CHAPTER 20

ASSISTING WITH HYGEINE, PERSONAL CARE, SKIN CARE, AND THE PREVENTION OF PRESSURE INJURIES

THEORY OBJECTIVES

page 308

- Describe the structure and function of the integumentary system
- Describe factors that influence personal hygiene practices
- List the skin areas most susceptible to pressure injuries
- Discuss risk factors for altered skin integrity
- Discuss the purposes of bathing
- Describe the difference in hygienic care for the younger and older adult

CLININICAL PRACTICE

page 308

- Describe how to prevent and stage a pressure injury
- Perform a complete bed bath and back rub
- Provide oral care for an unconscious patient
- Prepare to provide personal care for a patient, including nail care, mouth care, perineal care, and shaving
- Assist a patient with the care of contact lenses
- Instruct a patient in ways to prevent buildup of cerumen in the ears

SKILLS

PAGE 308

- Skill 20.1 Administering a bed bath and perineal care
- Skill 20.2 Administering Oral care to the unconscious patient
- Skill 20.3 Providing denture care
- Skill 20.4 Shampooing hair

- Step 20.1 Providing a tub or shower
- Step 20.2 Shaving a male patient

Hygiene is the proper care of the skin, hair, teeth, and nails to promote good health by protecting the body from infection and disease and to provide a sense of well-being.

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WHAT IS THE STRUCTURE OF THE SKIN?

page 308-309

Integumentary system contains the skin, hair, nails, and sweat and sebaceous glands. The skin is the LARGEST organ in the body and has 2 main layers: the **epidermis** and the **dermis.**

Epidermis: (outer, thinner layer) consist of stratified squamous epithelial tissue and does NOT contain blood vessels. It receives its nutrition by diffusion from vessels in underlying tissues. The uppermost layer of the epidermis is called the stratum corneum.

The bottom layer of the epidermis contains melanocytes that secrete melanin, the main determinant of skin color.

Dermis: (inner, thicker layer) is made of dense connective tissue that gives the skin strength and elasticity. It is also called the corium. The dermis CONTAINS blood vessels, nerves, fibroblasts, the base of hair follicles, and glands; the nails are derived from the epidermis. Fibroblasts produce new cells to heal skin after injury.

WHAT IS THE STRUCTURE OF THE SKIN?

page 308-309

- Hair and nails are made of keratin and do not have nerve endings or a blood supply.
- **Sebaceous glands** are oily substances called **sebum**. Sweat glands secrete sweat, and ceruminous glands (modified sweat glands) secrete a waxy substance called **cerumen.**
- Mucous membranes line the cavities or passageways of the body that open to the outside, such as the mouth and digestive, respiratory, and genitourinary tracts.

What are the functions of the skin and its structures? page 309

The skin has four main functions: PROTECTION, SENSATION, TEMPERATURE REGULATION, AND EXCRETION AND SECRETION.

The skin is the first line of defense in protecting the body from bacteria and other invading organisms. **It protects tissue from thermal, chemical, and mechanical injury.**

The sebaceous glands produces sebum, which helps make the skin waterproof by preventing water loss from underlying tissues and too much water absorption during bathing and swimming.

Melanin absorbs light and protects against ultraviolet rays. When exposed to ultraviolet light, the skin makes vitamin D.

The skin has sensory organs for touch, pain, heat, cold, and pressure,

The skin regulates temperature by dilating and constricting blood vessels and activating and inactivating sweat glands.

