



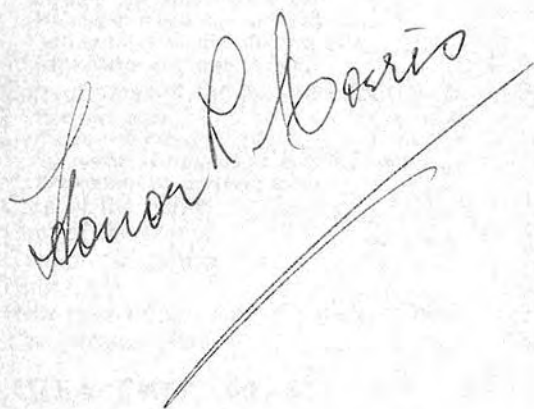
CARE OF THE SICK IN THE HOME

**ST. JOHN AMBULANCE
ASSOCIATION**



CARE OF THE SICK IN THE HOME

By Sister HONOR MORRIS, C.St.J., F.C.N.A.

A handwritten signature in cursive script, reading "Honor P. Morris", is written diagonally across the page. Below the signature is a long, sweeping horizontal line.

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CONTENTS

Acknowledgements	6
List of Illustrations	7
Preface	9
Foreword	11
Introduction	13
The person giving care	
Method of washing hands	
Patient's bedroom	
Suggested plan for daily care of the sick	

AREA ONE 16 - 39

The patient's comfort

Bedmaking	16 - 19
How to make an unoccupied bed	
How to make bed occupied by patient	
How to give bedpan and urinal	20
Lifting and moving patients	21 - 23
Lifting	
Lowering	
Turning	
Leaving the bed	
To a chair	
To a wheelchair	
To a commode	
To bath or shower	
Teaching the patient to move after a 'stroke'	23 - 31
Rolling towards unaffected side	
Transfer to chair with assistance—method one and method two	
Rolling towards the affected side	
Sitting towards the affected side	
Washing the patient in bed	32
Care of areas of the patient's body	33
Pressure areas	
Causes of pressure sores	
Signs and symptoms of pressure sores	
Prevention of pressure sores	
Care of the hands	35
Care of the feet	35
Care of the mouth	35
Hair Care	35
How to shampoo hair of patient in bed	37
The infested head	38

AREA TWO 40 - 51

Observation of the patient

Reporting signs and symptoms	40
Understanding temperature	40
Understanding thermometers	41
How to use thermometers	42
Suitable sites	
Methods used	
Rectal temperature	
Observations of pulse	44
Observations of respiration	45

General Observations	45
Appearance	
Skin	
Positions	
Eyes	
Sleep	
State of consciousness	
Pain	
Digestive tract	
Appetite	
Vomiting	
Faeces	
Constipation	
Diarrhoea	
Administering medicines through rectum	
Inserting a suppository	
Giving disposable enema	
Enemata for children	
Observations of urine	
Abnormalities of passing urine	
Urine testing	

AREA THREE 52 - 58

Food for the healthy and sick

Food groups	53
How much food we need	53
Nutrients for special purposes	54
Protein	
Fats	
Carbohydrates	
Mineral salts	
Vitamins	
Water	
Roughage	
Handling and service	55
Food poisoning	55
Food for the sick	56
Fluid diet	
Soft diet	
Light diet	
Full diet	
Special diets	
Feeding a patient	
Sick children	
Feeding the aged	
Table of diets	

AREA FOUR 59 - 67

Administration of medicines

General instruction and care	59
Giving medicines by mouth	59
Preparing the dose	
Measurement of liquids	
Tablets, pills, capsules and powders	
Times for giving medicines	
Giving medicines to children	
Other methods of giving medicines	62
Into the eye	
Into the nose — drops	
Into the nose — spray	

Material set **across the page** is included for **reference** if required, and for St John Ambulance Brigade personnel **after the first re-examination**, and may be included in competition work.

Giving injections in a private home	64	Fever associated with infectious disease	87
Oxygen therapy in the home	66	Communicable diseases	88
Methods of giving oxygen		Common cold	
Nasal cannula, venturi mask		Influenza	
Drugs to be used with oxygen		Whooping cough	
AREA FIVE 68 - 73		Diphtheria	
Bandaging		Measles	
Use of roller bandage	68	Chicken pox	
Simple spiral		Mumps	
Reverse spiral		Poliomyelitis	
Figure of eight		Infectious diarrhoea	
Spica		Infectious hepatitis	
Tubular gauze		Skin infections	
Elasticised tubular net		Gonorrhoea	
AREA SIX 74 - 76		Syphilis	
Hazards in the home		Ringworm	
Indoors	74	Tetanus	
Outdoors	75	A rigor and its treatment	93
Cars	75	AREA TEN 94 - 108	
AREA SEVEN 77 - 82		Care for special groups of people	
Inflammation		Emergency childbirth	94
Local effects	77	Onset of labour	
Constitutional responses		During the birth	
Dry heat treatment	78	The cord and its care	
Electric blankets		The mother's comfort	
Hot water bags		Some problems of babies and young children	98
Infra red lamp		Dietary problems	
Moist heat treatment	79	Gastro enteritis	
Steam inhalation		Heat rash	
Steam inhalation for child		Sore buttocks	
Compresses or foment		Thrush	
Spoon foment		Cradle cap	
Cold treatment	81	Worms	
Ice compresses		Summer hints	
Ice collar		Convulsions	
AREA EIGHT 83 - 85		Baby sitting	
Infection and how it is spread		Convalence following major surgery	100
Conditions for spreading	83	Bathing	
Prevention	83	Dress	
In the home		Nutrition	
By the person		Rest	
Methods of disinfection	84	Wound care	
Simple dressing techniques	84	Physiotherapy	
Dressing wound, small cut or laceration	85	Occupation	
AREA NINE 86 - 93		Care of the limb in plaster	101
Infectious Diseases		Rehabilitation	102
Means to prevent infection and spread	86	Living with the elderly person	104
Fever and its treatment	87	Emotional needs	
		Physical needs	
		Cleanliness	
		Care of the feet	
		Exercise	
		Food	
		Serving meals	
		Bladder incontinence	
		Medications	
		Confusion states	
		Care of the dying in the home	108
		Appendix	109
		Suggested syllabus for teaching	110

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LIST OF ILLUSTRATIONS

Patient made comfortable for meal	14, 57	Method of giving eye drops	62, 63
Bedmaking procedures	16 - 19	Syringes and areas for insulin injections	65
Placing the bedpan	20	Oxygen inhalation	67
Shoulder lift	21	Bandaging	68 - 73
Teaching patient to move after 'stroke'	23 - 31	Stove guard	74
Washing the patient	32	Safe clothing for children	75
Prevention of pressure sores with comfort aids	34	Filling hot water bag	78
Cleaning mouth	36	Use of infra-red lamp	78
Shampooing hair	38	Steam inhalation	79
Wiping thermometer	42	Spoon foment	81
Taking pulse	44	Cold compress	82
Inserting disposable enema	45	Adhesive dressings	85
Main food groups	52	Child birth	97
Measuring dose of liquid medicine	60	Washing scalp	99
Giving tablet to patient	61	Rehabilitation aids	102, 103
		The young living with the elderly	105

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Through many years of nursing, as a nurse educator for intensive care and Florence Nightingale Committee Member South Australia and Overseas, she has a professional knowledge which combined with her understanding of the needs of the sick makes this manual a worthy contribution to the work of the Order of St John in Australia.

Appreciation is expressed to all others who in various ways assisted including especially the following:

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A. H. TOYNE

Acting Director

St John Ambulance Association

Priory in Australia

FOREWORD

This book, 'Care of the Sick in the Home', has been produced by the St John Ambulance Association within the Priory of the Order of St John in Australia.

It is the authorised Nursing Manual, as is the Australian First Aid Manual, designed to give the best teaching instructions for Australian conditions.

It was written by Sister Honor Morris, C.St.J., F.C.N.A., and with her editorial panel, they have spared no effort and thought in its compilation.

It is superfluous of me to offer, on behalf of our Priory Chapter thanks and congratulations.

Undoubtedly it will serve to improve that standard of service given to those who wish to avail themselves of it for the benefit of themselves and others.

George Stening, Chancellor

PREFACE

In our present day society, hospital beds are occupied by patients who require major surgical procedures and by those who need special nursing care and investigation.

Therefore an increasing number of persons are being nursed in their own homes. Some knowledge of nursing care is an asset to members of the family, friends and neighbours in times of need.

Keeping these things in mind, this book has the following aims:

To teach men and women how to carry out simple nursing care in the home, using improvised and economical articles when necessary.

To enable people to know and recognise any changes in the condition of the patient which should be reported to the doctor.

To help those who care for the sick at home to acquire the knowledge of **how**, **when** and **why** daily nursing tasks are carried out.

To encourage the patient to **strive for independence** in any way according to the limitations of the particular condition.

To stimulate an interest in those persons who may wish to learn a more advanced knowledge of nursing care.

It is hoped that the information found in this book will relieve some of the anxieties which naturally arise when there are sick people who must be cared for at home.

