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CLINICAL NURSING PROCEDURES

The Art of Nursing Practice

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6th Edition

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5 CHAPTER

Hygiene Care

5.1: ASSISTING IN ORAL HYGIENE FOR A CONSCIOUS PATIENT

Halitosis: Persistent bad breath.
Cheilosis: Painful inflammation and cracking of one or both corners of mouth.
Gingivitis: Inflammation of gums.
Stomatitis: Painful inflammation of mouth and lip.

DEFINITION

Assisting the weak or debilitated patient for cleansing mouth by mechanical brushing of the teeth and rinsing of the mouth.

INDICATIONS

1. Mouth breathers.
2. Patients on NPO.
3. Oral surgery patients (sterile special mouth care).
4. Patients on oxygen inhalation.
5. Children under 3 years.
6. Patients who are unable to maintain adequate oral hygiene.

PURPOSES

1. To maintain the healthy state of mouth, teeth, gums, and lips.
2. To clean the mouth off food particles, plaque, and bacteria.
3. To relieve discomfort resulting from unpleasant odors and tastes.
4. To enhance the well-being and comfort and to stimulate appetite.
5. To prevent sores, caries, and infection to oral tissues.

COMPLICATIONS OF NEGLECTED MOUTH

1. Inflammation in various localized regions of the oral cavity. For example, halitosis, glossitis, pyorrhea, root abscess, parotitis, sordes and crust, dental caries, adenitis, tonsillitis, etc. **(Fig. 5.1A)**
2. Loss of appetite
3. Joint diseases
4. Rheumatic heart disease
5. Gastritis.

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Dental caries



Glossitis



Root abscess



Tonsillitis

Fig. 5.1A: Complications of a neglected mouth.

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ARTICLES (FIG. 5.1B)

A clean "mouth toilet tray" containing:

1. Face towel.
2. Tumbler/feeding cup containing water.
3. Soft bristled toothbrush.
4. Tooth paste/tooth powder/available dentifrice.
5. Mouth wash solution (according to patient's preference and availability).
   i. Sodium chloride
   ii. Thymol
   iii. Diluted solution of potassium permanganate 1:1,000
   iv. Listerine
   v. Chlorhexidine.
6. Cotton applicators/cotton balls.
7. Emollient in a container—glycerin, liquid paraffin, vaseline, and coconut oil.
8. K-basin/emesis basin (2 nos.).
9. Small mackintosh.
10. Clean gloves.



Fig. 5.1B: Oral care tray setting for conscious patient.

PROCEDURE

	Nursing action	*Rationale*
	Before procedure	
1.	Assess the condition of the patient, his mouth, and the level of consciousness.	Helps to determine the type of oral hygiene the patient requires.
2.	Inspect the integrity of lips, teeth, buccal mucosa, gums, palate, and tongue.	Determines the status of the patient's oral cavity and the extent of need for oral hygiene.
3.	Assess the patient's ability to grasp and manipulate toothbrush.	Determines the level of assistance required.
4.	Explain the procedure to patient and encourage him to participate.	Reduces anxiety and promotes patient participation.
5.	Pull the screen.	Provides privacy.
	During procedure	
6.	Wash hands and don gloves.	Prevents spread of infection.
7.	Bring the patient to edge of the bed nearest to the nurse.	Promotes correct body mechanics and ease of working.
8.	Position patient in high Fowlers/semi-Fowlers position as tolerated.	Provides comfortable working position.
9.	Place the small mackintosh with the face towel on the chest.	Prevents patient's clothing from soiling.
10.	Place K-basin close to the patient's chin.	Prevents soiling.
11.	Apply toothpaste to brush. Holding brush over K-basin, pour small amount of water over toothpaste **(Fig. 5.1C)**.	Moisture aids in distribution of toothpaste over tooth surface.
12.	Instruct patient to hold toothbrush bristles at 45° to gum line. Brush inner and outer surfaces of upper and lower teeth by brushing from gum to crown of each tooth **(Fig. 5.1D)**.	Angle allows brush to reach all tooth surfaces and to clean under gum line where plaque and tartar accumulate.
	 **Fig. 5.1C:** Applying toothpaste to brush.	 **Fig. 5.1D:** Brushing teeth, holding brush at 45°.
13.	Clean the biting surface back and forth; farther side first and then nearer side and upper jaw first and then lower jaw **(Fig. 5.1E)**.	Back and forth motion dislodges food particles caught between teeth and along chewing surface.
	 **Fig. 5.1E:** Method of brushing teeth.	
14.	Have the patient to hold the brush at the same angle (45°) over tongue and brush lightly over surface horizontally taking care not to initiate gag reflex.	Microorganisms collect and grow on tongue surface and contribute to bad breath. Gagging may cause aspiration of toothpaste or may induce vomiting.
15.	Allow patient to rinse mouth thoroughly by taking mouthful of water and spitting into the K-basin **(Fig. 5.1F)**.	Vigorous swishing motion helps to remove debris and toothpaste.

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	Nursing action	Rationale
	 **Fig. 5.1F:** Assisting patient in rinsing mouth.	
16.	Allow patient to rinse mouth with mouthwash as desired.	Mouthwash leaves a pleasant taste in mouth.
17.	Assist wiping mouth with face towel.	Promotes sense of comfort.
18.	Apply emollient to lips.	Prevents cracking and drying of lips.
19.	Assist patient to comfortable position.	
20.	Discard the waste, clean the used articles, and replace equipment as appropriate.	Leaves the unit clean and articles ready for further use.
21.	Wash hands.	
22.	Record the procedure including time, solution used, and condition of mouth.	

PEDIATRIC VARIATIONS

Positioning

- Stand with the child's back toward the adult. When in front of a mirror, both child and adult can see what is being done in the mirror.
- Sit on a couch or bed with the child's head resting in adult's lap with face up.
- Sit on the floor or stool with child's head resting between adult's thighs.