What are the functions of the skin and its structures?

page 309

- Sweat glands assist in maintenance of homeostasis of fluid and electrolytes. They serve as excretory organs because sweat glands contain nitrogenous wastes. As sweat evaporates, it produces a cooling effect.
- Sebum lubricates the skin and hair, keeping these structures softer and more pliable.
- **Mucous membranes protect against bacterial invasions, secrete mucous, and absorbs fluid and electrolytes.**

WHAT CHANGES IN THE SYSTEM OCCUR WITH AGING? PAGE 309

- Loss of elastic fibers and adipose tissue In the dermis and subcutaneous layers causes skin too be **thinner** and **more transparent**, with wrinkling and sagging.
- Loss of collagen fibers in the dermis makes the skin more fragile and slower to heal
- Decreased sebaceous gland activity causes **dry and itchy skin.**
- Temperature control is altered by the decreased sebaceous gland activity and the loss of skin density. This results in cold intolerance and puts the person at risk for heat exhaustion.
- Hair becomes thin and grows more slowly because of a decrease in the number of hair follicles.
- **Nail growth decreases, and the nails thicken**

FACTORES AFFECTING HYGEINE

page 309

Different cultures have different views on hygiene practices. In some cultures, people do not use deodorant products or bathe daily

The patients economic status may affect their hygiene because the money for supplies may or may not be available.

The ability to perform self-care may be affected by the patients mental or physical condition, which may be altered because of illness or injury.

- Person-centered care (bathing preference) pg 310
- Think critically pg 310
- Person-centered care (self-care abilities) pg 310

SKIN AND PRESSURE INJURIES

page 310

- The interference with circulation causes the skin to **blanch** (turn white or, in the darker skin, become pale). If the pressure is relieved at this point, the skin will become red or a darker color because of vasodilation.
- **Reactive hyperemia** is the process in which the blood rushes to a place where there was a decrease in circulation.
- Culture considerations pg 310

RISK FACTORS FOR PRESSURE INJURIES page 310

- Box 20.1 pg 310
- The first two risk factors listed deal with a patients mobility. If a patient is confined to a bed or chair, the same areas of the body sustain pressure.
- This also happens if a patient cannot change position independently, for example a patient who is paralyzed or unconscious.
- Moisture can lead to pressure injuries in a patient who is **incontinent** (has lost bowel or bladder control)
- Skin that is frequently wet leads to **maceration** (softening of tissue that increases the chance of trauma or infection)- not viable skin
- **Diaphoresis** (perspiration, sweating), not drying a patient properly after a bath, and the use of incontinence briefs also place a patient at risk because of moisture.

RISK FACTORS FOR PRESSURE INJURIES page 310

- A balanced diet is necessary to prevent injury development. **Without proper calories, protein, fluids, vitamins, and minerals, the body's cells, capillaries, and tissues are easily damaged.**
- Altered sensory perception places a person's risk for pressure injuries because they may not receive the body's signals of discomfort reminding them to change position.
- **Lowered mental awareness** is another consideration because patients who have lost the concept of time may not realize that they have been in the same position for a prolonged period.
- Lowered mental awareness may be caused by medication, anesthesia, or health problems.
- Think critically pg 310

SKIN ASSESSMENT FOR PRESSURE INJURIES

PAGE 310

- The Braden Scale for Predicting Pressure Score Risk is commonly used.
- After the initial assessment, reassess every 24 hours.
- This may be done while you are bathing your patient.
- Pay particular attention to the skin over the bony prominences.
- Check pressure areas when turning and repositioning your patient.
- Clinical goldmine box pg 310
- Braden scale documentation example pg 311
- Fig 20.3

SKIN ASSESSMENT FOR PRESSURE INJURIES

PAGE 312

- Redness normally can be expected to be present for one-half to three-fourths as long as the pressure prevented blood flow.
- If there has not been damage, you expect the redness to subside in 30-45 minutes. If the redness persists after that time, the pressure has damaged the skin and the underlying tissues because they have not received an adequate supply of blood, oxygen, and nutrients. Unrelieved the damage eventually will lead to tissue necrosis and a pressure injury.
- If you note a reddened area when repositioning a patient, reassess later to see whether reactive hyperemia is present. If the redness remains and the skin **does not blanch** to fingertip pressure, the patient has a stage 1 pressure injury.

STAGE 1 PRESSURE INJURY page 312

- An area of intact skin that is red, deep pink, or mottled skin that does NOT blanch with fingertip pressure. Warmth, edema, and induration (an area that feels hard) in comparison to surrounding tissue may be signs of stage 1 pressure injury.

