) contributes to patient well-being. Although the amount and type of required stimulation varies with each patient, you can prevent sensory overload or deprivation by accurately assessing his needs. When evaluating stimuli in the patient's environment, remember that illness is a stressor that may intensify the patient's responses, especially to noise and odors.

Promoting safety

Besides weakening the patient, illness and any accompanying treatment may impair his judgment and contribute to accidents. Be alert to hazards in the patient's environment, and teach him and his family to recognize and correct them. When caring for a patient with restricted mobility, you must help him as he's moved, lifted, and transported. By using proper body mechanics and appropriate assistive devices, you can prevent injury, fatigue, and discomfort for the patient and yourself.

Preventing complications

For the bedridden patient, immobility poses special hazards such as pressure on bony prominences; venous, pulmonary, and urinary stasis; and disuse of muscles and joints. These can lead to such complications as pressure ulcers, thrombi, phlebitis, pneumonia, urinary calculi, and contractures. To prevent complications, be sure to use correct positioning, meticulous skin care, assistive devices, and regular turning and range-of-motion exercises.

Promoting rehabilitation

The first step toward rehabilitation typically is progressive ambulation, which should begin as soon as possible — if necessary, using such assistive devices as a cane, crutches, or a walker. Effective rehabilitation may also require you to teach positioning, transfer, and mobilization techniques to the patient and his family. Give him and his family the opportunity to demonstrate the skill or technique so that problems may be corrected. Demonstrating a technique — such as transferring from a bed to a wheelchair — during hospitalization helps the patient and his family to understand it. Allowing them to practice it under your supervision gives them the confidence to perform it at home. Encourage them to provide positive reinforcement to motivate the patient to work toward his goals.

ADMISSION, TRANSFER, AND DISCHARGE PROCEDURES

ADMISSION

Admission to the nursing unit prepares the patient for his stay in the health care facility. Whether the admission is scheduled or follows emergency treatment, effective admission procedures should accomplish the following goals: verify the patient's identity and assess his clinical status, make him as comfortable as possible, introduce him to his roommates and the staff, orient him to the environment and routine, and provide supplies and special equipment needed for daily care.

Because admission procedures can color the patient's perception of the environment, they have a significant impact on subsequent treatment. Admission routines that are efficient and show appropriate concern for the patient can ease his anxiety and promote cooperation and receptivity to treatment. Conversely, admission routines that the patient perceives as careless or excessively impersonal can heighten anxiety, reduce cooperation, impair his response to treatment, and perhaps aggravate symptoms.

Equipment

Gown ▪ personal property form ▪ valuables envelope ▪ admission form ▪ nursing assessment form, if appropriate ▪ thermometer ▪ emesis basin ▪ bedpan or urinal ▪ bath basin ▪ water pitcher, cup, and tray ▪ urine specimen container, if needed.

An admission pack usually contains soap, comb, toothbrush, toothpaste, mouthwash, water pitcher, cup, tray, lotion, facial tissues, and thermometer. Because the patient's pack is included in his bill, he can take it home with him. An admission pack helps prevent cross-contamination and increases nursing efficiency.

Preparation of equipment

Obtain a gown and an admission pack.

Position the bed as the patient's condition requires. If the patient is ambulatory, place the bed in the low position; if he's arriving on a stretcher, place the bed in the high position. Fold down the top linens.

Prepare any emergency or special equipment, such as oxygen or suction, as needed.

Implementation

- Adjust the room lights, temperature, and ventilation.
- Make sure all equipment is in working order prior to the patient's admission.

