

Hygiene: Chapter 39
Restraints: Chapter 27
NUR 192



Scientific Knowledge Base

Physical hygiene is necessary for comfort, safety, and well-being.

Ill patients require assistance with personal hygiene.

Several factors influence a patient's hygiene practices, such as culture and age.

Good hygiene techniques promote normal structure and function of tissues.

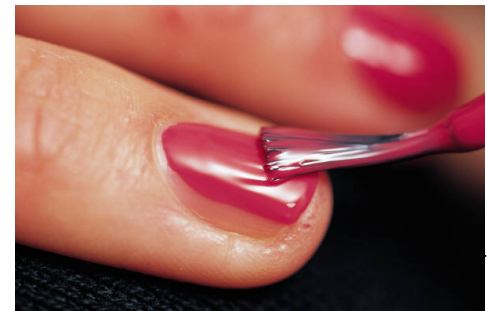
Apply knowledge of pathophysiology to provide preventive hygiene care.

The Skin

- Functions include:
 - Protection, secretion, excretion, temperature regulation, and sensation
- Two primary layers of skin:
 - **Epidermis:** shields underlying tissue
 - **Dermis:** contains bundles of collagen, nerve fibers, blood vessels, sweat glands, sebaceous glands, and hair follicles
 - **Subcutaneous:** contains blood vessels, nerves, lymph, and loose connective tissue filled with fat cells
- Skin is normally elastic, well-hydrated, firm & smooth.

The Feet, Hands, and Nails

- Feet, hands, and nails require special attention to prevent infection.
- The hand in contrast to the foot is used for manipulation rather than support.
- The condition of a patient's hands and feet influences his or her ability to perform hygiene care.
- The normal nail is transparent, smooth, and convex.

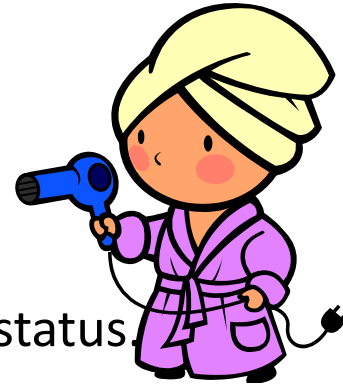


The Oral Cavity

- Cavity is lined with mucous membranes.
- Oral mucosa is light pink, moist, soft, smooth and with no lesions
- Medications, exposure to radiation, and mouth breathing can impair salivary secretion.
- Healthy Teeth appear white, smooth, shiny and properly aligned.
- Terms:
 - Xerostomia—dry mouth
 - Gingivitis—inflammation of the gums
 - Dental caries—tooth decay



Hair



- Growth, distribution, and pattern indicate general health status.
- Hormonal changes, nutrition, emotional stress, physical stress, aging, infection, and other illnesses can affect the hair.
- Sun, chemicals, hair products, permanents, and straightening and coloring agents can also affect the hair.

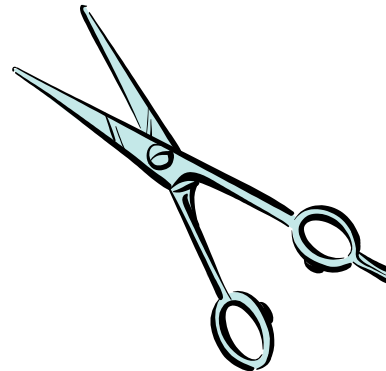


Eyes, Ears, and Nose

- When hygiene care is provided, the eyes, ears, and nose require careful attention.
- Clean the sensitive sensory tissues in a way that prevents injury and discomfort for a patient, such as by taking care to not get soap in his or her eyes.
- The sense of smell is an important aid to appetite.

