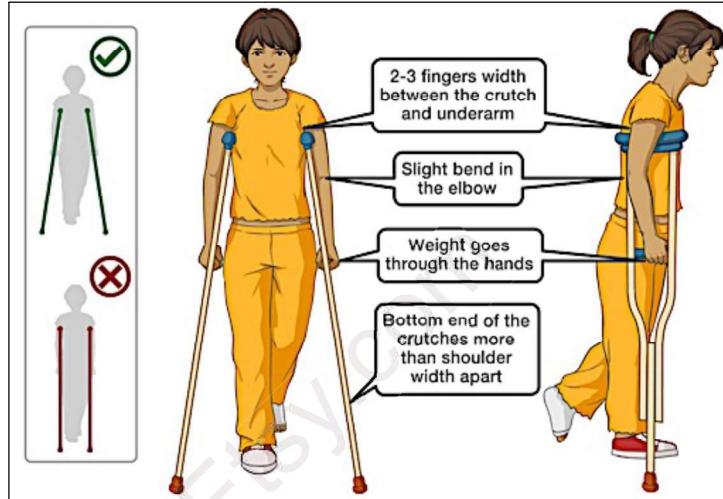


Lecture 4 • Mark Klimek • 96:58

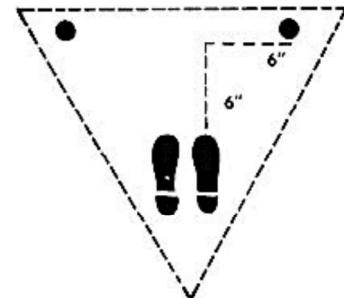
Crutches, Canes, Walkers

One of the major human functions is locomotion. Therefore, crutches, canes and walkers are tested on the NCLEX exam even though they are not really emphasized in school. Also, such knowledge is good for patient teaching. With that said, crutches, canes and walkers are devices used to help pts with an unstable gait, whose muscles are weak or who require a reduction in the load on weight-bearing structures.



How do you measure the length of crutches?

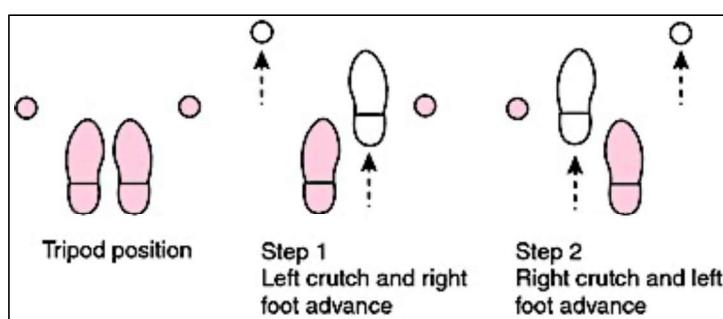
- Measuring crutches is important for risk reduction when ambulating and to avoid nerve problems
- The length of a crutch is measured by
 - Holding it vertically and placing the tip on the ground
 - Having **2 to 3 finger widths** between **the pad** and the **anterior axillary fold**
 - The tip is located to a **point lateral** (6 inches) and **slightly in front of foot** (6 inches)
- **Rule out landmarks on foot or say axilla!**
- Handgrip measurement
 - The angle of elbow flexion is 30 degrees
 - The wrists should be at the level of the handgrip



How to Teach Crutch Gaits?