Admitting the adult patient

- Speak slowly and clearly, greet the patient by his proper name, and introduce yourself and any staff present.
- Compare the name and number on the patient's identification bracelet with that listed on the admission form. Verify the name and its spelling with the patient. Notify the admission office of any corrections.
- Quickly review the admission form and the physician's orders. Note the reason for admission, any restrictions on activity or diet, and any orders for diagnostic tests requiring specimen collection.
- Escort the patient to his room and, if he isn't in great distress, introduce him to his roommate. Then wash your hands, and help him change into a gown or pajamas; if the patient is sharing a room, provide privacy. Itemize all valuables, clothing, and prostheses on the nursing assessment form or in your notes if your facility doesn't use such a form. Encourage the patient to store valuables or money in the safe or, preferably, to send them home along with any medications he may have brought with him. Show the ambulatory patient where the bathroom and closets are located.
- Take and record the patient's vital signs, and collect specimens if ordered. Measure his height and weight if possible. If he can't stand, use a chair or bed scale and ask him his height. *Knowing the patient's height and weight is important for planning treatment and diet and for calculating medication and anesthetic dosages.*
- Show the patient how to use the equipment in his room. Be sure to include the call system, bed controls, TV controls, telephone, and lights.
- Explain the routine at your health care facility. Mention when to expect meals, vital sign checks, and medications. Review visiting hours and any restrictions.
- Take a complete patient history. Include all previous hospitalizations, illnesses, and surgeries; current drug therapy; and food or drug allergies. Ask the patient to tell you why he came to the facility. Record the answers (in the patient's own words) as the chief complaint. Follow up with a physical assessment, emphasizing complaints. Record any wounds, marks, bruises, or discoloration on the nursing assessment form.
- After assessing the patient, inform him of any tests that have been ordered and when they're scheduled. Describe what he should expect.
- Before leaving the patient's room, make sure he's comfortable and safe. Adjust his bed, and place the call button

USING PATIENT CARE REMINDERS

When placed at the head of the patient's bed, care reminders call attention to the patient's special needs and help ensure consistent care by communicating these needs to the hospital staff, the patient's family, and other visitors.

You can use a specially designed card or a plain piece of paper to post important information about the patient, such as:

- allergies
- dietary restrictions
- fluid restrictions
- specimen collection
- patient deaf or hearing-impaired in right ear
- foreign-language speaker.

You can also use care reminders to post special instructions, such as:

- complete bed rest
- no blood pressure on right arm
- turn every 1 hour
- nothing by mouth.

Never violate the patient's privacy by posting his diagnosis, details about surgery, or any information he might find embarrassing.

and other equipment (such as water pitcher and cup, emesis basin, and facial tissues) within easy reach. Raise the side rails.

Post patient care reminders (concerning such topics as allergies or special needs) at the patient's bedside *to notify coworkers.* (See *Using patient care reminders.*)

Admitting the pediatric patient

- Your initial goal will be to establish a friendly, trusting relationship with the child and his parents *to help relieve fears and anxiety, which can hinder treatment.* Remember that a child under age 3 may fear separation from his parents; an older child may worry about what will happen to him.
- Speak directly to the child, and allow him to answer questions before obtaining more information from his parents.
- While orienting the parents and child to the unit, describe the layout of the room and bathroom, and tell them the location of the playroom, television room, and snack room, if available.
- Teach the child how to call the nurse. Stress that she'll always be available to take care of his needs, such as helping him to the bathroom.
- Explain the facility's rooming-in and visiting policies *so the parents can take every opportunity to be with their child.*
- Inquire about the child's usual routine *so that favorite foods, bedtime rituals, toileting, and adequate rest can be incorporated into the routine.*
- Encourage the parents to bring some of their child's favorite toys, blankets, or other items *to make the child feel more at home amid unfamiliar surroundings.*