Nursing Knowledge Base

- Number of Factors influence a client's personal hygiene.
 - Individualize care to preferences & practices
 - Use communication skills to promote the therapeutic relationship
- Hygiene care is never routine.
- During hygiene assess:
 - Physical limitations
 - Health promotion practices and needs
 - Emotional needs



Factors Influencing Hygiene

<p>Social patterns</p> <p>Ethnic, social, and family influences on hygiene patterns</p>	<p>Personal preferences</p> <p>Dictate hygiene practices</p>
<p>Body image</p> <p>A person's subjective concept of his or her body appearance</p>	<p>Socioeconomic status</p> <p>Influences the type and extent of hygiene practices used</p>

Factors Influencing Hygiene (cont'd)

<p>Health beliefs and motivation</p> <p>Motivation is the key factor in hygiene.</p>	<p>Cultural variables</p> <p>People from diverse cultures practice different hygiene rituals.</p>
<p>Developmental stage</p> <p>Affects the patient's ability to perform hygiene care</p>	<p>Physical condition</p> <p>May lack physical energy and dexterity to perform self-care</p>

Factors Influencing Hygiene (cont'd)

- Developmental stage
 - Skin (sensitive neonate skin, active glands in puberty, thinning and drying with age)
 - Feet and nails (dry skin, systemic disease footwear problems, chronic foot problems)
 - Mouth
 - Teeth (teething, caries, gum disease, *edentulous*)
 - Hair (shaving, puberty, aging)
 - Eyes, ears, nose

Critical Thinking

Integrate nursing knowledge.

Consider developmental and cultural influences.

Think creatively.

Be nonjudgmental and confident.

Draw on your own experiences.

Rely on professional standards.

Quick Quiz!

1. *You are caring for a non-English-speaking male patient. When preparing to assist him with personal hygiene, you should*
 - A. Use soap and water on all types of skin.
 - B. Ensure that culture and ethnicity influence hygiene practices.
 - C. Shave facial hair to make the patient more comfortable.
 - D. Know that all patients need to be bathed daily.

Nursing Process: Assessment

- Explore the patient's viewpoint.
- Assess:

Self-Care Ability

Oral cavity

Use of sensory aids

Skin

Hair and hair care

**Hygiene care
practices**

Feet and Nails

**Eyes, ears, and
nose**

**Cultural
influences**

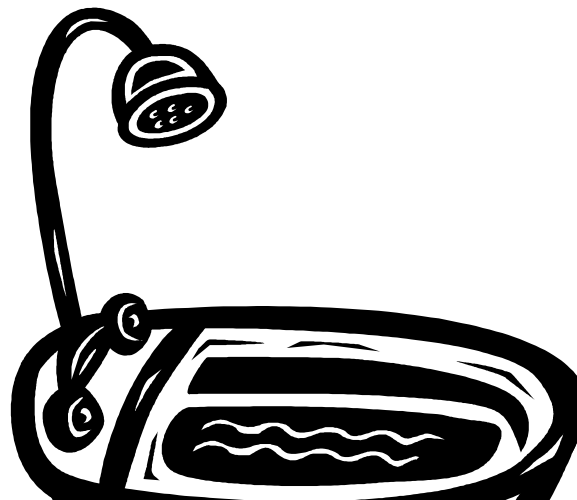
Nursing Assessment



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Problems During Bathing

- Commons Skin Problems Table 39-2
- Common Foot and Nail problems Table 39-3
- Common Hair and Scalp Problems
- Table 39-4
- Risk Factors for Hygiene Problems
 - Table 39-5



Nursing Process: Diagnosis

- Common diagnoses associated with hygiene:
 - *Activity intolerance*
 - *Bathing self-care deficit*
 - *Dressing self-care deficit*
 - *Impaired physical mobility*
 - *Impaired oral mucous membrane*
 - *Ineffective health maintenance*
 - *Risk for infection*
- Use the patients' actual alteration or the alteration for which they are at risk.

Nursing Process: Planning

- Goals and outcomes
 - Partner with the patient and family
 - Measurable, achievable, individualized
- Set priorities based on assistance required, extent of problems, nature of diagnoses
- Teamwork and collaboration
 - Health care team members
 - Family
 - Community agencies

Implementation

Use caring to reduce anxiety, promote comfort.

Administer meds for symptoms before hygiene.

Be alert for patient's anxiety or fear.

Assist and prepare patients to perform hygiene as independently as possible.

Teach techniques and signs of problems.

Inform patients about community resources.

Implementation (cont'd)

- Health promotion
 - Make instructions relevant.
 - Adapt instruction to patient's facilities and resources.
 - Teach the patient ways to avoid injury.
 - Reinforce infection control practices.
- Acute, restorative, and continuing care
 - Hygiene measures vary by patient needs and health care setting.