Brushing Technique

- The most suitable method for cleaning primary teeth is scrub method.
- The tips of bristles are placed firmly at 45° angle against the teeth and gums and moved back and forth in a vibratory motion.
- The ends of the bristles should be wiggling but not moving forcefully back and forth.
- All the surfaces of teeth are cleaned in this manner except inner surfaces of anterior teeth.
- To clean inner surfaces, place tooth brush vertical to the teeth and move up and down.
- Use 6–8 strokes for each section of teeth.

5.2: PERFORMING ORAL CARE FOR AN UNCONSCIOUS PATIENT

Unconscious patient: A patient who is not aware of oneself or about the surroundings and is not responding to external stimuli.

DEFINITION

Performing mechanical cleansing of the teeth and the mouth for an unconscious patient.

PURPOSES

1. To maintain integrity of the lips, tongue, and mucous membrane of the mouth.
2. To prevent and treat oral infection.
3. To clean and moisturize oral mucous membrane.
4. To stimulate salivation.
5. To prevent dental caries and tooth decay.
6. To prevent halitosis.

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ARTICLES (FIG. 5.2A)

1. Small mackintosh and face towel.
2. Artery forceps.
3. Dissecting forceps/thumb forceps.
4. Small bowl with mouthwash solution or normal saline.
5. Kidney tray.
6. Emollient.
7. Tongue depressor.
8. Clean gloves.
9. Cotton applicator.
10. Small jug with plain water.
11. Mouth gag.
12. Suction apparatus.
13. Square gauze piece (2" × 2").



Fig. 5.2A: Tray setting of oral care of unconscious patient.

PROCEDURE

	Nursing action	*Rationale*
1.	**Before procedure** Assess patient's oral hygiene.	Certain conditions, such as coated tongue, ulceration/red dry swollen tongue, halitosis, immunosuppressed patients with diabetes mellitus, etc., may require frequent oral care.
2.	Test for the presence of gag reflex by placing tongue blade on back half of tongue.	Reveals whether the patient is at risk of aspiration.
3.	Check the doctor's orders for specific precautions regarding the movement and positioning of patient.	Prevents injury to patient.
4.	Explain the procedure to patient and/or relatives.	Unconscious patients may retain ability to hear.
5.	Pull curtains.	Provides privacy.
6.	**During procedure** Raise bed to comfortable working level and arrange articles by bedside.	Use of good body mechanics prevents fatigue.
7.	Position the patient on side, head turned toward you.	Allows secretions to drain from mouth instead of collecting in back of pharynx and thus preventing aspiration.
8.	Place towel and mackintosh under the patients head and spread one towel over chest and an emesis basin under the chin.	Collects saliva that may drool from the mouth and prevents soiling of bed.
9.	Raise side rails of bed on both sides.	Prevents the patient from falling.
10.	Wash hands and don gloves.	Reduces transfer of microorganisms.
11.	Lower the side rails on the working side.	Use of good body mechanics prevents fatigue.
12.	Do not pour water into the mouth of an unconscious patient.	Prevents aspiration of fluid into the lungs because of poor gag reflex.
13.	Separate the upper and lower teeth with padded tongue depressor by inserting it quickly and gently if required.	Provides access to oral cavity.
14.	Take gauze piece with the dissecting forceps.	
15.	Wrap the gauze piece around the artery forceps covering its tip. Moisten the gauze piece with normal saline or dip in the cleaning agent **(Figs. 5.2B and C)**.	Covering tip of forceps prevents injury to the mucous membrane and gums.

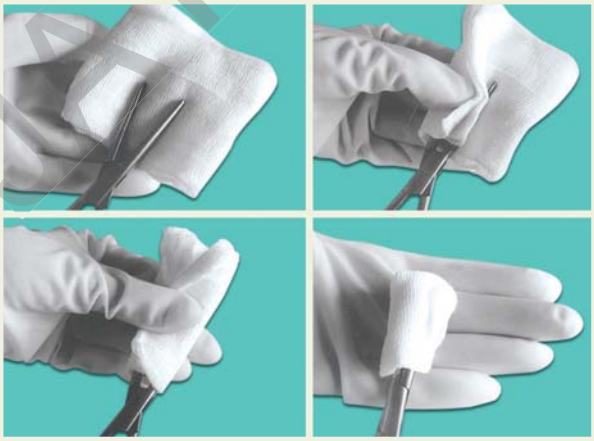


Fig. 5.2B: Wrapping gauze over artery forceps.

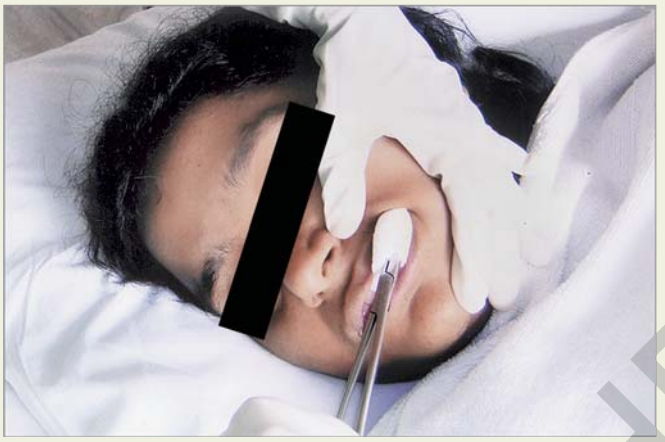


Fig. 5.2C: Squeezing gauze using dissecting forceps.

