CHAPTER 18
Hygiene and Care of the Patient’s Environment

Factors Influencing Personal Hygiene
- Social practices
- Body image
- Socioeconomic status
- Knowledge
- Personal preference
- Physical condition
- Cultural variables

Bathing

Sitz Bath
- Cleanses and aids in reducing inflammation of the perineal and anal areas of the patient who has undergone rectal or vaginal surgery or childbirth
- Water temperature 98° to 102° F

Cool Water Tub Bath
- May be given to relieve tension or lower body temperature
- Water temperature tepid, not cold—98.6° F

Warm Water Tub Bath
- Given to reduce muscle tension
- Water temperature 109.4° F

Hot Water Tub Bath
- Given to assist in relieving muscle soreness and muscle spasms
- Water temperature 113° to 115° F

Other Baths
- Complete Bed Bath
  - For patients who are totally dependent and require total assistance
- Tepid Sponge Bath
  - Administered to reduce an elevated temperature
- Medicated Bath
  - May include agents such as oatmeal, com starch, Burow’s solution, and soda bicarbonate
  - To reduce tension and relax the patient and to relieve pruritus caused by certain skin disorders

Figure 18-2
The sitz bath.

Skill 18-1: Steps 8e(1) & 8e(2)

Bed bath.


Skill 18-1: Steps 8e(3) & 8e(4)

Bed bath.


Skill 18-1: Steps 8h & 8i

Bed bath.


Skill 18-1: Steps 8r & 8u

Bed bath.


Skill 18-1: Steps 10d(1) & 10d(2)

Towel bath.

(From Elkin, M.K., Perry, A.G., Potter, P.A. [2004]. Nursing interventions and clinical skills [3rd ed.]. St. Louis: Mosby.)

Skill 18-1: Step 10e

Towel bath.

(From Elkin, M.K., Perry, A.G., Potter, P.A. [2004]. Nursing interventions and clinical skills [3rd ed.]. St. Louis: Mosby.)
Bathing

Back Care/Backrub
- Usually administered after the patient’s bath
- Promotes relaxation, relieves muscular tension, and stimulates circulation
- Nurse massages for 3 to 5 minutes
- Contraindicated if the patient has such conditions as fractures of the ribs or vertebral column, burns, pulmonary embolism, or open wounds

Skill 18-1: Steps 14e & 14f

Back rub.

Components of the Patient’s Hygiene

Care of the Skin
- When a person’s physical condition changes, the skin often reflects this through alterations in color, thickness, texture, turgor, temperature, and hydration.
- As long as the skin remains intact and healthy, its physiological function remains optimal.

Care of the Skin (continued)
- Collection of Data
  - Normal skin has the following characteristics:
    - Intact without abrasions
    - Warm and moist
    - Localized changes in texture across surface
    - Good turgor; generally smooth and soft
    - Skin color variations from body part to body part

Components of the Patient’s Hygiene

Care of the Skin (continued)
- Impaired Skin Integrity
  - A patient who stays in one position without relief of pressure can develop a pressure sore.
  - Patients especially at risk are the chronically ill, debilitated, older, disabled, or incontinent patient and the patient with spinal cord injuries, limited mobility, or poor overall nutrition.

Figure 18-5

Thirty-degree lateral position to avoid pressure points.
Using a rolled bath blanket as a pressure-reducing device.

Care of the Skin (continued)

- Impaired Skin Integrity
  - **Shearing force**
    - The tissue layers of skin slide onto each other, resulting in kinking or stretching of subcutaneous blood vessels; this results in an interruption of blood flow to the skin.
  - **Friction**
    - Rubbing of skin over a surface produces friction, which may remove layers of tissue.

Components of the Patient’s Hygiene

Care of the Skin (continued)

- **Stages of Pressure Ulcers**
  - Stage I: nonblanchable erythema of the skin
  - Stage II: partial-thickness skin loss; epidermis
  - Stage III: full-thickness skin loss, damage or necrosis of subcutaneous tissue
  - Stage IV: full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures

Diagram of shearing force exerted against sacral area.

A, Stage I pressure ulcer.
Stage II pressure ulcer.


Stage III pressure ulcer.


Stage IV pressure ulcer.


**Care of the Skin (continued)**

- **Nursing Interventions**
  - Assess improvement.
  - Assess size and depth of the ulcer, the amount and color of any exudate, the presence of pain or odor, and the color of the exposed tissue.
  - Specific interventions are determined by the stage of the ulcer.

**Oral Hygiene**

- Care of the oral cavity
- Helps maintain a healthy state of the mouth, teeth, gums, and lips
- Brushing the teeth removes food particles, plaque, and bacteria; massages the gums; and relieves discomfort resulting from unpleasant odors and tastes.

**Skill 18-2: Steps 9a & 9c**

Administering oral hygiene.

(From Elkin, M.K., Perry, A.G., Potter, P.A. [2004]. *Nursing interventions and clinical skills* [3rd ed.]. St. Louis: Mosby.)

**Components of the Patient's Hygiene**

**Oral Hygiene (continued)**
- Dentures
  - A set of artificial teeth not permanently fixed.
  - Should be stored in an enclosed, labeled cup for soaking or when they are not worn.
  - Should be cleaned as often as for natural teeth to prevent infection and irritation.
  - Oral care provided on a regular basis.