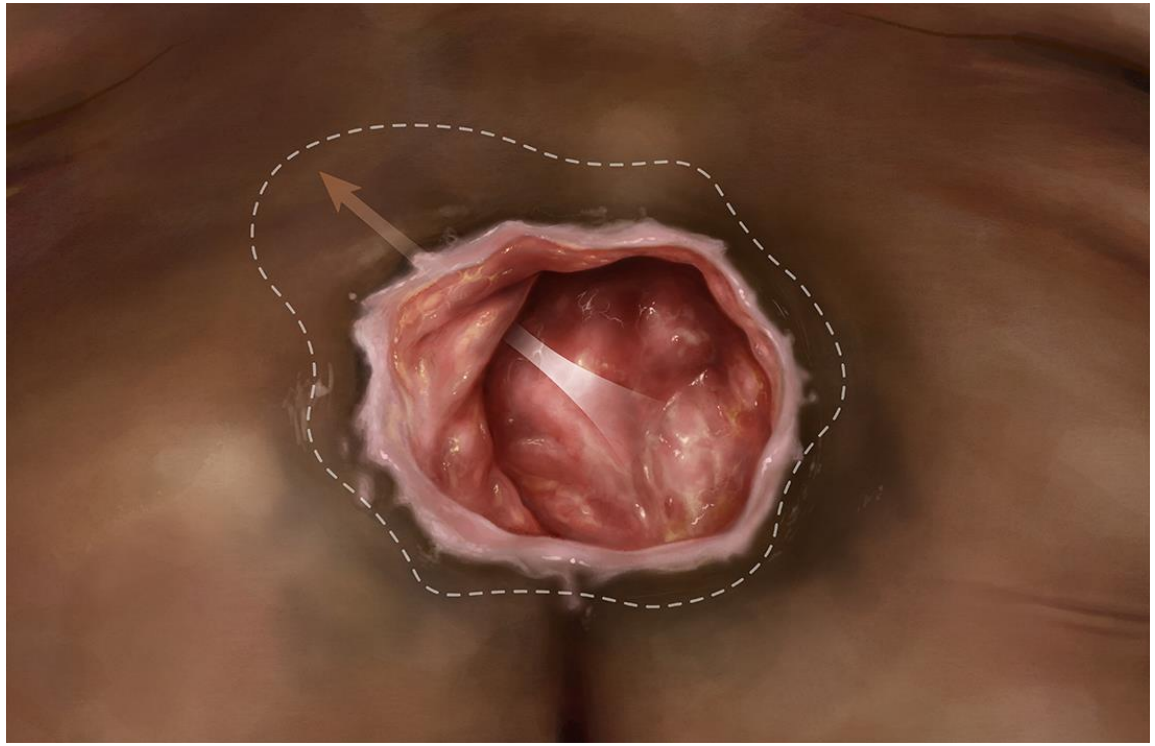
STAGE 2 PRESSURE INJURY page 312

- Partial-thickness skin loss with exposed dermis. The wound bed is pink or red and moist and may appear as an intact or rupture blister.