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	Nursing action	Rationale
16.	Swab each tooth gently but firmly and clean all the sides of the tooth. Clean chewing surface first and then inner and outer surface from gum to crown **(Fig. 5.2D)**.	Ensures thorough cleaning and prevents injury to the oral mucous membrane and gums.
	 **Fig. 5.2D:** Cleaning teeth from gum to crown.	
17.	Clean lower teeth on both sides followed by upper teeth on both sides.	
18.	Gently swab the roof of the mouth, gums, and inner side of cheeks.	
19.	Clean the tongue from back to front using artery forceps covered with gauze.	Ensures thorough cleaning of the tongue.
20.	Clean the teeth and tongue in similar way using plain water.	Ensures thorough removal of dentifrice or cleaning agent which may cause unpleasant taste.
21.	Apply emollient to the lips using cotton applicators.	Lubricates the lips to prevent drying and cracking.
22.	Position the patient in comfortable position. Raise side rails, lower bed.	
23.	**After procedure** Replace all the articles after discarding the waste, remove gloves, discard it, and wash hands.	Prevents transfer of microorganisms.
24.	Record date, time, solution used, condition of mouth, and any abnormalities, such as bleeding/inflammation.	

5.3: BATHING A PATIENT IN BED

DEFINITION

Cleansing the entire body of a dependent patient in bed.

PURPOSES

1. To remove transient microorganisms, body secretions, excretions, and dead skin cells.
2. To stimulate circulation.
3. To produce a feeling of well-being.
4. To promote relaxation and comfort.
5. To improve self-esteem.
6. To prevent or eliminate bad odor.

ARTICLES

1. Bedpan/urinal.
2. Basin.
3. Jugs with hot water and cold water [water of 110–115°F (43–45°C) for adults and 100 to 105°F for children].
4. Table or trolley.
5. Bath blanket/sheet.
6. Clean gloves.
7. Wash clothes (2 nos.).
8. Soap.
9. Towels (2 nos.).
10. Lotions, powders, deodorants (optional).
11. Change of bed linen (1 set).
12. Change of patient's dress (1 set).

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PROCEDURE

	Nursing action	*Rationale*
1.	**Before procedure** Prepare patient and environment: a. Explain the procedure to patient and relative and encourage participation from patient or relative. b. Close windows and doors to make sure that the room is free from drafts and switch off fan/AC. c. Provide privacy by drawing curtains and closing doors. d. Offer bedpan or urinal if he/she requires.	Reduces anxiety and encourages cooperation. Air currents increase loss of heat from the body. Reduces patient's embarrassment. Enhances comfort of the patient.
2.	Prepare bed and position patient appropriately: a. Place bed in a high position. b. Position patient close to right side of the bed or close to nurse. c. Raise side rails on both sides.	Reduces strain to nurse's back.
3.	**During procedure** Wash hands and put on clean gloves.	Reduces transmission of microorganisms.
4.	Lower side rails on the right side.	
5.	Arrange articles within your reach.	
6.	Make mittens with the wash cloth.	Mitts conserve heat of water and prevents tip of wash cloth from trailing and dripping over patient's body.
7.	Check temperature of water mixed in the basin by pouring water on the inner aspect of the palm of the patient.	Prevents risk of burns.
8.	Remove patient's clothing and cover with a bath blanket or sheet. Expose only that part of the body which is to be washed.	Ensures privacy and prevents chills for the patient.
9.	Wash face: a. Place one bath towel under patient's head. b. Wet bath mitt, squeeze water from it, so that it is not dribbling. c. Wash patient's eyes using separate corners of the bath mitt for each eye and wipe from inner canthus to outer canthus. d. Ask patient if he prefers using soap for the face (in unconscious patients avoid soap). e. If using soap, apply soap with the second mitt and then rinse with the first mitt, till the soap is completely removed. f. Wash, rinse, and dry patient's face, neck, and ears.	Prevents wetting of pillows and bed linen. Bath mitt retains temperature of water. Prevents transmission of organisms from one eye to another, wiping from inner to outer canthus prevents secretions from entering nasolacrimal duct. Soap has a drying effect and face is more exposed to the air than any other body part and hence tends to be drier. Soap if remains on skin will cause irritation.
10.	Wash arms and hand: a. Place bath towel lengthwise under arm farther to you. b. Wash, apply soap, rinse, and dry arms using long strokes from distal to proximal areas. c. Pat dry using the second bath towel. Do not rub. d. Wash axilla well. Exercise precaution, if there is an IV infusion on arm. e. Place folded towel on bed under hands and place basin on it. Attend to interdigital spaces. Immerse hand in basin and assist patient in washing hand. f. Repeat entire procedure for other arm.	Protects bed linen from becoming wet. Firm strokes from distal to proximal areas will increase venous return. Rubbing may cause skin injuries.
11.	Wash chest and abdomen: a. Fold bath blanket up to pubic area. Place towel over the chest and abdomen. b. Wash, rinse, and dry chest and abdomen giving special attention to skin folds under breasts. c. Keep chest and abdomen covered all along and use long firm strokes to wash the area. In women, wash chest and abdomen separately.	Prevents unnecessary exposure of patient.
12.	Change water if cold, dirty, or soapy.	
13.	Wash back of patient: a. Turn patient to side lying or prone position and expose back. b. Place towel lengthwise alongside back of patient. c. Wash, rinse, and dry using long, firm strokes from neck to buttocks. d. Give back massage.	
14.	Change bath water.	
15.	Turn patient back to supine position.	