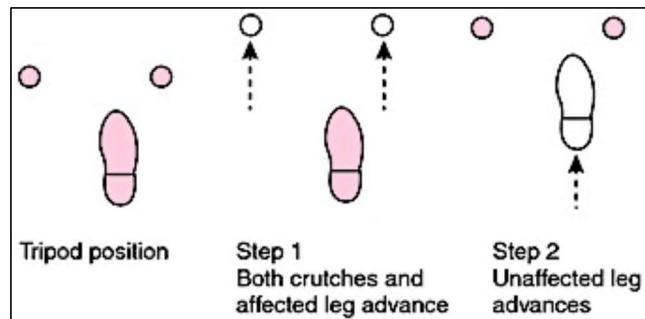
2-point gait—move a crutch and opposite foot together, then the other crutch with other foot together

- Together (Right leg & Left crutch)
→ Together (Left leg & Right crutch)
- For mild bilateral leg weaknesses



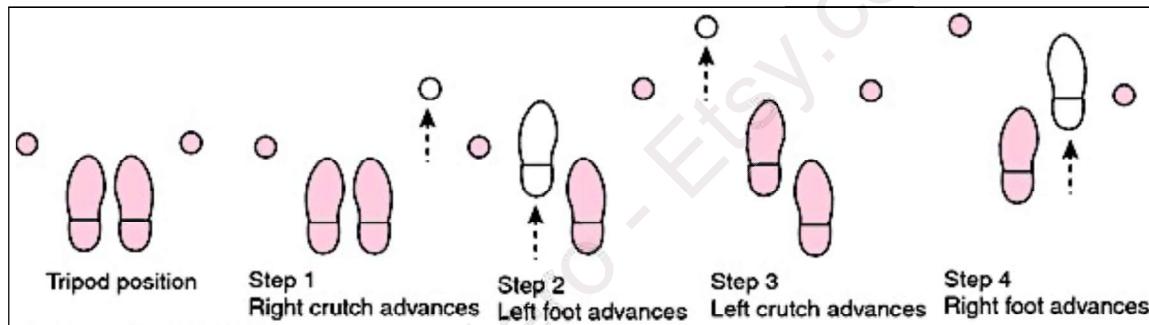
3-point gait—move (2 crutches & bad leg) together → Followed by unaffected leg

- The gait goes 3-1, 3-1, 3-1
- The affected (bad) leg is not on the ground
- The unaffected (good) leg is on the ground



4-point gait—move everything separately

- Move crutch → Move opposite foot → Followed by other crutch → Followed by opposite foot
- Right crutch → Left foot → Left crutch → Right foot
- 4-point gait is very slow but very stable



Swing-through is for non-weight bearing (amputees)

- Similar to 3-point gait
- The unaffected foot gets past the tip of both crutches
- The person may be an amputee or does not bear weight on the leg at all
- Can move really fast

When do you use these gaits?

- Use Even-point gait for even, odd-point gait for odd
- Use the even numbered gaits when weakness in the feet is evenly distributed
 - 2-point for mild problems
 - 4-point for severe
- Use the odd numbered gait when one leg is affected
 - 3-point for one leg
- If pt cannot bear weight or amputation
 - Swing-through

Example

A pt affected with early stages of rheumatoid arthritis. What gait should the pt use?

- Both legs affected (because it is a systemic disease)

- Early stage—mild
- 2-point gait

Example

A pt has left ATK (above the knee) amputation 2 days ago. What gait should the pt use?

- Non-weight bearing
- Swing-through

Example

Pt is first day postop, right knee, partial weight bearing allowed. What gait should the pt use?

- One leg affected
- Odd-numbered gait
- 3-point gait

Example

Pt is in advanced stages of ALS. What gait should the pt use?

- Bilateral leg weakness (because it is a systemic disease)
- Even-numbered gait
- Advanced stages = Severe
- 4-point gait

Example

Pt with left hip replacement, 2nd day postop on non-weight bearing instruction. What gait should the pt use?

- Non-weight bearing of 1 leg
- Swing-through gait

Example

Pt with bilateral (B/L) total knee replacement **first day postop**. Weight bearing is allowed. What gait should the pt use?

- Even-numbered gait = Bilateral
- Weight bearing
- First day postop = Severe
- 4-point gait

Example

Pt with bilateral total knee replacement **3 weeks postop**. What gait should the pt use?