Implementation (cont'd)

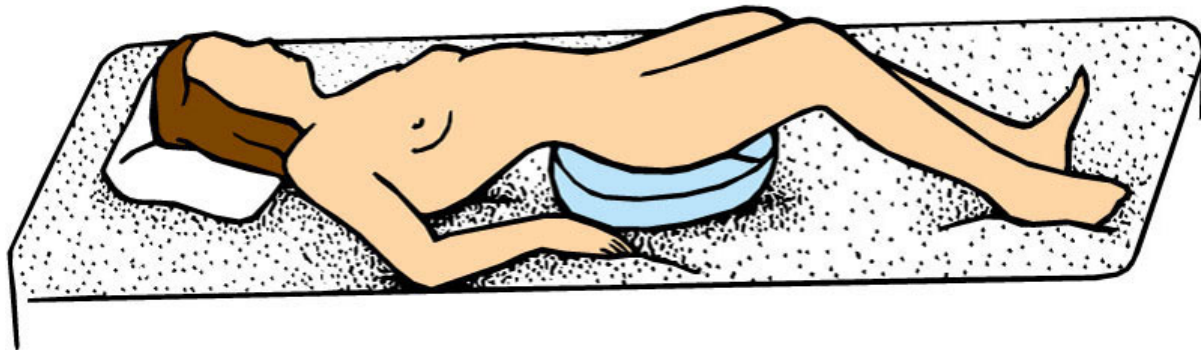
- Consider normal grooming routines, and individualize care.
- Bathing and skin care
 - Therapeutic: sitz, medicated
 - Complete bed bath/shower
 - Partial bed bath
 - Bag baths
 - Perineal care
- Back rub
- Foot and nail care

Types of Bedpans

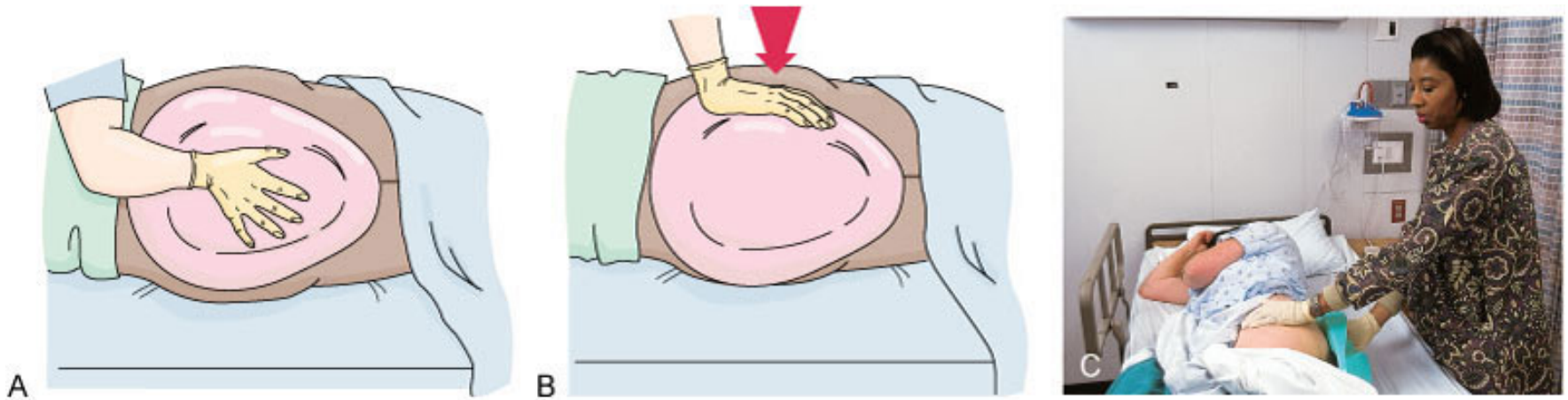


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Proper and Improper Position on a Bedpan



Positioning Immobilized Patient on Bedpan



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Bath Guidelines

Provide privacy.

Maintain safety.

Maintain warmth.

Promote independence.

Anticipate needs.

SKILL 39-1
Bathing &
Perineal Care

BED BATH

- **DEFINITION**

- Bed bath is assisting a bedfast patient to maintain his personal hygiene during the period of
- bed rest.