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	Nursing action	*Rationale*
16.	Wash legs: a. Place towel lengthwise under farther leg away from you. b. Bend leg at knee, supporting under leg and ask patient to hold position. If patient is unable to do it, ask another nurse/family member to support leg.	
	c. Use long, firm strokes to wash from distal to proximal/from ankle to knee and knee to thigh. Do not use such long strokes in patients having blood clots in lower extremities. For example; in deep vein thrombosis (DVT) as it may dislodge the clot. d. Wash, rinse, and dry the extremity. e. Fold towel and place beneath foot of the patient. Place basin with water under the foot and clean with mitt. f. Take out the foot and dry the extremity. g. Discard water. h. Repeat the entire procedure for the other leg.	Moving from distal to proximal improves venous circulation and removes dirt from skin pores.
17.	Encourage patient to clean perineal area with mitt. Discard it into a kidney tray.	Promotes patient's independence.
18.	Position patient in a comfortable manner.	Ensures patient wellbeing
19.	Apply moisturizer or body lotion if patient prefers or if skin is dry	Lotions prevent drying and chapped skin.
20.	Assist the patient in dressing.	
21.	Comb hair.	Ensures that the patient is well groomed which promotes well-being.
22.	Change bed linen.	
23.	**After procedure** Wash hands.	
24.	Record procedure: Record any specific observations made while bathing, e.g., pressure sores, skin integrity, etc.	
25.	Replace all articles.	

SPECIAL CONSIDERATIONS

1. Obtain assistance if required in case of helpless/unconscious patient.
2. If patient is obese or cannot move in bed, nurse may move from one side of the bed to the other side to ensure good body mechanics.
3. Assess patient's general condition before giving bath. If unstable, refrain from giving bath.
4. Bath should not be given immediately after food because it interferes with the process of digestion.

5.4: PERFORMING NAIL AND FOOT CARE

Callus and corns: Thickened layers of skin, often on the hands or feet, where friction repeatedly occurs.
Plantar warts: Small growth which appears on the heel or other weight-bearing parts of the feet.
Tinea pedis: Dermatophyte infection of the soles of the feet and the interdigital spaces caused by *Trichophyton rubrum*.

DEFINITION

It refers to the cleaning of hands and feet of a patient to prevent infection and maintaining skin integrity and hygiene.

PURPOSES

1. To keep the feet clean and dry.
2. To teach the patient proper way to inspect all surfaces of feet and hands for lesions, dryness, or signs of infection
3. To trim nails and keep them short to prevent injury.
4. To prevent accumulation of dirt and microorganisms underneath the nails.

INDICATIONS

1. Any patient who is unable to perform activities to maintain good hygiene.
2. Geriatric patients who are unable to do self-care.
3. Diabetic patients.
4. Unconscious patient.
5 Patients with cardiovascular and renal disease.

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ARTICLES (FIG. 5.4A)

1. Wash basin.
2. Wash cloth.
3. Bath or face towel.
4. Nail cutter with a nail file.
5. Warm water.
6. Soap in soap dish.
7. Body lotion.
8. Clean disposable gloves.
9. Paper bag/kidney tray.
10. A bowl with cotton swabs.
11. Bowl with antiseptic solution.
12. Bowl with cotton swabs soaked in antiseptic solution (optional: for diabetic and unconscious patients).



Fig. 5.4A: Articles for nail and foot care.

GENERAL INSTRUCTIONS

1. Inspect all surfaces of fingers, toes and space between them, feet-heel and soles, and nails. Pay particular attention to areas of dryness, inflammation, and cracking. Such an assessment helps determines frequency and level of hygiene required.
2. Assess color and temperature of toes, feet, and fingers, capillary refill of nails, palpate radial and ulnar pulses of each hand and dorsalis pedis pulse of feet; note character of pulse. It helps identify any circulatory alterations which may change the integrity of nails and increase patient's chance of localized infection, when break in skin integrity occurs.
3. Observe patient's gait; have patient walk down the hall or walk in straight line (if able) Painful disorders of feet can cause limping or unnatural gait.
4. Ask and take note of specific information, e.g., in female patients whether they use nail polish and polish remover frequently (Chemicals in these products can cause excessive dryness); type of footwear worn by patients (Types of shoes or footwear may predispose patient to foot and nail problems, e.g., infection, areas of friction, and ulceration); home remedies for existing foot problems, e.g., over-the-counter liquid preparations to remove corns, cutting of corns or calluses with razor blade or scissors, application of adhesive tape, etc.

PROCEDURE

	Nursing action	*Rationale*
	Before procedure	
1.	Assess patient's ability to care for nails or feet, visual alteration, fatigue, musculoskeletal weakness, etc.	Determines patient's ability to perform self-care and degree of assistance required from nurse **(Fig. 5.4B)**.



Fig. 5.4B: Common nail and foot abnormalities requiring specialized care.