STAGE 3 PRESSURE INJURY

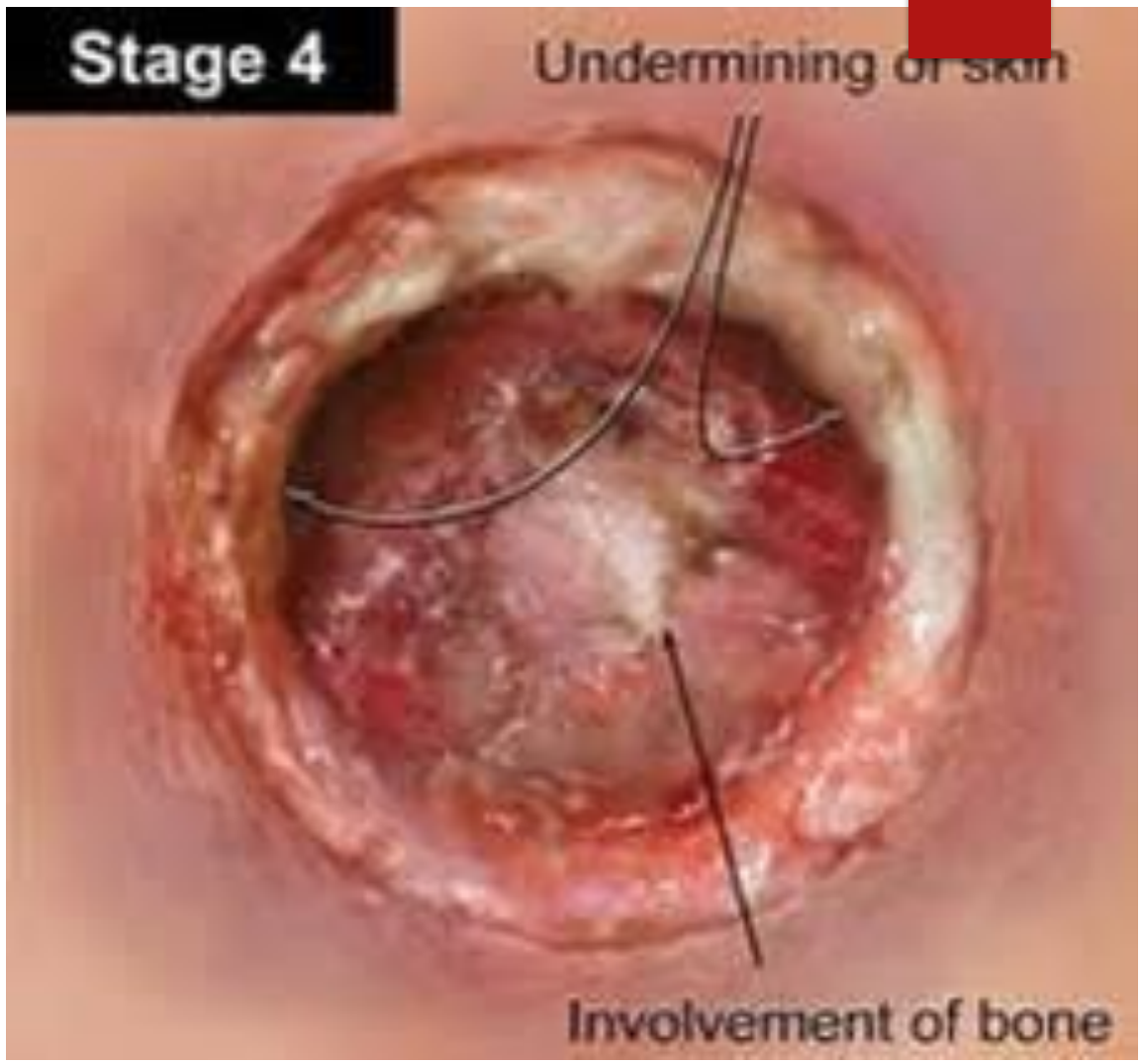
page 312

- Full-thickness skin loss that looks like a deep crater and may extend to the fascia. Subcutaneous tissue is damaged or necrotic, fat is visible. Undermining and tunneling may be present. There may be damaged to the surrounding tissue.