Special considerations

- If the patient doesn't speak English and isn't accompanied by a bilingual family member, contact the appropriate resource (usually the social services department) to secure an interpreter.
- Keep in mind that the patient admitted to the emergency department requires special procedures. (See *Managing emergency admissions.*)
- If the patient brings medications from home, take an inventory and record this information on the nursing assessment form. Instruct the patient not to take any medication unless authorized by the physician. Send authorized medications to the pharmacy for identification and relabeling. Send other medications home with a responsible family member, or store them in the designated area outside the patient's room until he's discharged. *The use of unauthorized medication may interfere with treatment or cause an overdose.*
- Find out the patient's normal routine, and ask him if he would like to make any adjustments to the facility regimen; for example, he may prefer to shower at night instead of in the morning. *By accommodating the patient with such adjustments whenever possible, you can ease his anxiety and help him feel more in control of his potentially threatening situation.*

Documentation

After leaving the patient's room, complete the nursing assessment form or your notes, as required. The completed form should include the patient's vital signs, height, weight, allergies, and drug and health history; a list of his belongings and those sent home with family members; the results of your physical assessment (see "Physical Assessment," page 24); and a record of specimens collected for laboratory tests.

TRANSFER

Patient transfer — either within your facility or to another one — requires thorough preparation and careful documentation. Preparation includes an explanation of the transfer to the patient and his family, discussion of the patient's condition and care plan with the staff at the receiving unit

or facility, and arrangements for transportation if necessary. Documentation of the patient's condition before and during transfer and adequate communication between nursing staffs ensure continuity of nursing care and provide legal protection for the transferring facility and its staff.

Equipment

Admission inventory of belongings ▪ patient's chart, medication record, and nursing Kardex ▪ medications ▪ bag or suitcase ▪ wheelchair or stretcher, as necessary.

Implementation

- Explain the transfer to the patient and his family. If the patient is anxious about the transfer or his condition precludes patient teaching, be sure to explain the reason for the transfer to his family members, especially if the transfer is the result of a serious change in the patient's condition. Assess his physical condition *to determine the means of transfer,* such as a wheelchair or a stretcher.
- Using the admissions inventory of belongings as a checklist, collect the patient's property. Be sure to check the entire room, including the closet, bedside stand, overbed table, and bathroom. If the patient is being transferred to another facility, don't forget valuables or personal medications that have been stored.
- Gather the patient's medications from the cart and the refrigerator. If the patient is being transferred to another unit, send the medications to the receiving unit; if he's being transferred to another facility, return them to the pharmacy.
- Notify the business office and other appropriate departments of the transfer.
- Have a staff person notify the dietary department, the pharmacy, and the facility telephone operator about the transfer (if within the facility).
- Contact the nursing staff on the receiving unit about the patient's condition and drug regimen and review the patient's nursing care plan with them *to ensure continuity of care.*

Transfer within the facility

- If the patient is being transferred from or to an intensive care unit, your facility may require new care orders from the patient's physician. If so, review the new orders with the nursing staff at the receiving unit.
- Send the patient's chart, laboratory request slips, Kardex, special equipment, and other required materials to the receiving unit.
- Use a wheelchair to transport the ambulatory patient to the newly assigned room unless it's on the same unit as his present one, in which case he may be allowed to walk. Use a stretcher to transport the bedridden patient.

MANAGING EMERGENCY ADMISSIONS

For the patient admitted through the emergency department (ED), immediate treatment takes priority over routine admission procedures. After ED treatment, the patient arrives on the nursing unit with a temporary identification bracelet, a physician's order sheet, and a record of treatment. Read this record and talk to the nurse who cared for the patient in the ED to ensure continuity of care and to gain insight into the patient's condition and behavior.

Next, record any ongoing treatment, such as an I.V. infusion, in your notes. Take and record the patient's vital signs, and follow the physician's orders for treatment. If the patient is conscious and not in great distress, explain any treatment orders. If family members accompany the patient, ask them to wait in the lounge while you assess the patient and begin treatment. Permit them to visit the patient after he's settled in his room. When the patient's condition allows, proceed with routine admission procedures.

- Introduce the patient to the nursing staff at the receiving unit. Then take the patient to his room and, depending on his condition, place him in the bed or seat him in a chair. Introduce him to his new roommate, if appropriate, and tell him about any unfamiliar equipment such as the call bell.