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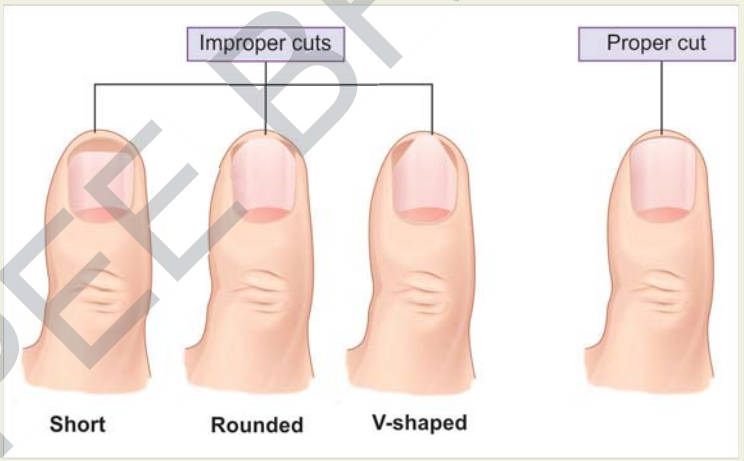
	Nursing action	*Rationale*
2.	Assess patient's knowledge of foot and nail care practices.	Determines patient's need for health teaching.
3..	Explain procedure to patient including the fact that proper soaking requires several minutes. In case of patients who are unconscious, soak nails with wet cotton swabs. In patients with diabetes, soak only for a few minutes.	Soaking softens the nails and enables easy cutting of the nails. In diabetic patients, extended soaking can result in accidental injury at the time of procedure leading to delayed wound healing.
	During procedure	
4.	Wash hands and arrange equipment on the over-bed table.	Easy access to equipment prevents delay.
5.	Pull curtain around bed or close room door.	Maintains patient's privacy.
6.	Assist ambulatory patient to sit in bedside chair; help bed- bound patient to supine position with head of bed elevated; place towel on mattress.	Sitting position facilitates immersing feet in basin.
7.	Fill washbasin with warm water. Test water temperature and have it about 43–44°C.	Warm water softens nails and thickened epidermal cells, reduces inflammation of skin, and promotes local circulation. Proper water temperature prevents burns.
8.	Place basin on towel and help patient place feet in basin for soaking toe nails. Place call light within patient's reach.	Patients with muscular weakness or tremors may have difficulty positioning feet. Patient's safety is maintained.
9.	Adjust over bed table to low position and place it over patient's lap (patient may sit in chair or lie in bed).	Easy access prevents accidental spills.
10.	Fill basin with warm water and place basin on towel on over bed table for soaking finger nails.	Warm water softens nails and thickened epidermal cells.
11.	Instruct patient to place fingers in basin and place arms in comfortable position.	Prolonged positioning can cause discomfort unless normal anatomical alignment is maintained.
12.	Allow patient's feet and fingernails to soak for 10–20 minutes and rewarm the water after 10 minutes, if necessary.	Softening of corns, calluses, and cuticles ensures easy removal of dead cells.
13.	Dry hands with towel.	
14.	Clip fingernails straight across and even with top of fingers using nail clipper **(Fig. 5.4C)**. Shape nails with file. Wipe each fingertip with cotton dipped in antiseptic solution.	Cutting straight prevents splitting of nail margins and formation of sharp nail spikes that can irritate lateral margins.
		
15.	Move over-bed table away from patient.	Provides easier access to feet.
16.	Put on disposable gloves and scrub callused areas of feet with washcloth.	Gloves prevent transmission of fungal infection and friction removes dried skin layers.
17.	Remove feet from basin and dry thoroughly.	
18.	Clean and trim toenails and do not file corners of toenails.	Shaping corners of toenails may damage tissues.
19..	Apply lotion to feet and hands and assist patient back to bed and into comfortable position.	Lotion lubricates dry skin by helping to retain moisture.
20.	Remove disposable gloves and place in receptacle; clean and replace equipment and supplies to proper place; dispose off soiled linen in hamper; wash hands.	Reduces transmission of infection.
21.	Inspect nails and surrounding skin surfaces after soaking and nail trimming. Place nail cutter in a bowl with antiseptic solution for 20–30 minutes then wash, dry, and replace.	Evaluates condition of skin and nails. Allows nurse to note any remaining rough nail edges.

Fig. 5.4C: Example of proper and improper nail trimming.

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	Nursing action	*Rationale*
	After procedure	
22.	Record procedure and observations (e.g., breaks in skin, inflammation, ulceration, etc., and patients response).	
23.	Report any breaks in skin or ulcerations to nurse in charge or physician.	These abnormalities can seriously increase patient's risk of infection and must be carefully observed.

SPECIAL CONSIDERATION

1. **Table 5.4.1** enlists the patients who are at risk for foot/nail problems and need special attention.

TABLE 5.4.1: Patients at risk for foot/nail problems.

High-risk category patients	*Etiology*
Older adults	Poor vision, lack of coordination, or inability to bend may contribute to difficulty in performing foot and nail care. Normal physiological changes and aging also result in nail and foot problems
Diabetic patients	Vascular changes associated with diabetes mellitus reduce blood flow to peripheral tissues Break in skin integrity places diabetic patients at high risk for skin infection
Heart failure and renal disease patients	Both conditions can increase tissue edema, particularly in dependent areas, such as legs and feet Edema reduces blood flow to neighboring tissues
Cerebrovascular accident or stroke patients	Presence of residual foot or leg weakness or paralysis results in altered walking patterns Altered gait pattern causes increased friction and pressure on feet

2. Appropriate foot care in patients diagnosed with diabetes ensures the maintenance of skin integrity and prevents risk of infection which otherwise may lead to reduced sensation of foot due to poor circulation and the underlying disease condition **(Fig. 5.4D)**.



Fig. 5.4D: Guidelines for diabetic foot care.

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3. Alert patients to the implications of neuropathy and ischemia so that regular foot care and inspection is encouraged and maintained.
4. Daily cleansing and moisturising of the feet, using either a pumice stone, foot file or seeing a podiatrist/chiropodist depending on the patients' risk category.
5. Ensure and encourage people with diabetes to attend their annual diabetes review, where feet are inspected for any deformity, callus or signs of ulceration, with sensation and vibration checks and affirmation of pedal pulses to ascertain their risk, and the need for further triage, if necessary
6. People with diabetes should be made aware of the checks they should be receiving on an ongoing basis. Health checks are performed by a healthcare providers (HCP) who is trained in delivering foot checks. The steps are:
   - Remove the patient's socks and shoes in order to perform systematic examination.
   - Examine footwear, making sure that they fit the person correctly, and do not cause any rubbing. Socks must also be suitable and preferably seamless.
   - Take a history from the patient, so that an assessment can be made on presence/absence of sensation (using 10 g monofilament), color of the feet, any warmth or inflammation, deformity, ischemia (palpating foot pulses), presence of corns or calluses or breaks in the skin. Two or more of the following, previous or present foot ulcer or amputation, neuropathy, peripheral vascular disease or foot deformities result in the classification of an 'at risk' foot.
   - Patients must be referred to the multidisciplinary foot team as per the risk category. Any limb-threatening or life-threatening diabetic foot problem, such as ulceration, suspected infection, ischemia, gangrene or charcot arthropathy must be referred immediately to acute care.