STAGE 4 PRESSURE INJURY page 312

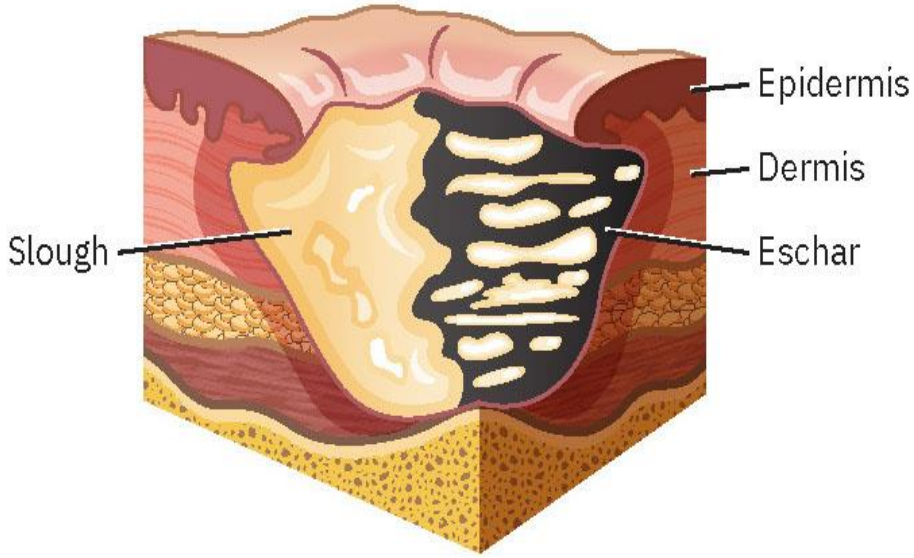
- Full-thickness skin loss with extensive tissue necrosis or damage to muscle, bone or supporting structure; sinus tracts may be present. Infection is usually widespread. The injury may appear dry and black, with buildup of tough, necrotic tissue (eschar), or it can appear wet and oozing.



UNSTAGEABLE PRESSURE INJURY page 312

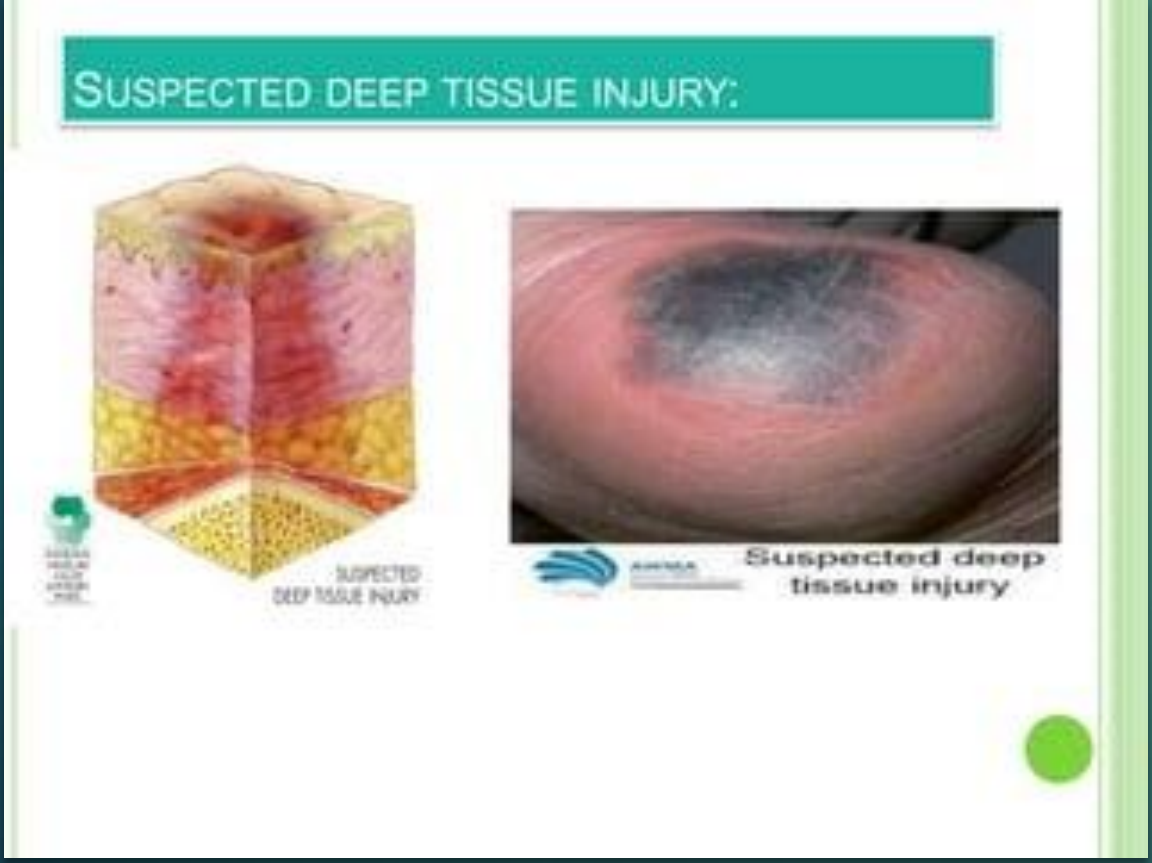
- Loss of full thickness of tissue. The base of the injury is covered by **eschar** (tan, brown, black) in the wound bed, or the base of injury contains slough (yellow, tan, gray, green, or brown)

