

Crutches, Canes & Walkers — the Ultimate Guide

Fitting numbers, every gait pattern, stair rules, and the safety traps the NCLEX loves — mapped to the Clinical Judgment Measurement Model, with a 60-second cram strip at the end. Mark each section reviewed to track your progress.

coral · safety-critical

amber · caution & pearls

sage · expected findings

teal · key info & mnemonics

violet · special considerations

gold · highest-yield

SECTION 01 / 12

Before the First Step — Ambulation Readiness

Every assistive-device question begins with assessment. The NCLEX loves to test what the nurse verifies *before* the patient ever stands up.

ASSESS FIRST

Pre-ambulation checklist

- Orthostatic vital signs — compare lying → sitting → standing BP & HR
- Dangle at bedside 1–2 min; assess for dizziness before standing
- Muscle strength, balance, ROM, and prior mobility level
- Orientation, ability to follow directions, vision
- Pain — medicate ~30 min before, but watch for sedation
- Non-skid, well-fitting, hard-soled footwear (never socks alone)
- Secure IV lines, drains, catheters; lock bed & chair wheels
- Clear the path — no clutter, cords, spills, or throw rugs

HIGHEST YIELD

Gait belt rules

- Apply snugly over clothing around the **waist** — two fingers should slide under
- Grasp with an underhand grip at the back/side
- Walk **slightly behind and to the patient's weaker side**
- Never grab clothing or the arm to steady a patient
- Contraindicated/adapted with: abdominal or thoracic incisions, ostomies, G-tubes, severe cardiac or respiratory disease, abdominal aneurysm, pregnancy

SAFETY CRITICAL

If the patient starts to fall

- **Do not try to hold the patient upright** — control the descent
- Widen your stance, pull the patient close to your body using the gait belt
- Extend one leg and let the patient slide down it to the floor, protecting the head
- Bend your knees — protect your own back
- Stay with the patient, call for help, assess before moving, then document & complete an incident report (do not reference the report in the chart)

EXPECTED

Who fits which device?

- **Crutches** — young/strong patients with one-sided lower-extremity injury; require upper-body strength & balance
- **Cane** — mild, *one-sided* weakness (CVA, arthritis, minor balance loss); patient can bear weight on both legs
- **Walker** — generalized or bilateral weakness, poor balance, older adults; maximum stability of the three

SECTION 02 / 12

Weight-Bearing Prescriptions

The provider's weight-bearing order determines which device and which gait are even possible. Decode the abbreviation before you pick an answer.

ORDER	MEANING	PRACTICAL TRANSLATION
NWB	Non-weight-bearing	0% — affected foot never touches the floor. Think 3-point crutch gait or NWB walker technique.
TTWB / TDWB	Toe-touch / touch-down	Toes rest on floor for <i>balance only</i> ($\approx 10\%$) — no body weight through the limb.
PWB	Partial weight-bearing	A prescribed fraction (often 30–50%) through the affected limb. 4-point or 2-point gait possible.
WBAT	Weight-bearing as tolerated	Patient self-limits by pain and tolerance.
FWB	Full weight-bearing	100% — device may be for balance/support only.

PEARL

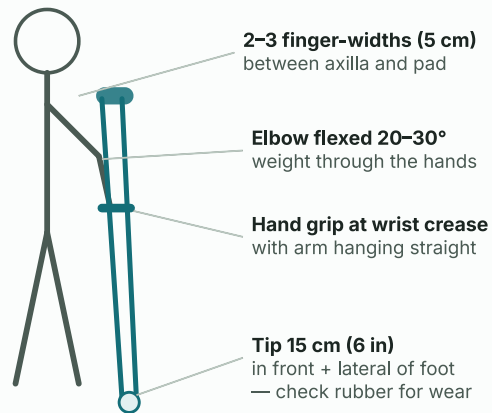
The gait follows the order

NWB → **3-point** gait (or swing gaits). PWB on both legs → **4-point** (max stability) or **2-point** (faster). If a question says the patient "cannot bear any weight on the right leg," any option that advances the right foot with weight on it is wrong.

SECTION 03 / 12

Crutch Fitting & Measurement

Fitting numbers are pure NCLEX gold. Memorize the finger-widths, the degrees, and — above all — where the weight goes.



HIGHEST YIELD

The three fitting checks

- **Axilla:** 2–3 finger-widths (about 5 cm / 2 in) between the axilla and the axillary pad while standing in tripod
- **Elbows:** flexed **20–30°** when hands are on the grips
- **Hand grips:** level with the wrist crease when the arm hangs straight at the side

SAFETY CRITICAL

Weight on HANDS — never the axillae

Resting body weight on the axillary pads compresses the **brachial plexus**, causing **crutch palsy** — radial nerve damage with numbness, tingling, and weakness of the forearm, wrist, and hand. Leaning on the pads is the classic "needs further teaching" answer.