INTRODUCTION

THE PERSON GIVING CARE

To give efficient and sympathetic nursing care in the home it is essential that this person be able to:

Help the patient to **regain independence** and strive towards a return to a healthy mode of living

Carry out carefully the instructions given by the doctor

Anticipate the needs of the patient during the dependent stage of their illness

Respect the patient's own wishes regarding family and household matters and religious beliefs

Encourage the patient by your understanding manner to express any anxieties

Provide physical comfort

Maintain a good standard of personal hygiene.

Hand care is important always. When caring for sick people it is essential to have a thorough routine to prevent infection passing from the patient to others and from you to the patient.

All people are a possible source of infection.

Unfortunately the sick are all too often the 'victim' of an infection which was not present at the onset of their illness. Therefore scrupulous hand care is essential.

METHOD OF WASHING HANDS

Roll up sleeves, remove watch and rings to prevent them scratching the patient's skin. Wet the hand, apply soap, and work lather over the hands and wrists, working well between fingers and around nail beds. A nail brush should be used under the nails to rid them of any firm dirt.

Rinse hands thoroughly under running water and repeat procedure. Dry hands well on a clean towel to prevent chapping.

A reliable antiseptic hand cream can be applied to keep the hands soft so that the skin does not become brittle and chapped thus scratching the patient's skin.

Any broken nails or infected areas require special attention. The nails should be moderately short and smoothly rounded to prevent scratching.

The importance of hand washing is stressed throughout this book wherever it is thought necessary.

THE TIME TO WASH HANDS

Before

Attending a patient for any special procedure

Handling patient's food tray

Eating

After

Attending to the patient, or handling any article or dressing used in nursing care

Visits to the toilet

Remember

Thorough hand washing rids the hands of most disease organisms.

The patients **depend on you** to give the best possible care and to ensure they do not acquire new infections. You must not infect other members of the family or yourself.

The hand basin should always be kept clean ready for use,

THE PATIENT'S BEDROOM

The patient's own room is usually the most convenient room in which to give the nursing care required. The familiar environment is reassuring to the patient.

If the room seems 'over furnished' it would be wise to suggest temporarily removing a furniture piece or 'knick-knacks' not required, however, the wishes of the patient should be considered.

THE MINIMUM REQUIREMENTS ARE

The Bed Preferably a single one as it is easier to reach the patient from either side.

MATRESS Should be firm and comfortable.

PILLOWS The number required is dependent on the position in which the patient is to be nursed, e.g. sitting upright or lying low.

If practicable, the bed should be placed to obtain the maximum light with minimum glare.

A small table (or a flat protected surface of some type) to place articles necessary to provide care, e.g. wash basin or the thermometer tray.

Two chairs One dining or kitchen type to hold bed linen during patient care, one comfortable lounge type for the patient's sitting out periods.

A bed lamp If available is of value for use for night care and also gives confidence to the aged or to young children.

A bell or whistle To attract attention should this be necessary.

A Suggested Plan for the Daily Care of the Sick

This will vary according to the needs of the patient and the other members of the family. It is best to plan what is to be done at different periods of the day.

One should appreciate that interruptions will occur and plans go astray.

Every endeavour should be made not to make the sick person feel a hindrance or a nuisance.

ON AWAKENING

Take and record the temperature, pulse and respirations and thereafter at whatever times the doctor orders (see Area Two, page 43).

Give a bed pan, urinal bottle, or assist the patient to the commode or toilet

Wash the patient's face and hands, and rinse the mouth.

Rearrange the pillows and make the patient comfortable

Serve breakfast, making sure the food is within easy reach of the patient. In the very sick it may be necessary to feed the patient.

AFTER BREAKFAST

The patient should rest for half an hour or longer

A full bed wash is given or patient is assisted to bathroom (see Area One, page 32).

Patient's teeth are cleaned, the hair is combed, and men are shaved

The bed is made with fresh linen daily if this is possible



Figure 1 Patient prepared and in a comfortable position for breakfast. Tray is placed securely and all items within easy reach.

Room floor is cleaned and the furniture dusted and flowers arranged

SPECIAL TREATMENT

Medicines Check the time at which they are given (see notes on medicines, Area Four).

Dressing of wounds Should not be carried out until a half hour has passed since bed making, sweeping and dusting is complete, so that room air will contain only minimum of dust particles and bacteria. This will lessen the possibility of introducing infection into the wound.

Doctor Prepare for his visit by having in readiness memos of patient's welfare and progress. For example, temperature, any pain present, and the type of pain and the time it occurred. Place a clean towel and soap in bathroom for the doctor to wash his hands.

LUNCH TIME

Prepare patient by repeating toilet requirements if necessary

Wash the patient's hands, and your own

See the patient is in a comfortable position

Serve the meal

AFTER LUNCH

A short rest period is beneficial

Attend to toilet needs

The skin requires special care to prevent it becoming sore (see notes on Prevention of Pressure Sores, Area One, page 34)

Repeat any special treatment due

Prepare patient for visitors or for some form of relaxation or occupation such as reading, knitting, chess, or looking at television

During this time the person giving care to the sick may be able to take a rest period

EVENING

Check the temperature, pulse and respiration if this is necessary

Medicines and/or special treatment should be given if required

Repeat any toilet requirements and attend to the skin

Serve the patient's meal

Allow for family companionship and visitors

Prepare the patient for sleep by repeating toilet procedures if required — check if position is comfortable and bed clothing adequate.

A drink of warm milk will often help a patient to sleep. However, if a sedative has been ordered, it must be given at the time stated if it is to be effective, and no mental or physical effort after it is desirable.

Note

Morning and afternoon teas or extra drinks can be given at suitable times

Change the position of the very sick person every two hours throughout the day

The mouth must be cleaned after each meal

The Patient's Comfort

BED MAKING

This every-day task is an important part of nursing care given to the sick person. It has been proved that a bed made up efficiently will allow the patient to rest with maximum comfort.

TWO PRINCIPLES involved in providing comfort are:

Bed linen **beneath** the patient **pulled tight** and tucked firmly under the mattress.

Bed linen **above** the patient must be **loose** and comfortable but secure.

HOW TO MAKE AN UNOCCUPIED BED

Requirements

Mattress with cover — an old blanket will serve this purpose if no mattress overlay is available

Two sheets

Blankets as required

Bed spread

Pillows and pillow cases as required



Figure 2 Requirements in order of use placed on chair and special requirements on stool

Special requirements

These items may be required to protect the mattress and lower bed linen should the patient be either very young or old, or sick from any condition which may cause soiling of the bed, e.g. kidney, bladder or bowel conditions.

A piece of plastic **long enough** to cover the mattress and its cover and to tuck in securely (or a special fine plastic protective cover with elasticized corners is available).

A smaller piece of plastic **wide enough to extend from the shoulders to the knees**, and sufficient length to tuck under the sides of mattresses.

One sheet of sufficient size to cover the smaller piece of plastic. A long sheet folded in half would be suitable.

METHOD

Collect all linen and place on a chair in the order in which it will be used. This saves time and inconvenience.

Mattress must have a **firm** base — improvised in special cases, if necessary, by wooden slats or wooden door. A feather mattress needs to be turned from top to bottom daily whereas an innerspring or rubber mattress requires less turning because of its greater stability.

The mattress should be pulled 'well up' to the head of the bedstead **before** commencing to make the bed.

Bottom Linen

If required, place the **long piece of plastic** over the mattress and cover — tuck in securely.

Place bottom sheet on bed, hem **smooth** side up, the middle fold in centre of bed. Allow sufficient sheet to fold securely over the head of mattress — **pull tightly**.

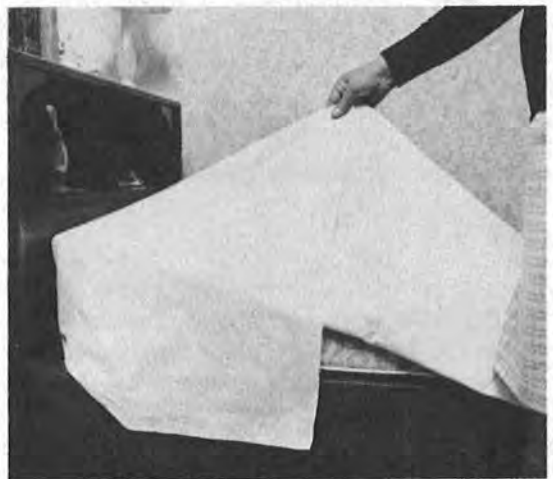


Figure 3 Mitred corner — Stage One

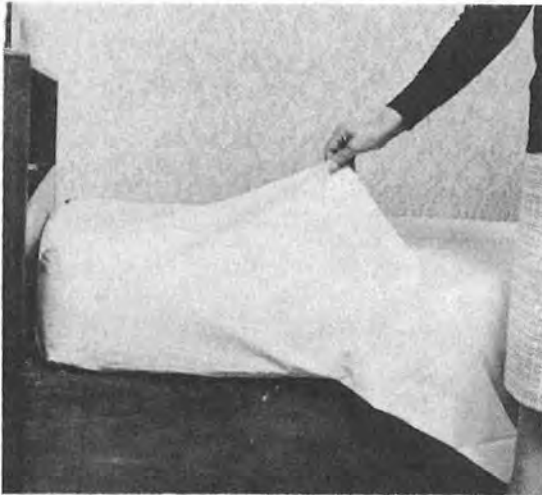


Figure 4 Mitred corner — Stage Two

Stand facing the head of bed, mitre the corner of the sheet to tuck it in. Straighten the sheet, face the foot of the bed and tuck the sheet under the mattress. (**Note:** Special tailored sheets with elastic ends will eliminate the necessity for mitred corners for the bottom sheet.)