(a)



(b)

DEEP TISSUE PRESSURE INJURY page 313



- Localized discolored intact skin that is maroon or purple or a blood-filled blister resulting from damage to underlying soft tissue from pressure or shearing. The area may be painful, firm, mushy, boggy, warmer, or cooler when compared to adjacent tissue.

SKIN ASSESSMENT FOR PRESSURE INJURIES

PAGE 313

- During staging, it is important to be aware of the following:
- Stage 1 pressure injuries may be just superficial or may be a sign of deeper tissue damaged and are not always accurately assessed in people with darker skin
- When eschar is present, the pressure injury is described as unstageable. **Escar must be removed to stage the pressure injury properly.**
- Document the location of any abnormality, its color and size, and reaction to the blanch test. Add other descriptive terms as they apply, including induration, blisters, drainage, odor, or eschar.
- **Healing pressure injuries are not "reversed stage". For ex: stage 4 pressure is not called a stage 3 pressure injury as it improves. This pressure injury would be called a "healing stage 4 pressure injury"**
- Lifespan consideration box pg 313

PREVENTION OF PRESSURE INJURIES

PAGE 313

- **Excellent nursing care is the main factor in the prevention of pressure injuries.**
- **Prevention is less time consuming and less costly than treatment of pressure injuries.**
- Safety alert box pg 313

TREATMENT AND CARE FOR PRESSURE INJURIES

page 313

- The team approach is the most effective method of pressure injury treatment.
- The team should include the patient, the family or caregivers, and health care providers.
- The plan should be consistent with the individual patient and family preferences, goals, and abilities.
- Include education on development and prevention of pressure injuries.
- Legal and Ethical considerations pg 314

BATHING

PAGE 314

BOX 20.2

Bathing has four basic purposes:

1. CLEANSE THE SKIN
2. PROMOTE COMFORT
3. STIMULATE CIRCULATION
4. REMOVE WASTE PRODUCTS SECRETED THROUGH THE SKIN

- Water should be warm but should NOT burn the patient. (approximately 105 F or according to agency policy)
- When water cools, REPLACE it!
- Box 20.3

TYPES OF BATHS

PAGE 315

- A bath may be cleansing or therapeutic, and complete or partial.
- **With a compete bath, all areas of the patient's body are washed.**
- Assignment and supervision box pg 315
- The term partial bath has two different meanings depending on your institution:
- One case it means that only certain parts of the body are bathed, such as the face, hands, axillae, back and perineal care.
- Another case a partial bath means that are complete bath is done- partially by the patient (the areas that can be reached) and partially by you (all other areas)
- Lifespan consideration box pf 315
- Evidence-based practice pg 315

CLEANSING BATHS

page 315

- The most common type of bath is a cleansing bath. It is generally provided in a bed, tub and shower. Bed baths are given to patients who are unable to use a tub or shower.
- Once the patient is in the tub or shower, add warmer water is desired.
- **Place a call light within easy reach of the independent patient. Check on the patient every 5 minutes and inform the patient that the bath should not exceed 15-20 minutes.**
- Clinical goldmine box pg 315