5.5 : PROVIDING GENITAL CARE/HYGIENIC PERINEAL CARE

Perineum: It is the area between the anus and vulva or scrotum.
External genitalia: The female external genitalia are the labia minora and majora (the vulva) and the clitoris.

DEFINITION

Genital care involves thorough cleansing of external genitalia and surrounding skin.

PURPOSES

1. To promote patient's comfort and cleanliness.
2. To prevent infection in high-risk patients.

INDICATIONS

1. Patients who are unable to do self-care.
2. Patients with indwelling catheter.
3. Patients with incontinence of urine or stool.
4. Patients having excessive vaginal discharge.
5. Patients recovering from rectal or genital surgery.
6. Following childbirth (postnatal care).

ARTICLES (FIG. 5.5A)

1. Wash basin
2. Soap dish with soap
3. Wash cloths (2 nos.)
4. Bath towel
5. Bath blanket/bed sheet
6. Bedpan
7. Disposable gloves
8. Cotton swabs
9. Kidney tray
10. Toilet tissues or diaper wipes.



Fig. 5.5A: Tray setting for perineal care.

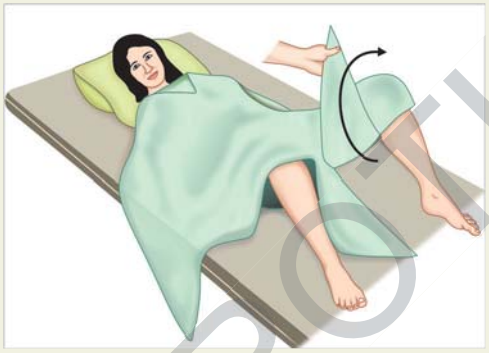
PROCEDURE

	Nursing action	Rationale
1.	**Before procedure** Explain the procedure and its purpose to patient.	Helps to minimize anxiety and embarrassment during procedure.
2.	**During procedure** Wash hands and don clean gloves.	Prevents cross-infection.
3.	Position patient with legs spread apart.	

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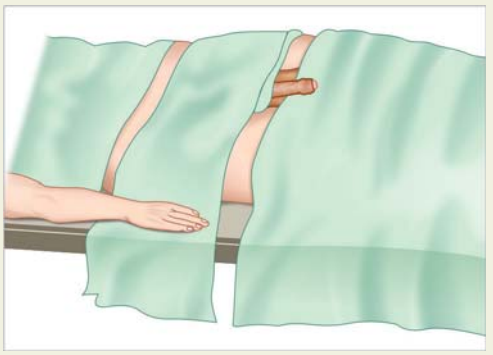
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	Nursing action	Rationale
4.	Assess genitalia for signs of inflammation, skin breakdown, infection, or contamination with fecal matter.	Determines the extent of perineal care required by patient.
5.	If fecal material is present, enclose in a fold of pad or toilet tissue and remove. With disposable wipes or tissue, cleanse buttocks and anus, washing from front to back. Cleanse, rinse, and dry area thoroughly. Remove and discard under pad and replace with a clean one.	Cleansing reduces transmission of microorganisms from anus to urethra or genitalia.
6.	Change gloves, if they are soiled.	
7.	Help patient to flex knees and spread legs apart **(Fig. 5.5B)**.	Provides full exposure of genitalia.
8.	Fold top linen down toward foot of bed and fold patient's gown above genital area.	Draping prevents unnecessary exposure of body parts and maintains patient's warmth and comfort during procedure.
9.	Diamond drape patient by placing bath blanket/top sheet with one corner between patient's legs, and another corner over patient's chest. The two side corners should hang over sides of bed. Tuck side corner around patient's legs and under hips **(Fig. 5.5B)**.	
	 **Fig. 5.5B:** Positioning and draping female patient for genital care.	
10.	Raise side rails. Fill basin with warm water.	Prevents patient from falling. Use of warm water promotes comfort.
11.	Place wash basin and toilet tissue on over-bed table and place wash clothes in basin.	Articles placed within reach of nurse prevents accidental spills.
12A.	Female genital care: a. Lower side rails and instruct patient to maintain dorsal recumbent position with knees flexed and legs apart. Note any restriction or limitation in positioning patient. b. Fold lower corner of bath blanket/sheet up between patient's legs onto abdomen. Wash and dry the patient's upper thighs. c. Wash labia majora while using nondominant hand to retract labia from thigh. With dominant hand, wash carefully in skin folds and wipe in direction from perineum to rectum. Repeat on opposite side using separate section of wash cloth. Rinse and dry area thoroughly. d. Separate labia with nondominant hand to expose urethral meatus and vaginal orifice. With dominant hand, wash downward from pubic area toward rectum using separate quarters of wash cloth for each stroke. Clean the vulva and labia minora on both sides and inside of labia majora on both sides. e. If patient can use bedpan, place bedpan and pour water over perineal area. Dry perineal area thoroughly with bath towel from front to back. f. Fold lower corner of bath blanket back between patient's legs and over perineum. Ask patient to lower legs and assume comfortable position.	Provides full exposure of female genitalia. Minimize degree of abduction if position causes pain because of arthritis or reduced joint mobility. Minimizes transmission of microbes. Keeping patient draped until procedure begins to minimize anxiety. Accumulated perineal secretions can soil surrounding skin surface. Skin folds may contain body secretions which harbor microorganisms. Wiping from perineum to rectum reduces chances of transmitting fecal organisms to urinary meatus. Cleansing method reduces transfer of microorganisms to urinary meatus (For menstruating women and patients with indwelling urinary catheter, cleanse with cotton balls). Rinsing removes soap and microorganisms more effectively than wiping. Retained moisture harbors microorganisms.
12B.	Male genital care: a. Lower side rails and assist patient to supine position. Note restriction in mobility, if any. b. Fold top half of bath blanket/sheet down below the penis. Position gown to cover chest. Wash and dry patient's upper thighs **(Fig. 5.5C)**.	Minimizes transmission of microorganisms. Keeping patient draped until procedure begins to minimize anxiety. Accumulation of perineal secretions can soil surrounding skin surface.