KEY INFO

Measuring a patient for crutches

- Standing: measure from the anterior axillary fold to a point 15 cm (6 in) lateral to the heel
- Supine: measure from the anterior axillary fold to the heel and add 5 cm (2 in)
- Quick estimate: patient height minus 40 cm (16 in)

CAUTION

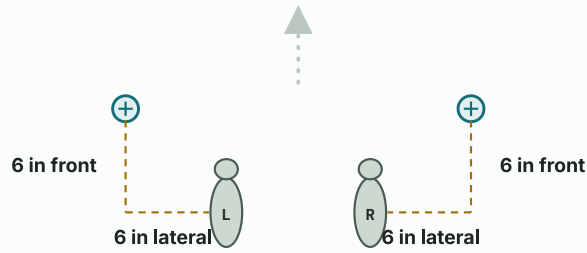
Equipment checks

Inspect rubber tips for wear and replace when worn smooth; check wing nuts/bolts for tightness; pads and grips intact. Worn tips on any device = fall risk = report/replace.

SECTION 04 / 12

The Tripod Position

The starting stance for every crutch gait — and a favorite fill-in-the-number question.



Wide triangular base = stability. Head up, pelvis over the feet.

EXPECTED

How to stand in tripod

Place each crutch tip **15 cm (6 in) in front of** and **15 cm (6 in) lateral to** each foot. Head up, back straight, pelvis over the feet, elbows slightly flexed. This wide base of support is what makes crutches stable.

PEARL

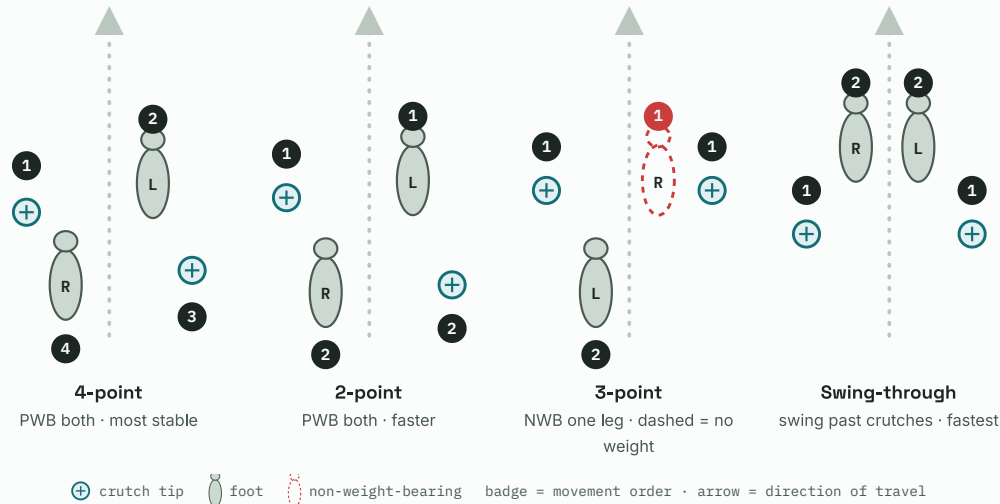
Posture teaching

Look **ahead**, not down at the feet. Take short steps at first. Fatigue, sweaty palms, and rushed long strides are the common causes of crutch falls.

SECTION 05 / 12

The Five Crutch Gaits

Match the gait to the weight-bearing status. The point count = the number of contact points on the floor during each phase — more points, more stability, slower speed.



GAIT	WEIGHT-BEARING REQUIRED	SEQUENCE	NOTES
4-point	PWB on <i>both</i> legs	R crutch → L foot → L crutch → R foot	Slowest, most stable ; always 3 points on the floor
3-point	NWB on one leg	Both crutches + affected leg forward → then unaffected leg	Requires arm strength & balance; the classic post-fracture gait
2-point	PWB on both legs	R crutch <i>with</i> L foot together → L crutch <i>with</i> R foot	Faster than 4-point; mimics natural arm swing
Swing-to	Weakness/paralysis of both legs	Both crutches forward → swing body <i>to</i> the crutches	Used with braces, paraplegia
Swing-through	Strong arms, both legs impaired	Both crutches forward → swing body <i>past</i> the crutches	Fastest, most advanced, least stable

CORRECTION

4-point exact order

The tested sequence is **right crutch → left foot → left crutch → right foot** — always advancing the crutch opposite the moving foot. If an option moves a crutch and the *same-side* foot in a 4-point gait, it's wrong.