**Hair Care**
- Combing, brushing, and shampooing are basic hygiene measures for all patients.
- Patient may shampoo in the shower or tub, use a portable chair in front of a sink, or in bed.
- Shaving the Patient
  - Patient may prefer to shave at the time of bathing.
  - Patients who have a bleeding disorder or are taking anticoagulants should use electric razors.
  - Do not allow a disoriented or depressed patient to use a razor with a blade.

**Hand, Foot, and Nail Care**
- Hands and feet often require special attention to prevent infection, odors, and injury.
- Assessment
  - Examine all skin surfaces.
  - Carefully assess between the toes.
  - Observe for adequate circulation.

**Perineal Care**
- Care of the genitalia
- Part of the complete bed bath
- Assess for signs of vaginal or urethral exudate, skin impairment, unpleasant odors, complaints of burning during urination, or localized tenderness or pain of the perineum.
- Catheter care is to be performed twice daily on all patients with indwelling catheters.
  - Includes cleansing of the meatal-catheter junction with a mild soap and water and sometimes application of a water-soluble microbial ointment.

**Skill 18-2: Step 10c**
- Administering oral hygiene.

**Skill 18-3: Steps 9a & 10e**
- Care of the hair, nails, and feet.


(From Poter, P.A., Perry, A.G. [2004]. *Nursing interventions and clinical skills* [3rd ed.]. St. Louis: Mosby.)
Skill 18-4: Step 9b

Female perineal care.


Skill 18-4: Steps 9e & 9g

Female perineal care.


Components of the Patient’s Hygiene

Eye, Ear, and Nose Care (continued)

- Care of the eyes
  - Cleansing of the circumorbital area of the eyes is usually performed during the bath.
  - Case involves washing with a clean washcloth moistened with clear water.
  - The use of soap is omitted because it may cause burning and irritation.
  - The eye is cleansed from the inner to the outer canthus.
  - Patient may need assistance with care of eyeglasses or contact lenses.

- Care of the ears
  - The ears are cleansed by the nurse during the bed bath.
  - A clean corner of a moistened washcloth rotated gently into the ear canal works best for cleaning.
  - A cotton-tipped applicator is useful for cleansing the pinna.
  - The nurse should teach patients never to use bobby pins, toothpicks, or cotton-tipped applicators to clean the internal auditory canal.

- Hearing aids
  - This involves routine cleaning, battery care, and proper insertion technique.
  - When not in use, the hearing aid should be stored where it will not become damaged.

Components of the Patient’s Hygiene

- Eye, Ear, and Nose Care (continued)
  - Care of the ears (continued)
    - Hearing aids
      - This involves routine cleaning, battery care, and proper insertion technique.
      - When not in use, the hearing aid should be stored where it will not become damaged.
Components of the Patient’s Hygiene

Eye, Ear, and Nose Care (continued)

- Care of the nose
  - The patient can usually remove secretions from the nose by gently blowing into a soft tissue.
  - Teach the patient that harsh blowing causes pressure capable of injuring the tympanic membrane, nasal mucosa, and even sensitive eye structures.
  - If the patient is not able to clean the nose, the nurse will assist, using a saline-moistened washcloth or cotton-tipped applicator; for excessive secretions, suctioning may be required.

Bedmaking (continued)

- It is the nurse’s responsibility to keep the bed as clean and comfortable as possible.
- This may require frequent inspections to make sure the bedding is clean, dry, and wrinkle free.
- Check the linens for food particles after meals and for urine incontinence or involuntary stool.
- Use proper body mechanics; raise bed to a working level.
Selected equipment and supplies for elimination.


Components of the Patient’s Hygiene

Assisting the Patient with Elimination
- Bedpan
  - A device for receiving feces or urine from either male or female patients confined to the bed
- Urinal
  - A device for collecting urine from male patients; urinals for females also available
  - Bedpans or urinals are used when a patient is unable to get up to go to the bathroom for the purpose of urination or defecation.

The bedside commode has a toilet seat with a container underneath.

Components of the Patient’s Hygiene

Assisting the Patient with Elimination (continued)
- The nurse should offer the bedpan or urinal frequently, because patients may accidentally soil bedclothes if their elimination needs are not met.
- Report any abnormalities and record in the nurse’s notes.
- Flow sheets are usually provided for documentation of normal voidings and stools.

Components of the Patient’s Hygiene

- Care of the Incontinent Patient
  - Incontinence is a very common problem, especially among older adults.
  - Incontinence occurs because pressure in the bladder is too great, sphincters are weak, or the innervation has been compromised due to illness or injury.
  - Incontinence may involve a small leakage of urine when the person laughs, coughs, or lifts something heavy.

Skill 18-6: Steps 11(2) & 11(3)

Positioning the bedpan.

(From Elkin, M.K., Perry, A.G., Potter, P.A. [2004]. Nursing interventions and clinical skills [3rd ed.]. St. Louis: Mosby.)
Components of the Patient’s Hygiene

Care of the Incontinent Patient (continued)

- Care requires the use of disposable adult undergarments or underpads.
- Cleansing the skin thoroughly after each episode of incontinence with warm soapy water and drying it thoroughly help to prevent skin impairment.
- When urinary incontinence results from decreased perception of bladder fullness or impaired voluntary motor control, bladder training can be helpful.