- Even-numbered gait = Bilateral
- Weight bearing
- 3 weeks postop = mild
- 2-point

Going Up and Down the Stairs With Crutches

- Remember this phrase
 - “Up with the **Good**, and Down with the **Bad**”

- When you go up the stairs, the good foot move up first
- When you go down the stairs, the bad foot move down last
- But, no matter what
 - Both crutches always move with the bad leg

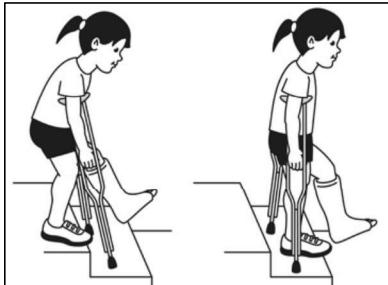


Figure 2. Crutcher.



Figure 3. Cane.

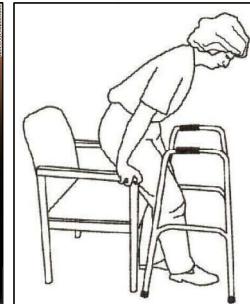


Figure 4. Walker.

Cane

- Hold cane on the **unaffected** (strong) side
- Advance cane with the opposite side for a wide base of support
- Handgrip should be at the level the wrist

Walker

- Correct way to use a walker
 - The walker is on the side of the pt, the pt **"Picks it up ... Sets it down ... Walks to it"**
 - Once the walker is in front of the pt, the pt **"Holds on to chair, Stands up, Then grabs walker"**
- Don't tie belongings to the front of the walker—Tie them to either side so it won't tip over
- The NCLEX board does not like tennis balls or wheels on walker can create problem

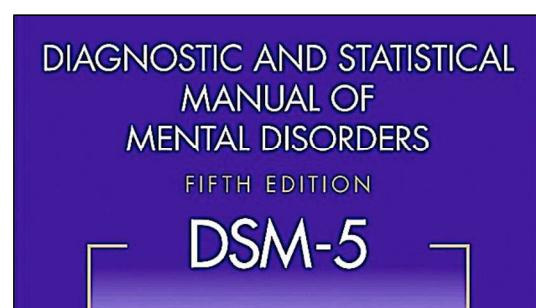
Psychiatry

First thing to ask in a psych question is: **"Is the pt psychotic or non-psychotic?"**

- The answer to this question will determine care plan, treatment, length of stay, legality, etc.

A **Non-psychotic** person has **insight** and is **reality based**. What kinds of answers do you pick for these people? What techniques do you use?

- **Good therapeutic communication** ... Looks like a Med/Surge pt
- Examples of therapeutic communications
 - That must be very difficult/overwhelming for you
 - How are you feeling?



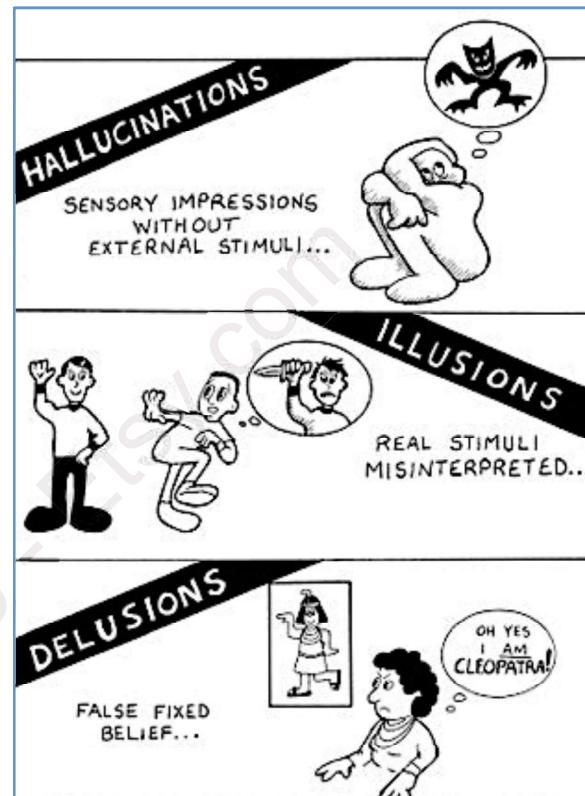
- Tell me more about your ...
- The exam is looking for “reflection, clarification, amplification, restatement, etc.”