MNEMONIC

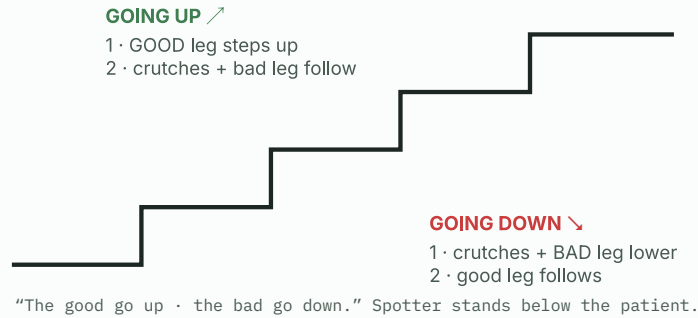
Point = contact count

"4-point" means four separate movements with maximum floor contact; "2-point" pairs opposite crutch + foot so only two points move at once. NWB questions almost always want **3-point**.

SECTION 06 / 12

Stairs with Crutches (and Canes)

If you memorize one line tonight, make it this one.



HIGHEST YIELD

UP with the GOOD, DOWN with the BAD

- **Going up:** unaffected (good) leg steps up first → then crutches + affected leg follow
- **Going down:** crutches + affected (bad) leg lower first → then the good leg follows
- Same rule for canes: good leg leads up; cane + weak leg lead down
"The good go up to heaven; the bad go down below."

PEARL

Use the handrail

When a rail is available: hold the rail with one hand, place **both crutches under the opposite arm**, and apply the same good-up / bad-down sequence. A spotter should stand *below* the patient on stairs (behind when ascending, in front when descending).

SECTION 07 / 12

Chairs, Doors & Daily Life on Crutches

Functional questions test whether the patient can live safely at home with the device.

EXPECTED

Sitting down

Back up until the chair touches the back of the legs → transfer **both crutches to the hand on the affected side** → grasp the chair armrest with the hand on the unaffected side → lower slowly, extending the affected leg forward.

EXPECTED

Standing up

Scoot to the chair edge → hold both crutches on the affected side → push up on the armrest with the free (unaffected-side) hand → stand on the good leg, get balanced, then form the tripod before stepping.

SAFETY CRITICAL

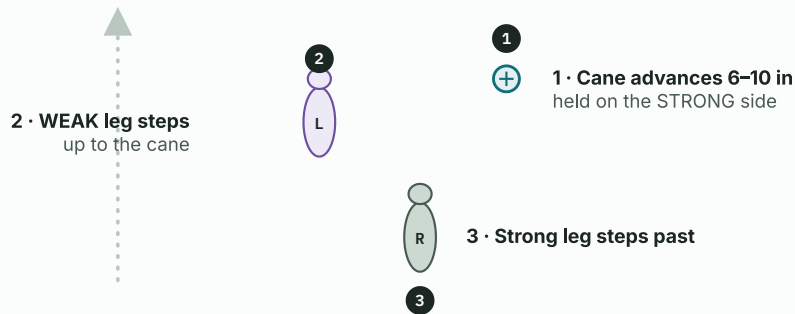
Home safety teaching

- Remove throw rugs, cords, and clutter; wipe spills immediately
- Avoid wet, icy, or highly polished floors
- Keep crutch tips dry — wet rubber slips
- Do not carry objects in the hands — use a backpack
- Rest before fatigue sets in; report any axillary numbness or tingling immediately

SECTION 08 / 12

Canes — Fit & Technique

One rule dominates every cane question: which side does it go on?



HIGHEST YIELD

Hold the cane on the **STRONG** side

The cane is always held in the hand on the **stronger / unaffected side**. This widens the base of support and lets the cane share the load *with* the weak leg as it steps, mimicking a normal reciprocal gait.

MNEMONIC

COAL

Cane Opposite Affected Leg. Sequence: advance the cane 15–25 cm (6–10 in) → step the **weak leg** forward to the cane → step the strong leg *past*. Cane and weak leg share the work.

EXPECTED

Fitting a cane

- Handle level with the **greater trochanter** (hip) / wrist crease with arm at the side
- Elbow flexed **15–30°** when gripping
- Cane too tall → shoulder hikes; too short → patient leans and stoops

PEARL

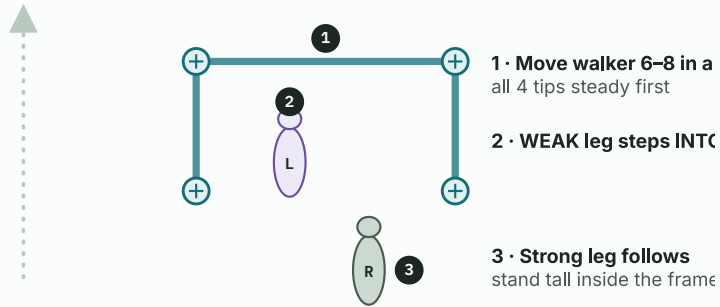
Quad canes

A four-tipped (quad) cane gives a wider base for patients needing more support (e.g., hemiparesis after CVA) — still held on the strong side; all four tips flat on the floor before weight goes through it. Flat/wide side of the base faces away from the body.