Figure 5 Mitred corner — Stage Three

If the smaller piece of plastic (draw sheet) is to be used, it is **now** placed across the bed so that it will extend from shoulders to knees. It is then covered by the smaller sheet. Tuck firmly under the mattress.

Go to the other side, commence at top, tuck bottom sheet firmly over the mattress and repeat the procedure of tucking linen under mattress by grasping it and pulling firmly towards you to straighten.

Place top sheet on bed, hem **wrong** side up, extend it about a hands span above the head of mattress. This is later used to fold over the blankets as a protection.

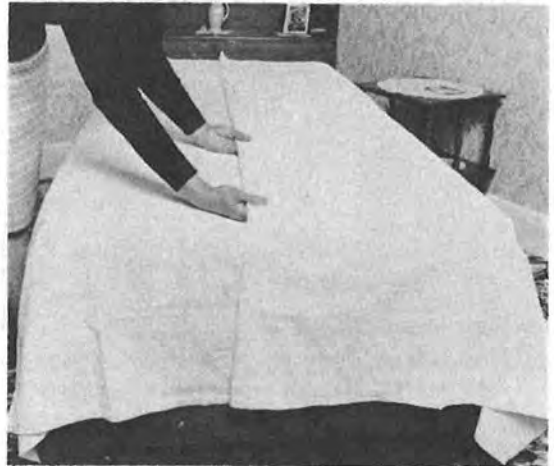


Figure 6 Making the pleat to prevent pressure on patient's feet

Top Linen

Grasp the sheet in the centre at bottom, make a pleat, approximately 5 centimetres (2 inches) deep (to allow adequate movement of toes to relieve pressure), tuck under mattress and mitre corners. (See illustration of alternate method to relieve pressure.)



Figure 7 Two pillows or bolster rolled in a sheet with ends twisted and securely tucked under mattress

Figure 8 A box of sufficient size with foam base to allow patient's feet to rest comfortably





Figure 9 Top sheet folded over to prevent blankets from soiling

The sides of the sheet are tucked under the mattress to halfway up the bed. This allows patient to have free movement in bed.

Blankets are placed on bed singly, the **top** edge just below top of mattress. At **foot** of bed they are turned under in the same way as top sheet. The top of sheet is folded back over the blankets.

Pillows are placed on the bed and the cases drawn on carefully. Arrange as required with the openings of the cases turned **away** from the bedroom door to complete a neat appearance.

Bedspread is placed on the bed to cover pillows at the top—the lower end and sides hang free and evenly.



Figure 11 Correct method of inserting a pillow into a pillow case

HOW TO MAKE BED OCCUPIED BY PATIENT

When patients are not permitted to get out of bed it is important that the bed be remade **daily or more often** if linen is soiled. This is usually done when the sick person is completely washed in bed, or when attending to toilet needs. It is sometimes necessary to have two persons to assist with the patient, or if this is not practicable, place a heavy chair at the side of bed for the patient to hold to prevent falling. The patient should be encouraged to move about and turn over in bed unaided if this is possible.



Figure 10 Top sheet and blanket folded under to allow patient freedom of movement

Preparation

Allow sufficient space to walk around the bed by moving bedside table. The chair is placed conveniently at the side of the bed with the necessary linen ready to use. A bucket or basket to hold soiled linen is placed by the side of the bed from which the linen will be finally removed.

Method

To remove **top** linen:

Remove bedspread, fold it neatly and place over back of chair.

Loosen blankets and sheet from under mattress. Each item is removed separately and folded neatly into three or four sections and placed over back of chair. Leave last blanket to cover patient. From under this the top sheet is drawn downwards and, if clean, folded and placed on chair.

Remove all but one pillow and place on the chair seat. (If patient becomes breathless when lying low, leave sufficient pillows on bed to prevent distress.)

Any foam cushions or cradles are removed from the bed at this stage.

Pull the mattress up towards top of bedstead.

Ask the patient to roll to far side of the bed, the head rests on a pillow.

To remove **bottom** linen:

Brush off any crumbs from the bottom linen.



Figure 12 Replacing bottom sheet with patient confined to bed



Figure 13 Replacing smaller sheet over protective plastic piece

Untuck lower linen, roll each piece in separately to the centre of the bed.

Replace the bottom sheet, mitre the corners.

If used, bring the plastic sheet back into position and cover it with a fresh sheet and tuck under the mattress.

The patient rolls over the bulk of folded linen in centre of bed and moves back towards the completed side. Bring the pillow for the head to rest upon.

Make up the opposite side in the same way.

The patient returns to centre of bed, assisted if necessary. The pillows are adjusted for the patient to sit up comfortably.

Replace the top sheet, take the blanket from beneath it towards bottom of bed and then replace it over sheet to prevent chilling. Tuck in sheet.

Replace remaining blankets as described earlier and then the bedspread, making sure patient's chest and shoulders are adequately covered.

Place the bedside table within easy reach. Have any item that the patient may require at hand.

Note

Bed linen **must not** be allowed to touch the floor because it will be contaminated by dust. When re-making an occupied bed, the pillows are the **last items** to be removed and the **first** to be replaced **after** attending bottom linen. This means the patient is disturbed for as short a time as possible.

HOW TO GIVE A BEDPAN AND URINAL

If the sick person is confined to bed it may be necessary to have a bedpan, urinal or commode in the house.

The bedpan and urinal can be hired from the local chemist shop or specified agencies. The flat 'perfection' type is the most suitable.

REQUIREMENTS

Bedpan and/or urinal, toilet paper. A cloth or sheet of paper to cover them. A basin of water, soap and a towel.

HOW TO USE THE PAN

Warm the pan by rinsing it with warm water, empty and dry. Cover it and carry to the bedside. Prepare patient.

Loosen bedclothes on one side of the bed

Remove any comfort aids and extra pillows

Move night attire free of the pan

Remove the cover and tuck it under mattress

Flex the patient's knees, raise the buttocks, and slide the pan underneath, broad end towards patient's waist



Figure 14 Placing the bedpan in position when patient can assist

Assist patient to sit up (if permitted) by placing one hand under the lower back whilst the other slides through the upper arm and grasps the patient's shoulder. The back **must** be adequately supported by pillows.

Leave the patient alone, toilet paper and bell within reach, and stay within call. If the person is too ill to leave, remain in the room.

To remove the pan:

Remove the supporting pillows and lower the patient

Flex the knees, slip one hand under patient's back and remove pan

Put pan on protected chair seat or on the floor and replace cover

If necessary, turn patient on to the side and complete toilet, leaving the anus and buttocks clean and dry

Straighten the bedding and make the patient comfortable — wash patient's hands

Remove the pan from the room (observe the urine and/or type of bowel action). Empty and clean with hot soapy water, disinfect and cover — it is then ready for further use. Wash hands.



Figure 15 Placing the bedpan when person giving care is alone and patient cannot assist

In the very sick and helpless patients who are unable to flex the knees to use the bedpan, one of the methods described in 'lifting and moving' patients can be used (see following section).

HOW TO USE A URINAL

If a urinal is not readily available or obtainable from a hiring agency, a clean, uncracked jar can be used when nursing male patients. The utensil is warmed and carefully positioned to avoid soiling the bed.

LIFTING AND MOVING PATIENTS

To prevent continued pressure on any part of the patient's body for too long a period it is necessary to change the position frequently, that is every two hours, and at times of special treatment.

Movement

Helps to improve circulation and relieves local pressure

Aids deeper breathing

Prevents stiffness of muscles and strain on joints

Relaxes the patient and relieves pain

An explanation of the reasons for movement in bed must be given to the patient and relatives to prevent complications occurring.

IMPORTANT POINTS TO REMEMBER

Always ask for help when a patient is too heavy or too hard to manage alone.

Stand in the **correct position** before you start—

Face the direction of the move

Place the feet far enough apart to maintain good balance

Stand close to the bedside

Keep the line of your back **straight** with head **erect** and chin 'tucked in'

Bend the knees to bring your body to work level

Keep **elbows close to the body** while lifting

Tell patient and helper **what** you intend to do

Give a signal — **ready** — both move at **exactly**

the same time (the strong leg muscles should do most of the work).

Where possible, **roll** the patient on the bed instead of lifting.

Correct lifting prevents patient discomfort, fatigue and back strain for the lifter.

METHODS USED TO MOVE PATIENTS

Shoulder lift. Cradle lift. (Two pairs of hands)

Rolling patient. (One pair of hands)

LIFTING OR RAISING THE PATIENT

Adjust weight evenly on both feet

Bend knees

Position the hands

Raise the patient by **straightening** knees and keeping elbows close to the body

LOWERING THE PATIENT

Check position of feet, knees and hands

Lower the patient by **bending** the knees

Note

Check that the bed is **steady before** lifting

Have pillows or cushions ready for use

METHOD OF TURNING PATIENT IN BED

The patient's knees should be slightly flexed and the feet crossed in the direction of the move. The patient may be able to assist with this movement (see special remarks in area on rehabilitation).