THERAPEUTIC BATHS

page 321

- Therapeutic means having healing or medical qualities.
- A whirlpool bath is done in a bathtub or special whirlpool tub that has a device that agitates the water. **Whirlpools are used to cleanse, stimulate circulate peripheral circulation, and provide comfort. .**
- Sitz baths are used to apply moist heat and clean the perineal or anal area. **The bath promotes healing and relieves pain and discomfort.** fig 20.6 pg 322
- Body soaks are usually indicated to cleanse open wounds or apply medicated solutions to an area.
- Cooling sponge baths are also known as tepid sponge baths. An order is usually needed before this type of bath can be used to bring down a fever.
- Clinical goldmine box pg 322

BACK MASSAGE

PAGE 322

- A back massage is an important part of hygiene care and involves the sense of touch. Benefits include:
- Communicates caring
- Foster trust in the nurse-patient relationship
- Provides an opportunity to assess the skin on the back
- Stimulates circulation of blood to the area
- Reduces tension and promotes circulation

- **Avoid open wounds and areas of pressure injury while performing a back rub.**
- Use more pressure on upward strokes toward the head and less pressure on downward strokes. The pressure should be firm but should not cause tensing or discomfort. Use short circular strokes paying particular attention to shoulder and neck.
- **An effective back rub should last approximately 3-5 minutes!**

PERINEAL CARE

page 323

Proper draping helps promote comfort with the procedure (fig 20.8)

Explain the procedure to reassure the patient and gain cooperation

Maintain a matter-of-fact attitude and be objective

A professional and dignified attitude can help reduce embarrassment.

MOUTH CARE

PAGE 323

- Mouth care removes food particles and secretions, which prevents **halitosis** (bad breath), feelings of uncleanliness, and dental **caries** (cavities)
- Promotes a better appetite and maintains the healthy state of the mouth, gums, teeth, and lips.
- **Lack of oral hygiene can have serious consequences, including increased risk of stroke, heart disease, and pneumonia.**
- Provide oral care on a regular basis, ideally four times a day.

MOUTH CARE FOR THE CONSCIOUS PATIENT

page 323

- To assist a patient with mouth care, raise the head of the bed 45-90 degrees.
- If the patient is unable to sit up, turn the patient to the side facing you.
- Brush from the gum line to the edge of the teeth. All surfaces of each tooth should be brushed. (fig 20.9)
- To assist with flossing the teeth, obtain 12-15 inches of floss. Report any excessive bleeding of the gums after flossing

MOUTH CARE FOR THE UNCONSCIOUS PATIENT

PAGE 323

- Provide full mouth care to an unconscious patient at least once every 4 hours.
- **If the patient is mouth breathing, perform oral care every 4 hours.**
- Mouth breathing causes the tongue to dry and become crusty. Remove any dry secretions because they cause halitosis and may obstruct airflow.
- Moist swabbing of the mouth is every 2 hours or PRN (as needed) to maintain the integrity of the oral cavity.

DENTURE CARE

page 232

- Dentures should be cleaned to prevent irritation to the gums and infection.
- Dentures should to relieve pressure on mouth tissues and to allow saliva to cleanse the tissue
- **When not in mouth, dentures are kept in a labeled denture container filled with water or normal saline.**

HAIR CARE

page 325

Brushing and combing the hair stimulates circulation, which helps promote hair growth, prevent hair loss, distribute oil along hair shafts, and bring nutrients to the roots.

BRUSHING AND COMBING PAGE 325

- A patient may have tangled or matted hair. Braiding he hair helps reduces tangles. Ask for permission from the patient before braiding. DO NOT cut the hair to remove tangles
- **A written informed consent is necessary to cut a patients hair.**

SHAMPOOING

PAGE 327

- Shampooing removes dirt, soil, blood, or solutions from the hair, and it stimulates the circulation of the scalp and eases brushing and combing.
- You must do the shampooing In bed if the patient is bedridden.
- Dry or rinse-less shampoo that does not require water is available for cleaning the hair.
- Another option is a shampoo cap such as a readybath shampoo cap.