The **Psychotic** person has **no insight** and is **not reality based**

- They don't think they're sick—everyone else has the problem
 - Examples are: delusions, hallucinations, illusions

Delusions, hallucination and illusion are psychotic symptoms

- **Delusions**—a false, fixed belief or **idea** or **thought**. There is no sensory component. It is all in your **head**. It is just a thought ... 3 types of delusion
 - **Paranoid**—People are out to get/kill me
 - **Grandiose**—“I'm Christ” ... “I am the President” ... “I am the world's smartest person”
 - **Somatic**—Body part (I have x-ray vision, there are worms inside my arm)
- **Hallucination**—a sensory experience
 - Auditory (1st m c)—voices telling you to harm yourself
 - Visual (2nd m c)—I see bugs on the wall
 - Tactile (3rd m c)—I feel bugs on my arm (Most common = m c)
 - Gustatory (taste)
 - Olfactory (smell)
- **Illusion**—a misinterpretation of reality. It is sensory



Differentiation between hallucination and illusion

- With illusion there is a **referent** in reality
 - A **referent** is something that both the clinician and the pt can refer to ... There is actually something there
 - The **cord** is a **snake**
- With hallucination, there is nothing there

Example

The pt staring at the empty wall says, “Listen, I hear demon voices.” Is that statement from the pt a hallucination and an illusion?

- There is no referent there
- This is a hallucination

Example

The same pt overhears nurses and doctors laughing and talking at the nursing station, and says, “I hear demon voices.” Is that statement from the pt a hallucination and an illusion?

- There is actually a referent (real people) there
- This is an illusion

Other examples

- A pt looks with a blank stare and says, “I see a bomb.”
 - This is a hallucination
- A pt looking at the fire extinguisher on the wall and says look, “I see a bomb.”
 - This is an illusion

How do you deal with these psychotic patients?

- To deal with these psychotic pt, the first thing to ask is what type of psychosis the pt has?

There are 3 types of psychosis

1. Functional psychosis
2. Psychosis of dementia
3. Psychosis of delirium

A. Functional psychosis—they can function in everyday life

- 90% of the followings make up this category
- Chemical imbalance in the brain
- They are “Skeezo, Skeezo, Major, Manics”
 - Schizophrenia, Schizoaffective disorder, Major depression (not depression), Mania

Example

- Bipolar = Depression and Mania
- Bipolar pts are psychotic in acute mania

B. Psychosis of dementia—what is their problem?

- Actual Brain destruction/damage
 - Due to Alzheimer, stroke, organic brain syndrome
 - Anything that says Senile/Dementia falls in the category

C. Psychotic Delirium—temporary, sudden, dramatic, episodic secondary to something else

- Loss of reality
 - Due to UTI, thyroid imbalance, adrenal crisis, electrolytes, medications/drugs

Recap

Approach to Answering Psychiatric Questions

- First thing to ask is
 - Is the pt **non-psychotic**? Or, is the pt **psychotic**?
- Pt is **non-psychotic**
 - Address pt as you would address any Med/Surg pts
 - Use therapeutic communication
- Pt is **psychotic**
 - Next, ask if they are **functional, demented, or delirious**?