Figures 16-17 The 'shoulder lift' used to raise patient up in the bed and on to a foam cushion. Note how hands are placed and support the patient's back during the lift. Pillows and cushion are removed for better view

Towards you

Place one hand firmly on the far shoulder and the other on the far hip

Turn the patient smoothly towards you

Adjust pillows as required

Extend the lower leg of the patient and flex the upper one.

It may be necessary to give the patient additional support by placing a pillow between the legs and another behind the back.

Away from you

Slide one arm under back until hand is **beneath far shoulder bone**. The other arm is placed under buttock to grasp **far side hip**. Draw both of your arms towards you, rolling the patient on to the side. Support with pillows and leave comfortable.

Do not leave the patient until you have ensured that there is no risk of a fall from the bed.

PREPARING PATIENT TO LEAVE THE BED

Before any patient is permitted out of bed for the first time to walk to the bathroom and/or toilet a **gradual alteration** from the lying position to sitting up and actually getting out of bed should be practised. This gradual alteration of position may require only an hour or two or be spread over a period of two or three days. The doctor will give advice in this matter.

The following procedure should be adopted

If the patient is lying low, **raise** to a **sitting up** position — two or three pillows — this lessens the tendency to dizziness. Leave for a short time.

The legs should then be dangled over the bed edge to encourage flow of blood to the feet.

The feet are placed on the floor. The patient's arms are used on the bed to afford support. A pillow is placed at lower back level to assist in supporting the back. This phase strengthens back, shoulders and arm muscles.

Before walking, the patient should practise standing and maintaining balance.

Low-heeled shoes should be worn for proper support — slippers do not afford this support.

Encourage the patient to maintain a **good posture**, head erect, neck, chest and lower extremities in alignment and body weight evenly distributed on both feet.

Support the patient. The position of the helper will vary depending on the condition of the patient. If a person is very weak or afraid of

falling, it may be necessary for the helper to grasp the elbow and/or waist of the patient firmly to provide additional support until confidence is gained. Under some circumstances it may be better to stand behind the person so that the normal step will have no interference. The helper may grip the dressing gown cord (securely tied) or a belt placed about the waist to eliminate strain as she alternates her step with the patient's.

ASSISTING PATIENT ON TO A CHAIR

Place prepared chair (rug and cushion) near bedside

Sit the patient up and slide legs over side of bed

Put on dressing gown and slippers

Help the patient to slide from bed to a standing position

The patient's hand is then placed on the far side arm of the chair, which is kept steady by the person assisting.

With a slight pivot movement of the feet the patient is then in position to lower or be lowered into the seat of the chair.

Cover the legs if necessary and leave any item that may be required within easy reach.

After severe sickness it is usual for 'sitting up' periods to be increased a little each day **unless** the patient cannot tolerate it. Any discomfort should be noted and the patient's position readjusted. Return the person to bed should the effort prove too tiring.

If for any reason the person feels too sick to persevere with the sitting out period, the doctor must be told.

ASSISTING PATIENT INTO A WHEELCHAIR

The same method is used with special care to—

Lock the wheels and steady the chair

Fold back the **footrests** to make it easier for patient to be seated.

In patients with a long term illness, who use a wheel chair, it may be necessary to have a **ramp** made over steps. This will enable the patients to spend some time in the garden. The ramp must be made by a skilled person and carefully tested before use.

ASSISTING PATIENT ON TO A COMMODORE

The method is the same as for sitting the patient on to a chair.

Toilet paper and bell left within reach if it is safe to leave person alone. It is necessary to obtain the doctor's permission for the **very sick** to use a commode.

ASSISTING PATIENT TO BATH OR SHOWER

Collect requirements — towels, washer, soap, talcum, clean attire.

Preparation and management

Place a non-skid rubber mat in the bath. Run in cold water first, then hot, and fill to about one-third full. **Test heat.**

If it is necessary to have a stool or chair to sit upon, it should be steadied in the bath or shower recess. Special bath fittings can be made or hired for the long-term patient. Detachable hand shower fittings can be used if desired.

A hand rail is useful to help patients into and out of the bath or shower.

Depending on the patient's ability to wash own body, the person giving care either remains to give assistance or leaves the patient alone.

Some patients may find it helpful to have their backs washed and dried.

The bathroom door should be left unlocked and the helper should stay within call. Remain

with a person who is depressed mentally, unsure of movement, or a child.

On completion of wash, place a towel across patient's back and assist to dry if necessary.

Note

Bathroom procedures are tiring for the patient. It is wise to provide for a rest period to follow, either in bed or sitting out, comfortably supported on a chair and footrest.

Should a person feel faint in the bath, release the plug and support the head and shoulders. After the water has escaped, place a bath towel over the patient to prevent chilling.

If help is near at hand, obtain it to assist the patient out of the bath.

Simple fainting may be caused by general weakness and sluggish circulation due to inactivity. This should be reported to the doctor on his next visit or **earlier** should the patient be slow to respond after being rested.

REFERENCE AREA

TEACHING THE PATIENT TO MOVE AFTER A 'STROKE'

Independence must be encouraged — the patient will appreciate being able to move about in bed without always needing help.

The movements required to assist the patient out of bed will be taught to both the patient and the relative or helper.

It is essential to persevere with patience in order to become familiar with the movements required.

ROLLING TOWARDS UNAFFECTED SIDE

Starting position

Figure 18 (1) The patient should be lying on one side of the bed to allow sufficient space to roll on to the unaffected side.

(2) The sound foot is hitched under the affected leg, which is then on top.

(3) The sound hand takes the affected hand obliquely outwards and upwards towards the affected side, and a downward movement of the arms is used to add momentum to the roll; the help that can be gained will vary with the stiffness of the affected side.





Rolling towards unaffected side —
Stage Two

Figure 19 The swing of both arms across the body to the sound side and active twisting of the hips enables the patient to roll towards the sound side braking with the sound knee and thigh.



Rolling towards unaffected side —
Stage Three

Figure 20 If no help can be gained from the arms or the patient finds it too difficult to roll in this manner the undersheet, mattress or chair arm may be held by the sound hand.



Moving from the lying to the sitting
position — Stage One

Figure 21 The head and shoulders are raised and brought over the sound side. The weight is taken on to the elbow of the sound side as the patient continues to lift head and shoulders.

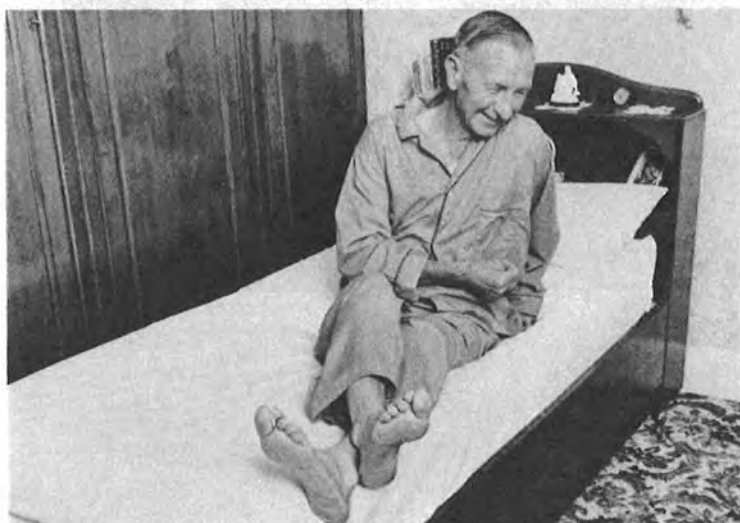
Moving from the lying to the sitting position — Stage Two

Figure 22 The movement is continued into the sitting position as the elbow is straightened and the balance adjusted.
(This sequence is reversed for lying down)



Sitting over the edge of bed to the unaffected side — Stage One

Figure 23 The head and shoulders are raised and the patient starts to transfer weight on to the sound side, the supporting arm must be far enough from the body to provide support without hurting the shoulder.
At the same time the sound leg prepares to assist the affected leg by tucking underneath it. The head and shoulders continue to lift and the legs move over the side of the bed.



Sitting over the edge of bed to the unaffected side — Stage Two

Figure 24 By extending the supporting arm, the patient pushes the body upright over the hips into the sitting position.



TRANSFER TO CHAIR WITH ASSISTANCE

General points: The chair is close at hand, placed so that it cannot tip or slip. The patient should wear well-fitting, preferably non-slip shoes, which give good support. Two methods are described and will vary with the condition of the patient.



METHOD ONE

Starting from where the patient's sound hand is helping in the sitting up position.

Stage One

Figure 25 The helper supports the affected side in such a way that any sudden unexpected movement will not cause an accident to occur. The affected leg is controlled at the knee by the helper's leg and the foot prevents the patient's foot from slipping. The helper supports the patient under the arm-pit and uses the second hand where it will help most, i.e. at elbow or back.



Stage Two

Figure 26 The patient rises taking the weight mainly on the sound leg and arm (i.e. weight over base) takes a step and transfers the hand to the far arm of the chair.