Transfer to an extended-care facility

- Make sure the patient's physician has written the transfer order on his chart and has completed the special transfer form. This form should include the patient's diagnosis, care summary, drug regimen, and special care instructions, such as diet and physical therapy.
- Complete the nursing summary, including the patient's assessment, progress, required nursing treatments, and special needs, *to ensure continuity of care.*
- Keep one copy of the transfer form and the nursing summary with the patient's chart, and forward the other copies to the receiving facility. However, don't send the patient's medications, Kardex, or chart. A transcript of the chart may be requested by the receiving facility.

Transfer to an acute-care facility

- Make sure the physician has written the transfer order on the patient's chart and has completed the transfer form as discussed above. Then complete the nursing summary.

DEALING WITH A DISCHARGE AGAINST MEDICAL ADVICE

Occasionally, the patient or his family may demand discharge against medical advice (AMA). If this occurs, notify the physician immediately. If the physician fails to convince the patient to remain in the facility, he'll ask the patient to sign an AMA form releasing the facility from legal responsibility for any medical problems the patient may experience after discharge.

If the physician isn't available, discuss the discharge form with the patient and obtain his signature. If the patient refuses to sign the AMA form, don't detain him – doing so violates his legal rights. After the patient leaves, document the incident thoroughly in your notes and notify the physician.

■ Depending on the physician's instructions, send one copy of the transfer form and nursing summary and photocopies of pertinent excerpts from the patient's chart — such as laboratory test and X-ray results, patient history and physical progress notes, and records of vital signs — to the receiving facility with the patient. Alternatively, following your facility's policy, substitute a written summary of the patient's condition and facility history for the excerpts from the patient's chart. Make sure this information is complete. If the Kardex isn't considered part of the patient's record in your facility, be sure to document all pertinent information for the receiving institution — by photocopying the nurse's notes if necessary. *This information legally protects the transferring facility and its staff and completes the patient's chart.*

Special considerations

■ If the patient requires an ambulance to take him to another facility, arrange transportation with the social services department. Ensure that the necessary equipment is assembled to provide care during transport.

■ Be especially careful that all documentation is complete when the patient is being transferred to another facility. *A communications breakdown can hurt the patient's chances for recovery.*

■ If the patient is being transferred to a different facility, make sure none of these patient care measures have been omitted: suctioning of airway, administering prescribed medications, changing soiled dressing, bathing an incontinent patient, and emptying drainage collection devices.

Documentation

Record the time and date of transfer, the patient's condition during transfer, the name of the receiving unit or facility, and the means of transportation.

DISCHARGE

Although discharge from a health care facility is usually considered routine, effective discharge requires careful planning and continuing assessment of the patient's needs during his hospitalization. Ideally, discharge planning begins shortly after admission. Discharge planning aims to teach the patient and his family about his illness and its effect on his lifestyle, to provide instructions for home care, to communicate dietary or activity instructions, and to explain the purpose, adverse effects, and scheduling of drug treatment. It can also include arranging for transportation, follow-up care if necessary, and coordination of outpatient or home health care services.

Equipment

Wheelchair, unless the patient leaves by ambulance ▪ patient's chart ▪ patient instruction sheet ▪ discharge summary sheet ▪ plastic bag or patient's suitcase for personal belongings.

Implementation

■ Before the day of discharge, inform the patient's family of the time and date of discharge. If the patient's family can't arrange transportation, notify the social services department. (Always confirm arranged transportation on the day of discharge.)

■ Obtain a written discharge order from the physician. If the patient discharges himself against medical advice, obtain the appropriate form. (See *Dealing with a discharge against medical advice.*)

■ If the patient requires home medical care, confirm arrangements with the appropriate facility department or community agency.