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	Nursing action	Rationale
	 **Fig. 5.5C:** Draping male patient for genital care.	
	c. Gently raise penis and place bath towel underneath. Firmly grasp shaft of penis, if patient is uncircumcised, retract foreskin. If patient has an erection, defer procedure until later. d. Wash top of penis at urethral meatus first using circular motion. Cleanse from meatus outward. Discard wash cloth and repeat with clean cloth until penis is clean. Rinse and dry gently. e. Return foreskin to its original position. f. Wash shaft of penis with gentle but firm downward strokes. Pay special attention to underlying surface of penis. Rinse and dry penis thoroughly. Instruct patient to spread legs apart slightly. g. Gently cleanse scrotum. Lift it and wash underlying skin fold. Rinse and dry.	Towel prevents moisture from collecting in inguinal area. Gentle but firm handling reduces chance of patient having an erection. Secretions capable of harboring microorganisms collect underneath foreskin. Direction of cleaning moves from area of least contamination to area of most contamination. This prevents microorganisms from entering urethra. Tightening of foreskin around shaft of penis can cause local edema and discomfort. Vigorous massage of penis can lead to erection, which can embarrass patient and nurse. Underlying surface of penis may have greater accumulation of secretions. Abduction of legs provides easier access to scrotal tissues. Pressure on scrotal tissues can cause pain.
13.	Fold bath blanket over patient's perineum and assist patient in turning to side-lying position.	Draping promotes comfort and minimizes patient's anxiety. Side-lying position provides access to anal area.
14.	If patient has urinary or bowel incontinence, apply thin layer of skin barrier containing petroleum jelly over skin.	Protects skin from excess moisture and irritants from urine or stool.
15.	Apply under pads, if required.	Reduces risk of bed linen from getting soiled.
16.	Remove gloves and dispose in proper receptacle.	Moisture and body secretions on gloves can harbor microorganisms.
17.	Assist patient to comfortable position and cover him/her with top sheet.	
18.	Remove bath blanket, dispose of all soiled bed linen, and return unused articles to storage area.	Reduces chances of transmitting microorganisms.
19.	**After procedure** Record procedure and the presence of any abnormal finding, e.g., character and amount of discharge and condition of genitalia.	Provides documented evidence and communication among health team members.
20.	Report any abnormality observed to nurse in charge and physician.	

5.6: PROVIDING A BED SHAMPOO/HAIR WASH

DEFINITION

Cleaning of hair with shampoo or soap to remove dirt, oil, and odor on scalp and hair for a helpless patient in bed.

PURPOSES

1. To keep hair clean and healthy.
2. To promote growth of hair.
3. To prevent loss of hair.
4. To prevent itching and infection.
5. To prevent accumulation of dirt, dandruff, and oil.
6. To prevent tangles.
7. To stimulate circulation.
8. To clean hair after pediculosis treatment.
9. To enhance personal appearance and self-esteem.
10. To observe the scalp.
11. To provide a sense of well-being.

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CONTRAINDICATIONS

1. Head and neck injuries.
2. Spinal cord injuries.
3. Surgeries on back and neck.

ARTICLES (FIG. 5.6A)

A tray containing:

1. Bath towels (2 nos.).
2. Washcloth or face towel.
3. Mackintosh (2 nos.).
4. Nonabsorbent cotton balls.
5. Bath blanket/sheet.
6. Oil (optional).
7. Shampoo or liquid soap.
8. Hair comb.
9. Kidney tray.
10. Basin.
11. Bucket.
12. Mug.
13. Jugs (2 nos.).
14. Low stool.
15. Clean linen.
16. Newspaper.



Fig. 5.6A: Tray setting for hair wash.

PROCEDURE

	Nursing action	*Rationale*
	Before procedure	
1.	Check the physician's order for specific precautions, if any for movement and positioning of the patient.	Patient may be at risk for injury while manipulating the head. In some hospitals, a physician's order is required for bed shampoo.
2.	Assess the general condition of the patient, the scalp, hair, and the need for shampoo.	Determines the presence of any condition that may require the use of special shampoo or treatment.
3.	Check the patient's preference for soap/shampoo.	
4.	Explain the procedure to the patient.	Relieves anxiety and helps the patient to cooperate.
5.	Adjust the bed to comfortable height.	Use of good body mechanics prevents injury.
6.	Close windows and put off the fan.	Prevents patients from going into hypothermia.
7.	Pull the curtains.	Provides privacy for the patient.
	During procedure	
8.	Wash hands. Fanfold the top linen to the foot end of the bed leaving a sheet or bath blanket over the patient.	Prevents cross infection. A sheet or bath blanket prevents patient from chilling.
9.	Make a trough with the mackintosh or use a Kelly's pad if available.	Allows dirty water to flow into the bucket.
10.	Unless contraindicated, move the patient's head to the edge of the bed, position the patient diagonally with head positioned inside trough **(Fig. 5.6B)**.	Prevents over stretching and allows use of good body mechanics.
	 **Fig. 5.6B:** Positioning patient for bed shampoo.	
11.	Place pillow under the shoulder so that the head is slightly tilted backward.	Prevents soiling of the bed.
12.	Protect the pillow and bed with a mackintosh and towel.	Prevents soiling of bed and pillow.
13.	Place the bucket on a low stool close to the side of bed.	Collects the dirty water.