Stage Three



Figure 27 The next move is to turn and move back until the edge of the seat can be felt against the back of the legs—then the patient can sit. The helper's foot is not withdrawn until the patient is seated.

Stage Four



Figure 28 Patient seated

TRANSFER TO CHAIR WITH ASSISTANCE

**METHOD TWO**

A heavily disabled patient (possibly in a rest home) may manage better with the helper assisting with pivoting movement from bed to chair.

Stage One

Figure 29 The patient sitting on the base of the bed with the feet on the floor.



Stage Two

Figure 30 The affected wrist is held with the patient's unaffected hand. Lift both hands over the head and around the neck of the helper. The helper should have a balanced stance in front of the patient with the back straight and bending forward from the knees, grasping the waist or the waist band of the patient. The helper's foot nearer to chair should be well back and the other foot between the patient's feet.

Stage Three



Figure 31 The helper then lifts the patient up and around into the chair, i.e. a pivot movement almost with one action.

Stage Four



Figure 32 Patient seated.

ROLLING TOWARDS THE AFFECTED SIDE

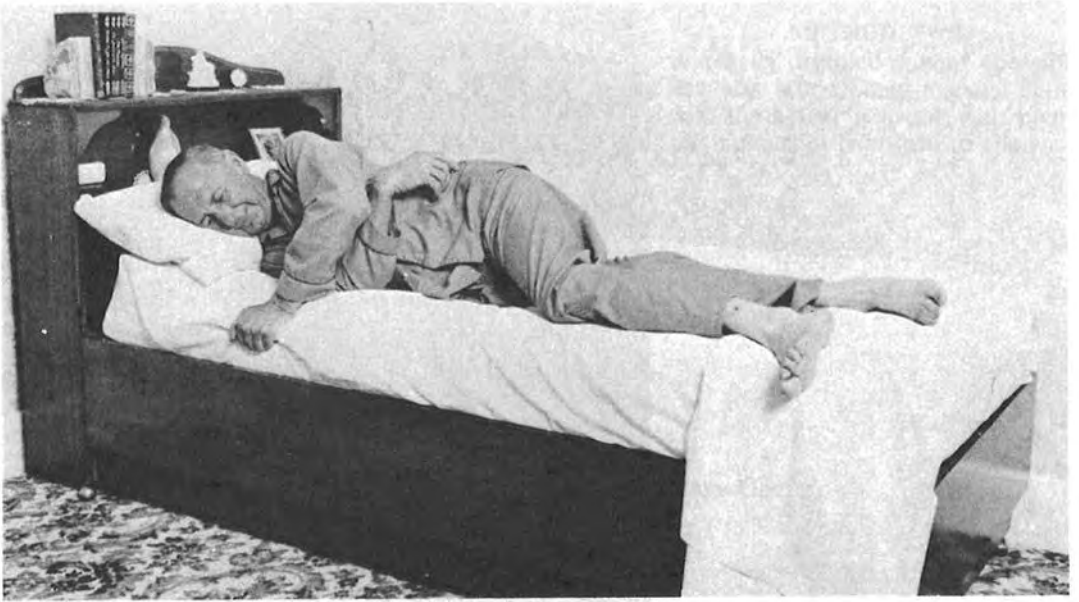


Figure 33 The patient must be sufficiently near the side of the bed to be able to hold the mattress. The movement is started by turning the head and shoulders towards the affected side.



Figure 34 The sound leg is bent at the knee and the foot placed flat on the bed. The movements of the head, trunk and arm are as mentioned before. As the arm pulls, the patient pushes with the sound leg to turn the body to the affected side. Again the sound knee and thigh act as a brake.

SITTING TOWARDS THE AFFECTED SIDE WITH ASSISTANCE



Figure 35 The affected leg is fully supported by the helper. The patient's sound arm clasps the helper's arm. The helper must remember to keep the back straight.



Figure 36 The patient is shown how to pull on the helper's arm (not be pulled) and to follow the affected leg around to the sitting position, taking care to keep the legs just clear of the bed: the patient's balance will be upset if the legs are too high.

Transfer to the chair as described earlier

WASHING THE PATIENT IN BED

When the patient is too sick to go to the bathroom, the alternative is to be washed in bed. This should be carried out at least **once** daily.

The purpose is to—

Keep the skin clean and refresh the patient
To give suitable attention to pressure areas to prevent the body becoming sore

REQUIREMENTS

Wash basin and water
Two bath towels and two wash cloths, changed daily if possible
Soap, deodorant, creamy skin lotion and powder if used
Body cologne is refreshing if carefully applied
Comb and hairbrush
Linen, bed clothes and night attire

METHOD

Prepare room

Close windows
Warm room in winter
Arrange toilet articles on bedside table
Place clean linen on chair

Prepare patient

Offer patient a bedpan — remove and empty it
Pull mattress to top of bedstead before commencing

Remove—

All upper bedclothes excepting one blanket
All but one pillow
The comfort aids, cradles and any supports
The patient's clothing

WASH THE PATIENT

This is usually carried out from **one side** of the bed

All areas of the body should be washed and dried thoroughly and observed for signs of pressure or other injury to the skin.

Place one towel under the head to protect pillow, the other across chest.

First wash and dry the face and neck

Place one towel lengthwise under the arm to protect bed linen, the other alongside limb in readiness for drying. It is usual to wash the limb furthest from you first.

The arm is washed using firm, long strokes. Special attention should be given to armpit. Rinse hands and forearm in basin of water and dry well.

Repeat with the other arm

Wash the front of the body and down to bed level at each side of the patient and dry well. Wash the pubic area if patient unable to do this. Empty basin and obtain clean, hot water and clean washer to wash legs and back.



Figure 37 By bending knee towards mid-line of patient the part of the thigh the patient is lying on can be washed during the leg washing procedure, thus saving unnecessary movement of patient.



Figure 38 One method of supporting the leg whilst bathing the foot in the bowl.

The legs are washed in the same manner as the arms. Each foot is bathed in basin by bending the knee and supporting it. Care must be taken to ensure each hip area is washed and attended well at this time.

Turn patient on to side: wash back, rinse soap off skin, and dry carefully.

Any special care of the skin is usually carried out at this time, e.g. a gentle massage with a special antiseptic and soothing creamy skin lotion.

Whilst patient is lying on side, attend to bottom linen — change sheet if necessary.

Replace night attire

Arrange pillows then sit or lay patient in desired position

COMPLETE THE TOILET

Clean teeth or perform a mouth toilet (see page 35)

Clean and cut toe nails, if necessary

Comb hair

Female patients may wish to use make-up on their face. (This can be left until after bed-make is completed.)

COMPLETE THE BEDMAKE

Replace comfort aids in correct positions

Replace top linen and bedspread

TIDY THE ROOM

Remove equipment and wash soap stain off the basin so that it is clean and ready for use.

Adjust bedside table, making sure a drink, bell, face tissues, spectacles (cleaned), or other requirements, e.g. a book or knitting are within the patient's reach.

Dry the towels

SPECIAL POINTS TO REMEMBER

Drape the patient with the blanket, exposing only the part to be washed.

Work quickly and smoothly, supporting limbs as necessity arises.

Pay particular attention to areas between the fingers and toes, and around nail beds. In women the fold under breasts must be dried carefully to avoid damage to the skin.

Use long firm strokes when washing limbs and back.

Assistance will be needed if the patient is very sick and/or heavy.

Explain to the patient and the assistant any move that you wish to make.

The patient who is able to wash his own body will require assistance to have the back washed and the bed remade.

CARE OF SPECIAL AREAS OF THE PATIENT'S BODY

Pressure areas. This term applies to special parts of the body which are subjected to pressure or other irritating factors.

PARTS OF THE BODY MOST LIKELY TO BE AFFECTED

Where the bone is near the surface of the body

Head At the back of the skull bone

Upper back By the shoulder blades

Lower back Over the centre bones of spine

Over sitting areas of buttocks

Shoulders and elbows

Hips and knees

Ankles and heels

Where two skin surfaces are in contact

Under breasts

In folds of buttocks

Behind knees

In crevices formed in groin

In bend of elbows

PRESSURE SORES OR BED SORES

The name 'pressure sore' or 'bed sore' is commonly used to describe the condition of the skin when prolonged pressure causes tissue

cells to be deprived of their blood supply and their nourishment **therefore keeping the skin and deeper tissues alive and healthy is a very important part of caring for the sick and the aged.**

CAUSES OF PRESSURE SORES

Unrelieved pressure — failure to change the patient's position frequently. The effect of pressure can be aggravated by the following:

FRICTION

From crumbs in bed, from food or plaster fragments if limbs encased in plaster

Creases or patches in bed linen

Splints too tightly bandaged in position causing limb swelling

Careless lifting of patient and placement of bedpan

MOISTURE

From patient remaining in wet or soiled bed
Damp bedpans being placed under buttocks

Sweating, causing dampness of night attire and bed linen

All of these things can be prevented

PREDISPOSING CAUSES

Certain conditions of patients make them more susceptible to development of pressure sores. In order to understand better those patients who will need very special care as soon as they become ill some conditions which interfere with the body's resistance are mentioned.