■ On the day of discharge, review the patient's discharge care plan (initiated on admission and modified during his hospitalization) with the patient and his family. List prescribed drugs on the patient instruction sheet along with the dosage, prescribed time schedule, and adverse reactions that he should report to the physician. Ensure that the drug schedule is consistent with the patient's lifestyle *to prevent improper administration and to promote patient compliance.* (See *Discharge teaching goals.*)

■ Review procedures the patient or his family will perform at home. If necessary, demonstrate these procedures, pro-

vide written instructions, and check performance with a return demonstration.

- List dietary and activity instructions, if applicable, on the patient instruction sheet, and review the reasons for them. If the physician orders bed rest, make sure the patient's family can provide daily care and will obtain necessary equipment.
- Check with the physician about the patient's next office appointment; if the physician hasn't yet done so, inform the patient of the date, time, and location. If scheduling is your responsibility, make an appointment with the physician, outpatient clinic, physical therapy, X-ray department, or other health services, as needed. If the patient can't arrange transportation, notify the social services department.
- Retrieve the patient's valuables from the facility's safe and review each item with him. Then obtain the patient's signature *to verify receipt of his valuables.*
- Obtain from the pharmacy any drugs the patient brought with him. Return these to the patient if drug therapy is unchanged. If giving a new prescription, provide an explanation of the dosage, schedule, and adverse effects.
- If appropriate, take and record the patient's vital signs on the discharge summary form. Notify the physician if any signs are abnormal such as an elevated temperature. *If necessary, the physician may alter the patient's discharge plan.*
- Help the patient get dressed if necessary.
- Collect the patient's personal belongings from his room, compare them with the admission inventory of belongings, and help place them in his suitcase or a plastic bag.
- After checking the room for misplaced belongings, help the patient into the wheelchair, and escort him to the exit; if the patient is leaving by ambulance, help him onto the litter. If the patient's family hasn't already made arrangements for payment, contact the business office.
- After the patient has left the area, strip the bed linens and notify the housekeeping staff that the room is ready for terminal cleaning.

Special considerations

- Whenever possible, involve the patient's family in discharge planning *so they can better understand and perform patient care procedures.*
- Before the patient is discharged, perform a physical assessment. If you detect abnormal signs or the patient develops new symptoms, notify the physician and delay discharge until he has seen the patient.

Documentation

Although your facility's policy determines the extent and form of discharge documentation, you'll usually record the time and date of discharge, the patient's physical condition, special dietary or activity instructions, the type and frequency of home care procedures, the patient's drug regimen, the dates of follow-up appointments, the mode of departure and name of the patient's escort, and a summary of the patient's hospitalization if necessary.

HOME CARE

DISCHARGE TEACHING GOALS

Your discharge teaching should aim to ensure that the patient:

- understands his illness
- complies with his drug therapy
- carefully follows his diet
- manages his activity level
- understands his treatments
- recognizes his need for rest
- knows about possible complications
- knows when to seek follow-up care.

Remember that your discharge teaching must include the patient's family or other caregivers to ensure that the patient receives proper home care.

ASSESSMENT

TEMPERATURE

Body temperature represents the balance between heat produced by metabolism, muscular activity, and other factors and heat lost through the skin, lungs, and body wastes. A stable temperature pattern promotes proper function of cells, tissues, and organs; a change in this pattern usually signals the onset of illness.

Temperature can be measured with a mercury, an electronic digital, or a chemical-dot thermometer. Oral temperature in adults normally ranges from 97° to 99.5° F (36.1° to 37.5° C); rectal temperature, the most accurate reading, is usually 1° F (0.6° C) higher; axillary temperature, the least accurate, reads 1° to 2° F (0.6° to 1.1° C) lower; and tympanic temperature reads 0.5° to 1° (0.3° to 0.6° C) higher.

Temperature normally fluctuates with rest and activity. Lowest readings typically occur between 4 and 5 a.m.; the highest readings occur between 4 and 8 p.m. Other factors

also influence temperature, including gender, age, emotional conditions, and environment. Keep the following principles in mind. Women normally have higher temperatures than men, especially during ovulation. Normal temperature is highest in neonates and lowest in elderly persons. Heightened emotions raise temperature; depressed emotions lower it. A hot external environment can raise temperature; a cold environment lowers it.