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	Nursing action	*Rationale*
14.	Plug the ears with nonabsorbent cotton balls.	Prevents shampoo entering into the ears.
15.	Place a wash cloth or a towel over the eyes.	Prevents shampoo entering into the eyes.
16.	Wash hands.	Prevents spread of microorganisms.
17.	Loosen and remove tangles.	
18.	Mix cold and hot water and test the temperature with the back of hand.	Warm water is comfortable and facilitates removal of dirt and sebum.
19.	Start cleaning at hairline and working toward the back of the head symmetrically using shampoo.	Shampoo helps to remove dirt, sebum, and dandruff from the scalp.
20.	Rub shampoo and massage the scalp well **(Fig. 5.6C)**.	Rubbing and massaging of scalp adds to the comfort of the patient and effectiveness of shampoo.
21.	Rinse thoroughly with water.	Removes soap and dirt.
22.	Repeat washing and rinsing until hair is clean, squeeze off water from hair.	Prevents chilling.
23.	Instruct patient to inform nurse, if any discomfort or pain occurs.	
24.	Dry hair with second towel **(Fig. 5.6D)**.	
	 **Fig. 5.6C:** Massaging scalp using shampoo.	 **Fig. 5.6D:** Drying hair.
25.	Remove the trough and place it in the bucket. Discard the cotton plugs used to plug ears into the K-basin.	
26.	Reposition the patient in proper alignment.	Enhances patient's comfort.
27.	Spread the hair over mackintosh and towel placed on the pillow and allow it to dry.	Enhances patient's comfort.
28.	Change linen if wet.	Enhances patient's comfort.
29.	Offer hot drink.	Enhances patient's comfort.
30.	**After procedure** Take all articles to the utility room and clean them. Disinfect the towels, mackintosh, basin, and bucket. Send soiled linen to laundry. Wash hands.	Reduces risk of transmission of microorganisms.
31.	Return to bedside when the hair is dry. Comb and arrange the hair. Remove mackintosh and towel from the bed. Make the patient comfortable.	Improves self-esteem of patient.
32.	Record the procedure and report any abnormalities, if present.	Ensures communication between staff members.

SPECIAL CONSIDERATIONS

1. Consider cultural, religious, and personal preferences of patients.
2. Special precaution should be taken in positioning patient if central venous lines are present.
3. Assess for pediculosis and apply medication for pediculosis capitis as prescribed or as per hospital practice commonly used parasiticides:
   - Carbolic lotion 1:40
   - Anti-lice shampoo
   - Vinegar and coconut oil.

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5.7: PERFORMING EYE CARE

Conjunctivitis: Inflammation or infection of the conjunctiva.
Canthus: The outer or inner corner of the eye, where the upper and lower lids meet.

DEFINITION

Process of cleaning one/both eyes using prescribed solution for removing secretion and for preventing infection.

PURPOSES

1. To relieve pain and discomfort.
2. To prevent infection.
3. To prevent any further injury to the eye.
4. To provide instillation of an eye drops or application of an eye ointment.

ARTICLES

A clean tray with a sterile eye dressing pack containing:
1. Gallipot
2. Cotton balls
3. Disposable towel
4. Sterile swabbing solution, e.g., normal saline
5. K-basin
6. Sterile gloves (if eye is infected)
7. Mackintosh
8. Pillow.

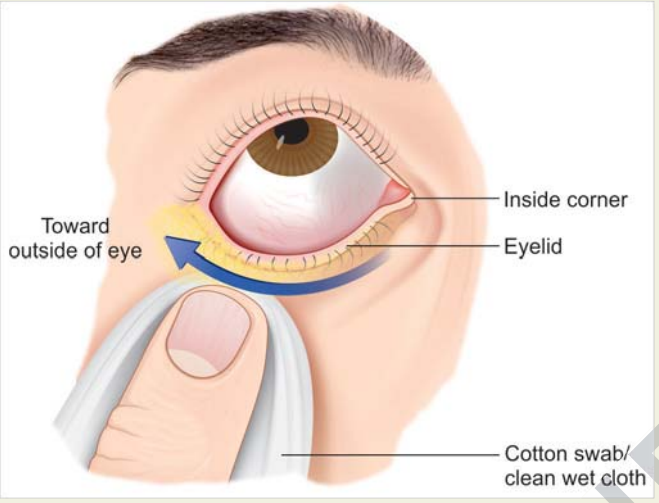
PROCEDURE

	Nursing action	*Rationale*
	Before procedure	
1.	Check the physician's order, progress notes, and nursing care plan.	Obtains specific instruction/information.
2.	Identify the patient.	
3.	Explain to patient what will be done and how he may cooperate. Allow patient to ask questions.	Obtains patient's consent and cooperation and promotes patient education.
4.	Ensure privacy.	Avoids unnecessary embarrassment.
5.	Collect and prepare articles.	
6.	Position the patient comfortably, preferably in the supine position or seated with head inclined backward.	
7.	Ensure adequate light source taking care not to dazzle the patient.	Enables maximum observation of the eye without causing the patient harm or discomfort.
	During procedure	
8.	Wash and dry hands.	Prevents infection.
9.	Always treat the uninfected eye first.	Avoids cross-infection.
10.	Always bathe the lids first, with the eyes closed.	Avoids secretion on the lid from entering into eyes.
11.	Lightly moisten swab in the prescribed solution.	If the swab is too wet, the solution will run down the patient's cheek. This increases the risk of cross-infection.
12.	Gently swab from the inner canthus of the eye to the outer canthus using each swab only once until all discharge has been removed **(Fig. 5.7A)**.	Avoids the risk of discharge entering into the lacrimal duct.

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	Nursing action	*Rationale*
	 **Fig. 5.7A:** Cleaning an infected eye.	
13.	Gently dry the patient's eyelids to remove excess moisture.	
14.	Ensure that the patient is comfortable.	
15.	Replace the equipment safely.	
16.	**After procedure** Wash hands and dry.	
17.	Document the procedure appropriately and report any abnormal findings.	

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