Poor circulation of the blood, due to—

Old age
Heart disease
Diseases of blood vessels

Malnutrition — poor nourishment due to—

Insufficient or unsuitable foods (very thin or very fat patients)

Body's inability to use food to best advantage (diabetes)

Prolonged illness (malignant growths, tuberculosis)

Immobility due to—

The patient being too ill to move without help
Injury to nerves causing loss of sensation and/or paralysis. Unconsciousness from any cause — (probably not nursed at home).

SIGNS AND SYMPTOMS OF PRESSURE SORES

Early

Redness of the area
Irritation and numbness
Tenderness

Late

Blue discolouration of skin
Break in the skin

PREVENTION OF PRESSURE SORES

Relieving pressure — Alter the position of the patient every **two hours**. Turn from one side to the other and then on to back at intervals depending on condition.

Bony areas may be protected by foam plastic overlays for mattress, foam or rubber pads,



Figure 39 Keeping pressure off heels by using foam cushion.

soft pillows and cushions and, if available, sheep skins. These can be strategically placed to prevent pressure on a part, e.g. a pillow or pad under the ankles will prevent pressure on the heels. A soft pillow placed between the legs when the patient is lying on the side prevents pressure on knee and ankle bony parts.

Eliminating friction — Careful positioning of a patient on to the bedpan.

Avoid 'dragging' patient up or down in bed by careful lifting and moving techniques

Eliminating moisture — Ensure the bed linen and night attire are dry by changing as often as they become damp or soiled

Offer the very sick a bedpan or urine bottle at regular intervals

Keep the skin **clean and dry**. Urine and faeces must always be washed off the skin — paying particular attention to the pubic area and the buttocks. It is not sufficient to change the bed linen and night attire, as excretions are irritating to the skin and offensive to smell. If the patient is unable to control these, doctor may order local applications of a waterproof cream to protect the skin and/or special appliances. Incontinent pads can be made from soft old linen or a sanitary napkin can be used.



Figure 40 Variety of comfort aids showing foam back support, sheep skin, 'Reston' flotation pad with linen carrying handles and foam cushion.

REMEMBER

It is easier to prevent a sore from developing than to treat it.

A reddened area is the first sign of pressure, learn to recognise this, remember the **cause** and **remove** it.

If, in spite of care, special treatment should be necessary the doctor or district nurse will prescribe this and direct the course of action.

CARE OF THE HANDS

Wash and dry thoroughly between fingers

The nails can be kept clean by use of a nail brush and by passing the cleaning end of a nail file under their edges.

Finger nails should be filed to give a **rounded finish**.

The cuticle can be pushed back with a soft towel or, should it be necessary, a reliable brand of cuticle cream can be smeared around the nail edge.

Nail polish applied carefully over clean, dry nails may boost the morale of a sick woman.

CARE OF THE FEET

(This is applicable to the patient and also to the person giving care)

Soak the feet in warm water to soften skin and nails.

Gently rub the heels and soles of feet to remove dead skin (a rough towel or pumice stone used carefully is a help).

Dry the feet thoroughly, especially between the toes, and powder lightly. A special dry and deodorising talcum powder is available for persons whose feet perspire freely. Any persistent

moisture or soggy between toes needs to be brought to the doctor's attention.

Toe nails are cut straight across, using nail clippers or strong scissors.

Note

Diabetic persons need the services of a chiropodist to cut nails. Special care must be taken to prevent any break in the skin of these patients as serious conditions can develop because of poor circulation and resultant weakened resistance to infection.

CARE OF THE MOUTH

The purpose of mouth care is to—

Provide a clean and fresh mouth for the patient's comfort;

Prevent the tongue and lining of the mouth from becoming dry and cracked;

Prevent bacteria from causing infection in the mouth or body.

Teeth should be cleaned **after each meal** and more often if necessary in very sick patients, or those with a high temperature.

Before breakfast, a mouth wash can be given to refresh the mouth.

Requirements

Toothbrush and toothpaste or powder

Mug or glass of water or mouth wash lotion

Small basin

Towel

Place all within reach of the patient

If the patient has dentures and is unable to clean own teeth—

Remove dentures with a tissue if patient is unable to do this — place them in a basin and take to bathroom.

Turn on the cold water tap to a gentle flow and clean dentures with dentifrice and brush.

Pay particular attention to crevices between teeth on both sides of plate. Note if plate is damaged in any way as this could cause injury to soft tissue of mouth (check with patient's dentist).

Rinse the dentures in cold water, return them (moist) in the clean basin to the patient.

If the sick person is able to rinse own mouth, he is assisted to do so before the teeth are replaced — if not see Special Mouth Care.

SPECIAL MOUTH CARE WHEN THE PERSON IS VERY SICK OR HELPLESS

Requirements

A small tray or plate on which are placed three small jars.

One containing warm water to which a quarter of a teaspoon of baking soda has been added. (This is especially good for cleaning particles of food and stale mucous from the mouth.)

One containing clean cold water or a refreshing mouth wash to wipe around mouth after it has been cleaned.

One containing cotton wool balls.

One pair artery forceps (to hold cotton balls). These can be hired from chemist. Cheap plastic forceps can be purchased for the long-term patient if special probe sticks are unavailable. As an alternative, large specially prepared cotton wool tipped probe sticks. Use only the large strong type as others can be dangerous if they break in the mouth.

Paper wipes or tissues.

Paper bag for disposal of soiled swabs.

Lanolin or cream for lips if dry or sore.

How to clean mouth

Tell the person what you will be doing

Wash your hands

Position the head comfortably and conveniently with a tissue under the chin

Examine the mouth, teeth and gums in a good light to give you a clear idea of the condition of the mouth.

Place the paper bag nearby to hold the soiled swabs

Moisten the cotton wool, pressing out excess moisture on side of jar

Steady the chin with one hand and gently clean the inner surface of mouth. Starting with the



Figure 41 Cleaning the mouth of the very sick or helpless patients.

upper areas, clean out one part of the mouth at a time, discard the soiled swabs and use a fresh one for each area. Be sure to clean right into corners of the mouth, between cheek and gums, and under tongue.

Clean the tongue last as pressure may cause person to 'gag'

When the mouth is clean, dip a cotton ball into clean, cold water or mouth wash and wipe around gums, inside cheek and tongue to leave mouth refreshed.

Wipe lips and around mouth

Smear cream on lips if dry or sore

Remove bag with used swabs and tissues (burn if possible) and prepare tray for use again.

Wash hands

Results of a neglected and dirty mouth

Discomfort

Bad breath (halitosis)

Loss of appetite (anorexia)

Dry and cracked lips

Brown stains (sordes) which consist of dry saliva, dried food particles, mucus, and micro-organisms.

Infection which may spread to the salivary glands, causing a condition called parotitis. Tonsillitis or earache may develop.

Patients who will need frequent mouth care

Elderly patients who may also be helpless

Patients with a high temperature

Those on a fluid diet, for example, milk

Those who are temporarily not having anything by mouth

Those who have difficulty in swallowing

HAIR CARE

All patients need to receive daily hair care.

Brushing removes loose surface dust and also stimulates circulation of the blood in the scalp. Brushing and combing the hair not only keeps it healthy but improves the appearance and morale of the patient.

In some cases of partial paralysis a long-handled comb enables patients to attend to their own hair toilet. (A long-handled comb can have a smooth stick attached to it to give added length, making it easier to manipulate.)

Brushing and combing the hair of the very sick and helpless patient

Requirements

Hair brush (preferably natural bristle) and comb, towel, hair cream or lotion (if necessary)

Method

The patient should be comfortable, sitting up or lying down.

Place a towel around the neck and drape it over the pillow for protection.

Part hair in centre from front to back.

Brush one side at a time. If the hair is tangled, start brushing at the ends holding strands of hair over fingers until hair is smooth and all areas of the scalp have been reached.

Arrange hair to best appearance and comfort.

Remove towel and leave patient comfortable. Clean brush and comb.

The scalp should be observed and any unusual condition, scratches and swellings should be reported.

REFERENCE AREA

How to shampoo the hair of a patient in bed

Patients with long-term illness need a hair shampoo at regular intervals. Select the type of shampoo suitable for the condition of the patient's hair — dry or oily — and the method which the patient is able to tolerate.

A dry shampoo (preferably for oily hair and scalp)

A new aerosol spray is now available for an oily scalp and is much easier to remove than some of the heavier powder types.

Requirements

Aerosol spray, two towels, brush

Method

Place patient in a comfortable position and cover the shoulders with one of the towels.

Shake the spray can and hold about eight inches from the hair, spraying on to roots and separating the hair with a comb or the fingers.

Blend through hair and leave for one or two minutes.

Lightly rub with a towel all over and brush out thoroughly.

A wet shampoo

This is really the most effective way of cleaning the hair and scalp.

Requirements

Shampoo	Waterproof protector for bed (plastic sheet or raincoat)
Washer	Small pillow covered with plastic (or a rolled towel)
Clean brush and comb	Chair or low table, plastic covered
A commercial hair rinse (or a little vinegar or lemon juice as a substitute)	Paper to protect the floor
Dipper or jug	Extra blanket, if required
Bucket of water	Hair drier, if available

Method

If possible two persons should carry out this task, saving time, fatigue, and strain. In winter, warm the room.

Bring all requirements into bedroom; place smaller items on covered table or chair within easy reach at head of bed.