SHAVING

PAGE 327

- Either a safety razor or an electric razor may be used
- Check an electric razor before use for any possible electrical hazard.
- **Any razor should be used on only one patient to provide for infection control**
- Be gentle and use short strokes with the safety razor.
- **Check the patients' health record to see whether the patient has any bleeding tendencies or is receiving medications that would contraindicate the use of a safety razor.**
- **A safety razor should not be used when a patient has a low platelet count, is receiving anticoagulant, is undergoing chemotherapy, or is on aspirin therapy.**

MUSTACHE AND BEARD CARE PAGE 327

- Cleanse mustaches and beards with warm, damp washcloth or wash with soap and water.
- **You may not shave off a beard or mustache without a written, informed consent.**

NAIL CARE

PAGE 327

- You may need to provide care for those who are unconscious, blind, confused, unsteady, or in a cast or traction.
- Nail care includes regular trimming, cleaning under the nails, and cuticle care.
- **NEVER cut the toenails of a patient with diabetes or circulatory disease of the lower extremity without a written order.**
- Soak the nails in warm soapy water for 5-10 mins, especially if they are dirty or thickened.
- Hangnails are painful and a possible source of infection
- Use nail clippers to cut the toenails straight across to prevent them from growing into the skin along the sides. Fig 20.11pg 331
- Observe the color of the nail beds to monitor circulation in the extremities. (temp, color, CRT)
- Patient education box pg 329

EYE CARE

PAGE 329

- Assess your patients eyes for drainage, crusting, or redness
- If crusting is noted, soak the eyelid with a warm, damp washcloth for 2-3 minutes to soften the crust and ease its removal.
- Use a different part of the cloth for each eyelid.
- Perform more frequent eye care for unconscious patients; administer lubricating drops as ordered.
- Health promotion box pg 330
- Artificial eye: an eye that is not implanted needs to be removed daily for cleaning .

EAR CARE

page 331

- Hearing acuity may be affected if cerumen or foreign material collects in the external ear canal.
- Remove these materials by gently washing the external ear canal with a warm washcloth.
- **NO object, including cotton-tipped applicators should be inserted into the ear canal.** why?
- You may need to irrigate the ear if the wax is dried or excessive. Notify MD if irrigation is needed.
- Home care considerations box pg 331

HEARING AIDS

PAGE 332

- There are five types of hearing aids; behind the ear, "mini" behind the ear, In the ear, in the ear canal, completely in the ear canal.
- Fig 20.13
- Clean the hearing aids as directed to decrease buildup of wax and drainage, which can damage the hearing aids.
- Clinical goldmine box pg 332

KEY POINTS

- The skin is the largest organ of the body. The main function of the skin are to protect, sense, regulate temperature, excrete, and secrete.
- Changes from aging may cause the skin to wrinkle and sag, become dry and itchy, have altered temperature control, and be more fragile and slower to heal.
- To determine self-care abilities, assess the patients physical and cognitive abilities.
- Pressure injuries are graded according to four stages plus the categories "unstageable" and "deep pressure injury"
- Pay particular attention to assessing areas over bony prominences
- Purpose of bathing are to cleanse the skin, promote comfort, stimulate circulation, and remove waste products from the skin.
- When providing peri care for a female, wipe from front to back to prevent infection.
- Maintaining oral hygiene prevents halitosis and dental caries
- Shaving with a safety razor is contraindicated in patients who are on anticoagulants, chemo, or aspirin.
- Trim toenails straight across, an order is needed to trim the toenailss of patients with DM and peripheral vascular disease (PVD)

Resourceful videos

- Pressure Injuries (Ulcers) Nursing | Patho, Causes, 6 Stages, Braden Scale
- How to use a sitz bath