- **PURPOSE**

- 1. To clean and refresh the patient.
- 2. To promote comfort.

Equipment

- 1. Basin
- 2. Basin hot water: 105-110F & 2/3 Full
- 3. Lotion thermometer
- 4. Soap and soap dish
- 5. Tooth brush and paste or oral swabs
- 6. Patients own toiletries (soap etc.)
- 7. Bath towels - 3
- 8. Wash cloth - 4
- 9. Bathing blanket / draw sheet (optional)
- 10. Patients brush and comb
- 11. Nail Cutter: check facility policy on this
- 12. Disposable gloves for oral and perineal care
- 13. Clean patient clothes
- 14. Clean bed linen
- 15. Bed pan or urinal [if required]
- 16. Bathing trolley / trolley- may see this in some settings
- 17. Equipment for catheter care if required
- 18. Equipment for mouth care if required
- 19. Receptacle for soiled bed linen – linen bag
- 20. Receptacle for soiled disposable- linen bag

SKILL 39-1

Bathing & Perineal Care

Implementation

- Oral hygiene
 - Brushing removes particles, plaque, and bacteria; massages the gums; and relieves unpleasant odors and tastes.
 - Flossing removes tartar at the gum line.
 - Rinsing removes particles and excess toothpaste.
- Patients with special needs: diabetes, artificial airways, unconscious, chemotherapy

Care of Dentures



Implementation

- Hair and scalp care
 - Brushing and combing
 - Distributes oil
 - Prevents tangling, as does braiding
 - Obtain permission before braiding or cutting.
 - Procedures for head lice
 - Shampooing
 - Shaving
 - Mustache and beard care

Shampooing Hair of Patient Who Is Bed-Bound



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Shaving



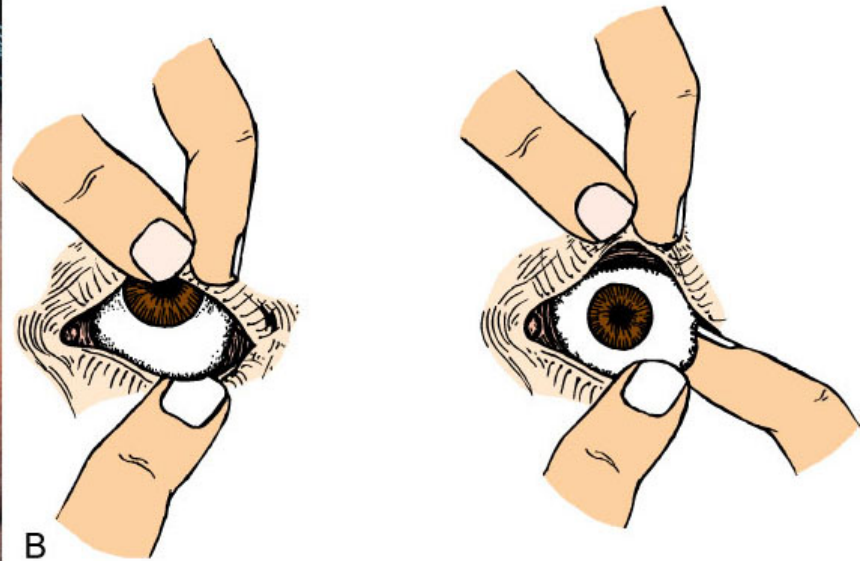
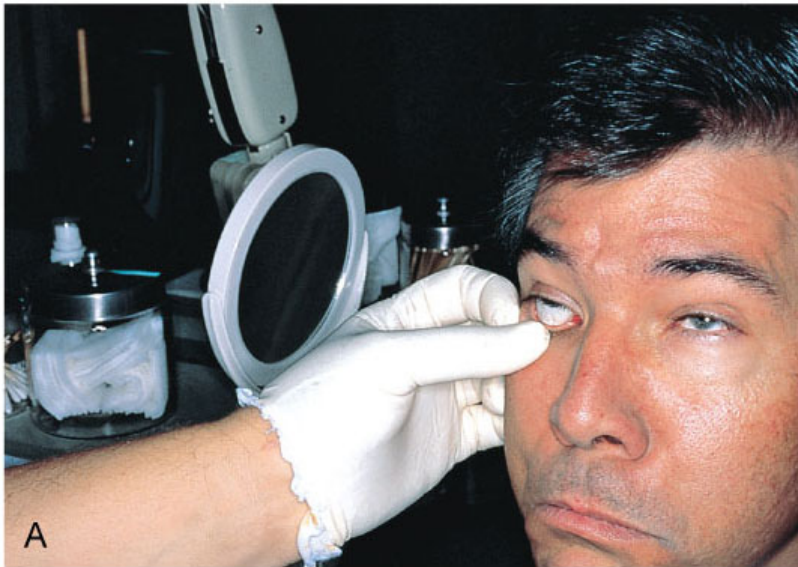
Quick Quiz!