Equipment

Thermometer (mercury, electronic, chemical-dot, or tympanic) ▪ water-soluble lubricant or petroleum jelly (for rectal temperature) ▪ facial tissue ▪ disposable thermometer sheath or probe cover (except for chemical thermometer) ▪ alcohol pad.

Preparation of equipment

If a thermometer is included in the admission pack, keep it at the patient's bedside and, on discharge, allow him to take it home. Otherwise, obtain a thermometer from the nurses' station or central supply department. If you use an electronic thermometer, make sure it's been recharged. (See *Types of thermometers.*)

Implementation

■ Explain the procedure to the patient, and wash your hands. If the patient has had hot or cold liquids, chewed gum, or smoked, wait 15 minutes before taking an oral temperature.

Using a mercury thermometer

■ Hold the thermometer between your thumb and index finger at the end opposite the bulb.

■ If the thermometer has been soaking in a disinfectant, rinse it in cold water. *Rinsing removes chemicals that may irritate oral or rectal mucous membranes or axillary skin.* Avoid using hot water *because it expands the mercury, which could break the thermometer.* Using a twisting motion, wipe the thermometer from the bulb upward.

■ Then quickly snap your wrist several times while holding the thermometer to shake it down to below 98° F (36.7° C). *Shaking causes the mercury to descend into the bulb.* The mercury will then expand in response to the patient's body temperature and be forced upward.

■ To use a disposable sheath, disinfect the thermometer with an alcohol pad. Insert it into the disposable sheath opening; then twist to tear the seal at the dotted line. Pull it apart.

Using an electronic thermometer

■ Insert the probe into a disposable probe cover. If taking a rectal temperature, lubricate the probe cover *to reduce friction and ease insertion.* Leave the probe in place until the maximum temperature appears on the digital display.

Using a chemical-dot thermometer

■ Remove the thermometer from its protective dispenser case by grasping the handle end with your thumb and forefinger, moving the handle up and down to break the seal, and pulling the handle straight out. Keep the thermometer sealed until use.

Using a tympanic thermometer

■ Make sure the lens under the probe is clean and shiny. Attach a disposable probe cover.

■ Stabilize the patient's head; then gently pull the ear straight back (for children up to age 1) or up and back (for children age 1 and older to adults).

■ Insert the thermometer until the entire ear canal is sealed. The thermometer should be inserted toward the tympanic membrane in the same way that an otoscope is inserted. Then press the activation button and hold it for 1 second. The temperature will appear on the display.

■ **PEDIATRIC ALERT** *For infants younger than age 3 months, take three readings and use the highest.*

Taking an oral temperature

■ Position the tip of the thermometer under the patient's tongue, as far back as possible on either side of the frenulum linguae. *Placing the tip in this area promotes contact with superficial blood vessels and contributes to an accurate reading.*

■ Instruct the patient to close his lips but to avoid biting down with his teeth. *Biting can break the thermometer, cutting the mouth or lips or causing ingestion of broken glass or mercury.*

■ Leave a mercury thermometer in place for at least 2 minutes or a chemical-dot thermometer in place for 45 seconds *to register temperature;* for an electronic thermometer, wait until the maximum temperature is displayed.

■ For a mercury thermometer, remove and discard the disposable sheath; then read the temperature at eye level, noting it before shaking down the thermometer. For an electronic thermometer, note the temperature; then remove and discard the probe cover. For the chemical-dot thermometer, read the temperature as the last dye dot that has changed color, or fired; then discard the thermometer and its dispenser case.

Taking a rectal temperature

■ Position the patient on his side with his top leg flexed, and drape him to provide privacy. Then fold back the bed linens to expose the anus.