SECTION 09 / 12

Walkers — Fit & Technique

Maximum stability, strictest rules. Walker questions are usually safety questions in disguise.



MNEMONIC

WWAL

Walker With Affected Leg. Lift/move the walker 15–20 cm (6–8 in) forward → step the **weak leg** in first → then the strong leg. Step *into* the walker, never up to the front bar.

EXPECTED

Fitting a walker

- Hand grips at the level of the **wrist crease** with arms relaxed at the sides
- Elbows flexed **15–30°** when gripping
- Patient stands *inside* the frame, upright — not hunched over it

SAFETY CRITICAL

The four walker NEVERs

- **Never** use a standard walker on stairs or escalators
- **Never pull up on the walker to stand** — it tips. Push up from the chair armrests, *then* grasp the walker
- Never step forward until **all four tips (or wheels) are steady on the floor**
- Never carry items in the hands — attach a pouch or basket

PEARL

Pick-up vs. rolling walkers

- **Standard (pick-up):** lifted with each step — most stable; needs arm strength & some balance
- **Two-wheeled:** front wheels roll, back legs glide — for patients who can't lift repeatedly
- **Rollator (4-wheel):** hand brakes + seat; smoother but least stable — lock brakes before sitting on the seat; not for significant balance loss

SECTION 10 / 12

Device-to-Device Comparison

One table to settle every "which device / which side / which leg first" question.

	CRUTCHES	CANE	WALKER
Best for	One-leg injury, strong upper body	Mild one-sided weakness	Bilateral weakness, poor balance
Which side	Both sides	Strong (unaffected) side	Both hands, stand inside frame
Elbow flexion	20–30°	15–30°	15–30°
Grip height	Wrist crease	Greater trochanter / wrist crease	Wrist crease
Moves with	Gait-dependent	Cane + weak leg (COAL)	Walker then weak leg (WWAL)
Stairs	Up good first / down bad first	Same rule	Never (standard walker)
Stability rank	Least of the three	Middle	Most stable

MNEMONIC

The weak leg travels with the device

For both cane and walker, the **affected leg advances with (or right after) the device**, so the equipment absorbs load the weak limb can't. The strong leg always moves last — it's the one that can support the body alone.

SECTION 11 / 12

NGN Clinical Judgment Map

How assistive-device content shows up across the six CJMM cognitive skills on Next Gen items.

CJMM SKILL	WHAT IT LOOKS LIKE IN A MOBILITY ITEM
Recognize cues	Worn crutch tips; axillary tingling; patient leaning on pads; walker used to pull to stand; orthostatic drop before ambulating
Analyze cues	Tingling hands + leaning on axillary pads → developing crutch palsy; hunched posture → device fitted too low
Prioritize hypotheses	Fall risk and nerve injury outrank speed of ambulation or patient preference
Generate solutions	Refit the device; reteach COAL/WWAL; switch gait to match new weight-bearing order; add gait belt
Take action	Demonstrate, then require return demonstration; walk on the weaker side slightly behind; replace worn tips
Evaluate outcomes	Correct return demo; no axillary numbness; erect posture; no near-falls; patient verbalizes stair rule

PEARL

"Needs further teaching" red flags

- "I rest my armpits on the pads when I get tired"
- "I keep my cane on my weak side so it can help that leg"
- "I pull myself up using the walker"
- "I lead with my injured leg going upstairs"
- "My throw rugs keep the floor from being slippery"

Each of these is the correct answer when the stem asks which statement indicates *incorrect* understanding.

SECTION 12 / 12

60-Second Cram Strip

Last look before the exam door.

01 Axilla ↔ pad: 2–3 finger-widths (5 cm)	02 Elbows 20–30° (crutches) / 15–30° (cane & walker)	03 Weight on HANDS — pads on axillae = crutch palsy (radial n.)
04 Tripod: tips 6 in front + 6 in lateral to feet	05 4-pt = PWB both, most stable · 2-pt = PWB, faster · 3-pt = NWB	06 UP with the good, DOWN with the bad
07 COAL — Cane Opposite Affected Leg, held on STRONG side	08 Cane handle at greater trochanter	09 WWAL — Walker With Affected Leg; step INTO the frame
10 Never pull up on a walker; never take a standard walker on stairs	11 All 4 tips down before stepping; replace worn rubber tips	12 Gait belt on; stand slightly behind on the WEAK side
13 Falling patient: widen stance, slide down your leg, protect the head	14 No throw rugs, no wet floors, no carrying items in hands	