2. *A young girl with long hair is experiencing a problem with matting. The most appropriate action to take would be*
- A. Cutting the matted hair away.
 - B. Braiding the hair to reduce tangles.
 - C. Using a grease-type product to tame the hair.
 - D. Keeping the hair oil free by applying powder every morning.

Implementation

- Care of the eyes, ears, and nose:
 - Basic eye care
 - Eyeglasses
 - Contact lenses
 - Artificial eyes
 - Ear care
 - Hearing aid care
 - Nasal care

Removal of a Prosthetic Eye



Hearing Aids: In the Canal



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Hearing Aids: Behind the Ear



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Hearing Aids: In the Ear



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BOX 39-13
Care & Use of Hearing Aids

Implementation

- Patient's room environment
 - Maintaining comfort: temperature, noise, lighting, ventilation, odors
 - Beds
 - Features: raising, adjusting, side rails
 - Clean, comfortable, and safe
 - Positions of Bed: Table 39-6
 - Bed making
 - Occupied
 - Unoccupied

Foot Boots



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Communication



Linen Care



Bedmaking - General



▶ BED MAKING

▶ A. Gather all the required linen and accessories before making the bed.

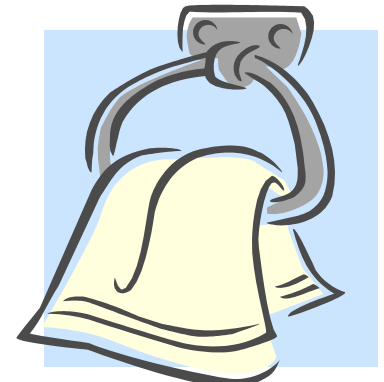
- ▶ Linen Bag/ Mattress pad if soiled
- ▶ Sheets.: Bottom sheet/fitted sheet; drawsheet; top sheet, pillowcases
- ▶ Pillowcases.
- ▶ Blankets.: if soiled
- ▶ Bedspread: if soiled
- ▶ Waterproof pads if needed
- ▶ Extra pillows.

ID patient: be aware of any pertinent patient care information: activity tolerance/restrictions, wounds, Ivs, Foley Catherter.
check orders for activity restrictions

- ▶ b. Avoid shaking the linen to prevent the spread of microorganisms and dust particles.
- ▶ c. Avoid placing linens, clean or dirty, on another patient's bed.
- ▶ d. Do not place dirty linen on the floor.
- ▶ e. Do not hold dirty linen against your uniform.
- ▶ f. Always use good body mechanics; raise the bed to its highest position to make bed-making easier.
- ▶ g. Stay on one side of the bed until it is completely made; then move to the other side and finish the bed. This saves time and steps.
- ▶ h. Observe the patient and document any nursing observations.
- ▶ Check for areas of redness that may lead to decubiti formation.
- ▶ Note tolerance of activity level while out of bed.
- ▶ Note observations about the physical and emotional status of the patient.
- ▶ Note any patient teaching or reinforced teaching given and the patient's response.
- ▶ Check for drainage, wetness, or other body fluids and record observations.