Place the bucket on paper at side of bed.

Prepare the patient

Move the patient to near side of bed and place towel around neck and pin in place. Remove pillows from under head.

Place a small pillow or the folded towel under shoulders to allow head to be slanted back. If for any reason the person finds it difficult to be comfortable in this position, leave pillows in place and protect them.

Prepare bed

Make a protective 'trough' for the bed by rolling the side and one end of the waterproof or plastic sheet towards the centre, forming a large continuous roll. Place this on the bed with **one side** of the roll between the patient's head and the top of the bed. The other side fits under the neck and rests against the pillow under the shoulders.

Drop the free ends of roll into bucket.

Fold upper bedclothes back to patient's waist and replace with a small blanket.

The Shampoo

Pour warm water slowly and carefully (from dipper or jug) over the hair, using the face washer to protect eyes.

Pour shampoo solution over head and work into hair and over scalp, using a rotating, firm but gentle pressure of finger tips.

Rinse hair and repeat the shampoo.

Finally rinse with clean water or a commercial hair rinse until all traces of shampoo are removed. Hair will 'squeak' when clean and free of soap.

Squeeze water from hair. **Dry thoroughly** and dress as desired.

Leave patient comfortable and the room tidy.



Figure 42 A shampoo for the hair of a sick patient with a long term illness.

REMEMBER

Select a time when the patient is rested and can rest again after shampoo.

Have **all** requirements at hand before disturbing the patient.

Tell the patient (and the helper) what you wish them to do to help.

Work **quickly** and **smoothly** to prevent patient becoming tired and chilled.

Those persons **not confined** to bed will have the shampoo carried out in the bathroom, suitably positioned for comfort.

THE INFESTED HEAD (PEDICULOSIS)

Pediculosis is the condition of being infested with lice, which spread disease and cause severe fevers to occur.

The pediculus or louse is a small parasite that infests hairy parts of the body and the skin. Particular care is necessary in persons with long hair and with beards.

Three types of lice

Head lice, body lice (mostly confined to the hairy parts of the trunk), pubic lice (confined to pubic hair).

Pediculosis is caused by lack of personal cleanliness. However, it may be transmitted by direct or indirect contact, especially in overcrowded living areas.

When the head is infested with lice, there is much skin irritation and the consequent scratching may cause an infected rash, which may require treatment by a doctor. Small swellings may appear, especially behind the ears and at the back of the neck as a result of this infection.

TREATMENT

The relative or person giving care must be tactful when giving treatment and must guard against becoming infested.

General requirements

A wrap-around apron or overall and a head scarf for the **person giving treatment**.
A tray or substitute on which is placed two jars: One with pieces of cotton wool. One with lotion or cream as prescribed. This is obtainable from the Public Health Department (Lorexane is usually prescribed).

Toilet articles as required.

Two towels, one of these and a piece of plastic are used to cover the shoulders (or pillow) should the person be confined to bed, for the treatment of head lice. A paper bag or pieces of newspaper to hold soiled swabs. Either of these should be placed into a plastic bag to prevent escape of moisture.

Method of treatment for head lice

The treatment is usually carried out over a period of several days.

First day—

Wrap the plastic and a towel around the patient's shoulders for protection

Wash the hair in the usual way and partially dry it

Apply the lotion, saturating the hair — arrange it as desired

Leave for twenty-four hours

Second day—

Repeat previous day's treatment and leave lotion on hair and scalp for a further eight to ten days

Tenth day—

Shampoo again, by which time the treatment should be completed

If the eggs of the lice (nits) are still present attached to the hairs it will be necessary to repeat the above procedure again.

The hands should be washed thoroughly after each treatment.

Body and pubic lice

The following directions are recommended procedures:

The person has a bath, shower, or is washed in bed.

For pubic lice — the cream is applied from the naval to thighs in front, and on a similar area on the back.

For body lice — apply cream to trunk and underarms.

Do not bath for a further twenty-four hours when, after another bath, a further application of cream is applied to the specific areas.

Ten days later, the entire procedure is repeated. It is then hoped the treatment is complete.

For women requiring treatment of pubic lice, the labia should not be parted as the area between these folds of skin is extremely sensitive to the cream and tenderness of the part will result.

Personal clothing and bedding

These must be thoroughly disinfected by the use of 10 per cent Dicophane dusting powder or similar preparations as directed.

Garment seams require special care to ensure they are free of lice. They must be laundered or dry cleaned in the usual way after effective disinfection to ensure skin irritation does not occur.

Observation of the Patient

Careful observation of the patient is a very important part of caring for the sick, because alteration in the patient's condition is an important guide to treatment.

In this area we have given detail for the large number of Australians living in outlying areas who have to rely on two-way radio network to contact the Flying Doctor Service, as it is important that all signs and symptoms are noted and reported.

Observation is of particular importance in the nursing of patients who cannot make known their needs such as:

Infants and small children

Delirious and unconscious patients

Diseases and injuries are revealed by the signs and symptoms which are present.

A SIGN is anything which is observed by the onlooker (in this case the person giving care).

Deformity — patient may have a fractured leg

Swelling — which may be due to a sprained ankle or a growth (tumour)

Colour — patient may be pale due to 'shock' following a fall, or severe bleeding from any cause (see notes on observation of the skin.)

A SYMPTOM is an abnormal sensation noticed by the patient

Pain — headache

Numbness of an area — arm may be paralysed following a 'stroke'

IMPORTANCE OF REPORTING SIGNS AND SYMPTOMS OF SICKNESS

Become familiar with normal appearances so that abnormal signs may be recognised. Encourage your family, friends or neighbours to seek medical help early when problems present themselves.

Note and report accurately signs and symptoms as they occur.

Quote the patient's actual words when reporting symptoms to the doctor.

Report any suspected change in the patient's condition as soon as possible, no matter how slight or vague it may be, e.g. abnormal bleeding or swelling.

It is essential for all members of the general public to know that the early detection of disease may save the patient from long periods of ill-health.

Throughout Australia there are clinics for **the detection and/or investigation of specific conditions such as:** cancer, heart disease, diabetes, tuberculosis, dental abnormalities, mental ill-health, eye conditions (such as glaucoma), gonorrhoea and syphilis.

Clinics are also available **for advice** on such matters as: family planning, infant and maternal welfare, district nursing services, domiciliary care, drug addiction and alcoholism, and many others.

UNDERSTANDING TEMPERATURE

Body temperature is the degree of heat of the human body. It is measured by a clinical thermometer.

In health the balance between heat produced and heat lost is controlled by a special 'heat regulating centre' in the brain. In a very young baby the temperature control may be inadequate to adjust to the temperature changes in its environment.

Heat is produced in the body in the following manner:

By the process of oxidation whereby the food eaten is used as fuel by the body tissues. (Additional temporary heat is gained by taking in food or drink above body temperature.)

By the work of the muscles — movement, exercise.

By activity within the liver and other organs.

Heat is lost from the body by:

The **skin** by the evaporation of perspiration

The **lungs** in exhaled air

The **kidneys** in the urine

The **bowel** in the faeces

Normal body temperature varies between:

36° - 37.2°C (97° - 99°F). The average being 37°C (98.4°F).

Clinical variations in temperatures

Collapse below 35.0°C 95°F

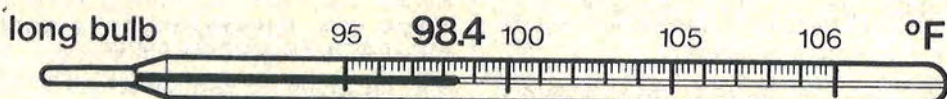
Sub-normal between 35.0-36°C 95- 97°F

Pyrexia between 37.2-40°C 99-104°F
(above normal)

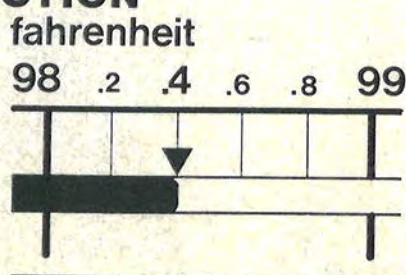
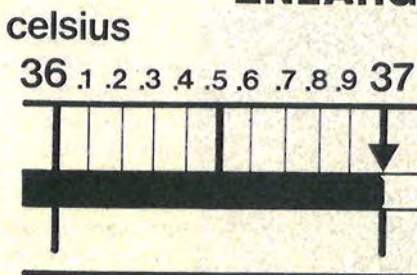
Hyperpyrexia over 40.0°C 104°F

Doctor must be called whenever necessary, e.g. if temperature rises and remains above normal for several hours.

Oral thermometers



ENLARGED SECTION



Rectal thermometer



UNDERSTANDING THERMOMETERS

Their purpose To record the temperature of a person or substance.

Scale of reading Celsius grade or Fahrenheit

Types Clinical: Measuring body temperatures

Lotion: Measuring temperatures of fluids

It is of interest to note that a one-use disposable clinical thermometer has been developed. It may be too costly, however, for home use.

HOW TO READ A CLINICAL THERMOMETER

Pick up the thermometer by the non-bulbous end.

Hold it between thumb and first finger: notice the **heavy** and **light** lines in the glass tubing.

Heavy lines: The **Degree** lines.