Functional = (1) Acknowledge feeling, (2) Present reality, (3) Set limits, and (4) Enforce these limits

Demented = (1) Acknowledge their feeling, and (2) Redirect them—give them something they can do

Delirious = (1) Acknowledge feeling, (2) Reassurance about **safety** and **temporariness** of their condition

Functional Psychosis

- **Schizo, mood disorders thought process, and mania (chemicals out of whack)**
- This pt has the potential to learn reality (no brain damage)
- Your role as a nurse—teach reality
- Use the 4 step process to teach reality
 - (1) Acknowledge feeling, (2) Present reality, (3) Set limits, and (4) Enforce these limits

What does this look like in a question?

1. The answer acknowledges **pt's feeling** (look for the word “feel”)
You seem upset ... That is so sad ... It's been so difficult ... Tell me more about how you're feeling
2. Now, **present reality** ... “I know you see that demon, but I don't see a demon” ... Or, “I am a nurse, this is hospital, this is your breakfast”
3. **Set limit.** “We are not going to address that. Stop talking about...”
4. **Enforce limit.** “I see you're too ill, so our *conversation is over*.” Ends the conversation.
You're not punishing the client by taking away privileges

Psychosis of dementia

- They cannot learn reality ... Don't present it! They can't learn it! Thus frustrates them, and may discourage you!
- Deal with their problems in 2 steps
 - (1) Acknowledge their feeling, and (2) Redirect them—give them something they can do

Do not confuse not **presenting reality** with **reality orientation** (Person, place, and time)

- Reality orientation = Pt is oriented to person, place, and time

Example

- Alzheimer lady is the lobby of waiting area of her nursing home. It is Sunday and she is all dressed up. You say to her, “Mrs. Smith, you are all dressed up.” She said, “Yeah! My husband is going to pick me up. We are going to church.” The problem is that the husband has been dead for 10 years.
 - She has a false, fixed belief
 - She is delusional (or she is psychotic)
 - What do you say to her?
 - First, acknowledge her ... You say, “That sounds nice.” (**acknowledging**)
 - Second, redirect her ... You say, “Why don't we sit down here and talk about church? ... What church do you go to?” (**redirecting**)
 - Don't tell her husband is dead!, which is presenting reality

Psychosis of delirium

- This is temporary, **sudden**, dramatic, **episodic**, secondary loss to reality
- Usually due to some chemical imbalance in the body
- Causes—UTI, thyroid imbalance, adrenal crisis, electrolytes, medications/drugs
- To manage these pts, treat the underlying cause
 - Acknowledge feeling
 - Reassure them of **safety** and **temporariness** of their condition
- They lost touch with of reality—Redirect them is futile

Example

A pt with schizoaffective disorder who points to 2 people talking across the room. The pt says, “Those people are plotting to kill me.” What would you say? What is the most important word in the vignette?

- **Schizoaffective**—psychosis
- I can see that would be frightening. They are not plotting.
- We are not going to talk about that. I can see you are too ill. We are ending the conversation

Example

A pt with Alzheimer disease who during your conversation points to 2 people talking across the room and says, “You see these people, they are plotting to kill me”

- **Alzheimer Disease**—category is dementia
- Acknowledge feeling—“I understand you seem to be scared”
- Redirect—Let’s go somewhere you feel safe

Example

A pt with delirium tremens who during your conversation points to 2 people talking across the room and says, “You see these people, they are plotting to kill me”

- **Delirium tremens** ...
- “That must be scary”
- But you are safe. Your fear will go away when you get better

Psychotic symptoms

Loose associations

- **Flight of Ideas:** Rapid flow of thought
- **Word Salad:** Throw words together and toss out ... (Sicker than flight of ideas)
- **Neologisms:** Make it up
- **Narrowed self-concept:** When a psychotic refuse to change their clothes or leave the room. Leave them alone
 - This is a functional psychosis
 - **“Don’t make a psychotic do something they don’t want to do”**
- **Idea of reference:** You think everyone is talking about you



Dementia hallmark: Memory loss, inability to learn

- Always acknowledge feeling
- 2nd step always begins with “Re” ... Reassure, Redirect, Reality

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