Bedmaking

- **a. Unoccupied (Closed) Bed. An unoccupied bed is one that is made when not occupied by a patient.**
- (1) Raise the bed to a comfortable working height, if adjustable.
- (2) Lower siderails, if present.
- (3) Remove pillows and pillowcases. Set the pillows aside in a clean area.
- (4) Fold and set the blankets and spreads aside (to be reused).
- (5) Loosen the linen along the edges of the bed, and move toward the end of the bed.
- (6) Wash the mattress if necessary, turn the mattress to the opposite side if necessary, and replace the mattress pad as needed. Observe the mattress for protruding springs.
- (7) Place the bottom sheet. Fitted sheet.
 - 1 Fit the sheet on the lower edges of the mattress first. Then lift the mattress and fit the sheet on the top edges of the mattress.
- (8) Place a draw sheet on the center of the bed, if it is needed.
 - (a) Tuck in the free edge on one side.
 - (b) Stretch the draw sheet from the opposite side and tuck in the free edge.
- (9) Place the top sheet, blanket (if used), and bedspread.
 - (a) Position evenly on the bed.
 - (b) Miter the bottom corners, tucking all three parts together.
 - (c) Leave the loose ends free.



Bedmaking

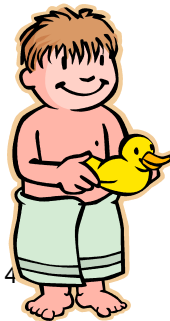
- (10) Fanfold the top linen back to the foot of the bed.
- (11) Place a clean pillowcase over the pillow and place it at the head of the bed.
 - (a) Invert the pillowcase over one hand so the inner back seam is visible.
 - (b) Grasp the edge of the pillow with one hand holding the pillowcase at the seam.
 - (c) Use the opposite hand to guide the pillowcase over the pillow.
- (12) Adjust the bed to its lowest position, if adjustable.
- (13) Reposition the head up slightly, if the patient prefers.
- (14) Raise the side rail opposite the side of the bed where the patient will enter.



Bedmaking

Skill 39-5

- **Occupied (Open) Bed. An occupied bed is one that is made while occupied by a patient.**
- (1) Wash your hands.
- (2) Identify the patient, explain the procedure, and be sure you will have the patient's cooperation.
- (3) Check the condition of the bed linens to determine which supplies you will need.
- (4) Provide for the patient's privacy (throughout the procedure).
- (5) Obtain the articles of linen that you will need.
- (6) Place the bath blanket over the patient and the top cover.
- (7) Loosen the top bedding from the foot of the bed and remove it. If possible, have the patient hold the bath blanket while you pull the top covers from under it from the foot of the bed.
- (8) Move the mattress to the head of the bed if needed.
- (9) Move the patient to the distal side of the bed.
- (10) Loosen bottom linens from head to foot. With seam side down, fanfold linens from top layer to bottom layer and tuck under buttocks, back & shoulder.
- Make the bed on one side. Apply linens in order as unoccupied bed, place centerfold along middle of bed lengthwise & position under buttocks & torso. Fanfold each item under patient as you go.
- (11) Move or turn the patient to the clean side of the bed, and finish making the bed on the opposite side. By pulling/removing dirty linen & pulling/tucking clean linen. Place the clean linen on top, and remove the bath blanket.
- (12) Attach the patient's signal cord within reach.
- (13) Provide for the patient's safety and comfort.
- (14) Tidy the room.



Surgical or Recovery Bed



Bedmaking

- **c. Anesthetic, Surgical, or Post-Op Bed. This is a bed that is prepared to receive a patient from the operating room.**
- (1) Gather all needed supplies:
 - (a) Large sheets (2).
 - (b) Drawsheet (1) or an additional large sheet.
 - (c) Blanket.
 - (d) Pillow(s).
 - (e) Pillowcase(s).
 - (f) Towel.
 - (g) Waterproof pads Chux[®], if drainage is anticipated.
- (2) Make the bed as though you are making an unoccupied bed, except that the top sheet and blanket are not tucked under the mattress at the foot of the bed, and the corners are not mitered.
- (3) Fanfold the top covers to the side or to the foot of the bed.
- (4) Place a towel or disposable pad (Chux[®]) at the head of the bed. This is intended to protect the sheet if the patient should vomit.
- (5) It is a good idea to place a drawsheet on the bed because it can be used to move the patient more easily.
- (6) Place the pillow(s) on a chair near the bed or in an upright position at the head of the bed.
- (7) Leave the bed in the high position.
- (8) Lock the brakes on the bed.
- (9) Move the furniture away from the bed to allow for easier access to the bed for the recovery room stretcher and personnel.
- (10) Make certain an emesis basin is readily available and suction is available where indicated.
- (11) Keep Chux[®] available to use if necessary.

Evaluation

- Evaluate during and after each intervention.
- Observe for changes in patient's behavior.
- Consider the patient's perspective.
- Often it takes time, repeated measures, and a combination of interventions for improvement.
- Expected outcomes met?
- Patient's expectations met?
- Ask questions to determine appropriate changes to interventions.

Safety Guidelines

- Communicate clearly with team members.
- Incorporate patient's priorities.
- Move from the cleanest to less clean areas.
- Use clean gloves for contact with nonintact skin, mucous membranes, secretions, excretions, or blood.
- Test the temperature of water or solutions.
- Use principles of body mechanics and safe patient handling.
- Be sensitive to the invasion of privacy.

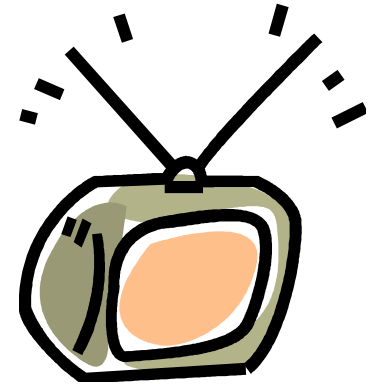
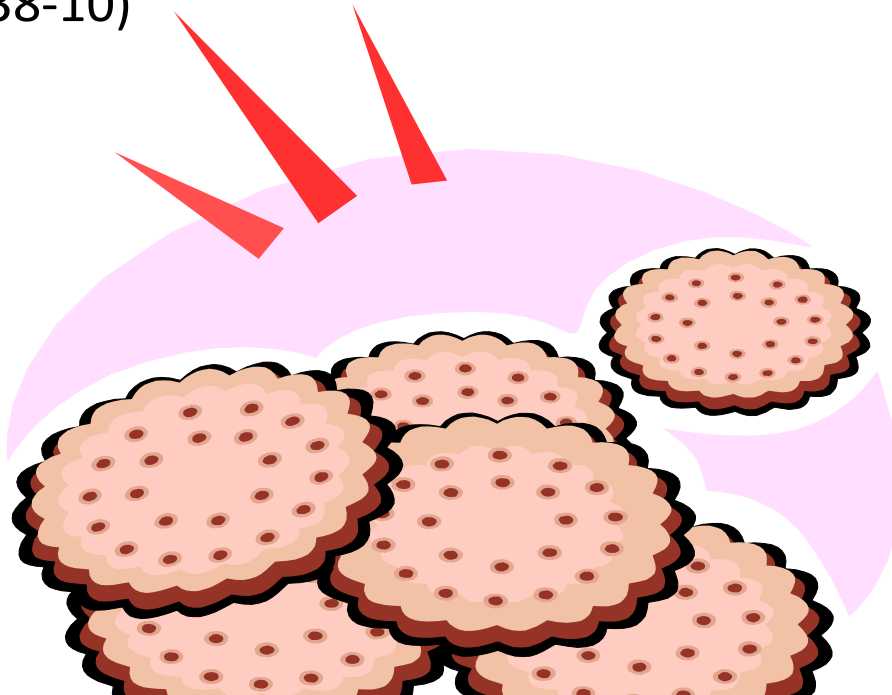
Restraints

- A physical restraint is a human, mechanical and or physical devise that is used with or without a client's permission to restrict his or her freedom of movement or normal access to a person's body and is not a usual part of treatments plans.



Alternatives to Restraints

- Orient client
- Companionship and supervision
- Diversionary activities
- Relaxation
- (table 38-10)

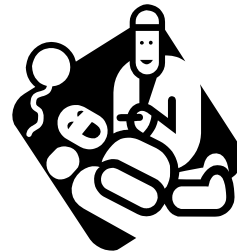


Types of Restraints

- Wrist Restraint.
- Mitten Restraint.
- Bed Restraint.
- Mummy Restraint.

Protocol Restraints

- 1. Must have doctors order to restraint patient –must be renewed every 24 hrs
- 2. Must release restraint every 2 hours and inspect skin and document.
- 3. Must also document offering bathroom privileges.





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