Light and shorter lines: Each represents 0.1 or 1/10th of a degree if Celsius, or 0.2 or 2/10ths of a degree if Fahrenheit (check the insert diagram).

The thermometer registers body temperature when the bulb end is placed in the mouth under the tongue or in other parts of the body (see later notes).

The warmth causes the mercury in the bulb to rise in the hollow centre of the glass tube: the **line** where the mercury remains stationary is the level of the temperature. The thermometer may require rolling in the fingers to find the level of mercury.

Note

The mercury of the clinical thermometer returns to the bulb only when the thermometer is shaken down by a few sharp jerks of the wrist.

Practice improves the speed and accuracy of reading.

HOW TO USE A THERMOMETER

Check to see that mercury is down to 35°C (or 95°F).

Wipe the thermometer with cotton wool ball (swab) moistened in water to remove antiseptic taste. (Used swabs are put in paper bag.) Place the clean, dry thermometer in position — keeping in mind the special instruction regarding the site as described below.

After use, wipe thermometer with a cotton wool ball well moistened with antiseptic, to remove any organisms on it.

Read the temperature (holding thermometer carefully to avoid breakage) and write it down on a pad or a notebook.

Shake the mercury down — to either 35°C or 95°F and replace thermometer in its container.

WHEN THE THERMOMETER IS NO LONGER REQUIRED BY THE PATIENT

The thermometer and its container is soaked in a reliable household disinfectant for half an hour, rinsed, dried, and stored.



Figure 43 Method of wiping non-disposable thermometer before and after use.

WHEN A THERMOMETER IS NOT READILY AVAILABLE

The home nurse **must** use her powers of observation to help her decide if patient has a temperature above normal. This may be noted by a flushed colour of the cheeks and by feeling the heat of the patient's forehead.

SUITABLE SITES OF THE BODY FOR TAKING THE TEMPERATURE

In the **mouth (oral)** used for most adults unless:

- The patient is breathless
- Very ill from any cause
- Has injuries to mouth or nose
- Delirious, confused or mentally ill
- Unconscious

In the **armpit (axilla)**

Used in some of the above conditions, and in injury to mouth and nose.

In the **groin** — used sometimes in a child.

In the **rectum** — often used for infants and the unconscious patient. With the exception of newer and specialised techniques now available in large hospitals, the most accurate reading is obtained here. This is because of large blood vessels in the walls of the rectum through which the warm circulating blood flows.

Note

The temperature should be taken in the same place each time if an accurate reading is to be made.

REQUIREMENTS (Oral, Axilla and Groin)

- One small household tray or plate.
- Three small bowls or jars containing cotton wool balls, antiseptic, and tap water.
- A paper bag to hold swabs
- Cover for tray when not in use
- A watch with a second hand
- One thermometer in its container
- A memo pad and pencil

METHODS OF TAKING TEMPERATURES

By mouth (oral)

Be sure that the patient has not had a hot or cold drink or medicine in the five minutes prior to taking temperature.

Place the thermometer under the tongue and ask the patient to close the lips (but not the teeth) on it.

Leave in position for two minutes or longer **if stated on the thermometer.**

In armpit (axilla) and groin

Make sure that the area is **dry** by wiping it with the patient's towel.

Place the bulb of the thermometer between the two folds of skin. It is usually necessary to hold patient's arm across the chest or cross one thigh over the other to hold thermometer in position. If able to do so, the patient may be asked to assist.

Leave in position at least two to five minutes. (It is usual to check the pulse and respirations whilst the thermometer is registering the body temperature — see later notes.)

REMEMBER

When temperature of the patient is recorded in any place other than the mouth it should be noted on the memo pad (or chart).

A patient's temperature is usually taken every four hours **unless** the doctor orders otherwise e.g. it is usually omitted in the middle of the night.

The pulse and respirations are counted and recorded whilst the temperature is being registered (see next two sections).

Always tell the patient what you are about to do **because** it lessens anxiety and enables the patient to co-operate with the procedure.

Take care to—

Use a **clean** thermometer

Clean it immediately after use, **before** shaking mercury down, to prevent spreading micro-organisms (germs).

Disinfect when **no longer required** by patient.

REFERENCE AREA

Rectal temperature (rarely required in the home, but instructions included in this manual, should the doctor request this method).

Equipment required:

One tray (or large plate) on which are placed—

A jar with a swab on the bottom and containing household disinfectant to hold the rectal thermometer.

A rectal thermometer is usually distinguished by a **round**, coloured bulb, and is obtainable from a chemist.

The case for this thermometer should be labelled '**Rectal Thermometer**'.

A jar or small tube of lubricant, vaseline or similar jelly.

A bowl or jar of dry swabs, or face tissues, to wipe thermometer.

Paper bag for soiled swabs.

SPECIAL INSTRUCTIONS

Ensure privacy for the patient

Ask the patient to lie on the **left** side, if possible (assist if required), with the knees flexed (bent), head on one pillow. Do not expose the patient unnecessarily. Lubricate the thermometer sparingly. Squeeze a small amount of lubricant on to a swab or tissue and wipe this over the bulb end of the thermometer.

Insert about 5 cm (2 inches) of the thermometer through the anus and into the rectum and hold in position for two minutes.

Note: The patient **must not** be left while the thermometer is in position — it will slip out of place.

Remove the thermometer, wipe the bulb end, read temperature, and record it. Replace thermometer into disinfectant.

Discard soiled swabs into paper bag, which should then be burned.

OBSERVATION OF THE PATIENT'S PULSE

THE PULSE AND ITS SIGNIFICANCE

The pulse is a wave of expansion felt in an artery with each contraction (beat) of the heart. The pulse may be felt in any artery which passes over a bone near the surface of the body.

SITES WHERE THE PULSE MAY BE OBSERVED (that is, Counted and Felt)

Radial artery — felt on the front surface of the wrist, on the thumb side. This is the most commonly used site.

Carotid artery — felt pulsating on either side of the trachea (windpipe) in the neck.

Temporal artery — felt in front of the ear.

The latter two are rarely used in caring for the sick at home and are included for completeness.

OBSERVATIONS TO BE MADE WHEN EXAMINING THE PULSE

Rate The number of times per minute the pulse wave or beat passes along an artery — general description: fast or slow.

Rhythm The regularity by which the beats follow each other. The rhythm may be recorded as either regular or irregular by the home nurse.

Volume or strength of the beat The volume may be recorded as either good, weak, feeble, thready, full or bounding, or imperceptible, that is the pulse is too weak to be felt.

NORMAL PULSE RANGES

Children 2-10 years	90-110 beats per minute
Adults	60- 80 beats per minute
Aged	rate becomes slower with advancing years

CONDITIONS AFFECTING THE PULSE RATE

Age, emotions, exercise Will cause variations in pulse rate in normal living

Haemorrhage and shock Will cause abnormal changes in pulse rate

Heart conditions

Infections

Drugs

Cerebral (brain) conditions

HOW TO CHECK THE PULSE

Required: Watch (or a clock) with a second hand.

The patient **must be** at rest either lying down, or sitting comfortably in a chair.

The arm may be placed across the chest or by the side, or resting on the arm of a chair or nearby table top.

Locate the artery by placing two or three fingers on the **inside** of the **wrist**, just below the level of the patient's thumb and a little from the outside of the limb. (Between the tendons and wrist bone).

Press fingers firmly enough to feel the pulse beat.

Count the number of beats in one minute, using the watch or a clock.

Record the **rate, rhythm and volume.**

Report to the doctor or sister **if variations** from normal are noted.



Figure 44 Showing the correct placements of finger for the pulse at the wrist.

OBSERVATION OF THE PATIENT'S RESPIRATION

RESPIRATION

Respiration is the process by which oxygen is supplied to the body cells and carbon dioxide removed from them. This must be a continual process in order to sustain life.

It involves the act of breathing, during which air passes into and out of the **lungs**.

There are **two phases** to this act of breathing:

Breathing In (inspiration) The cavity of the chest is enlarged causing the lungs to expand. This expansion causes air containing 21 per cent of oxygen, to be sucked in through the upper air passages.

Breathing Out (expiration) Air, with **much less** oxygen (approximately 16 per cent) and more carbon dioxide, plus some water vapour, is expelled from the lungs as the chest returns to its normal size.

In between inspiration and expiration a diffusion (interchange of gases) occurs in the lower-most part of the air passages in the lungs and the blood in the vessels surrounding them. This breathing in and out of air, followed by a slight pause, is **one respiration**. The nurse counts **only one phase**, i.e. **either** the rise **or** fall of the chest wall.

NORMAL VARIATIONS IN RESPIRATION RATE

Infants	30-40 per minute
Children	20-26 per minute
Adults	16-20 per minute

After checking the pulse, leave your fingers in position and count the respirations.

This avoids any self-consciousness which may cause an alteration in the patient's breathing pattern.

THE POINTS TO BE OBSERVED

The rate is **number of breaths** in one minute. Rate may **increase** in most feverish conditions and chest conditions. Rate may **decrease** in coma due to damage to the brain, and after certain drugs have been given to the patient, e.g. sleep-inducing drugs (hypnotics).

The regularity is when breaths are regular or irregular in time as may occur in conditions of anxiety.

The character is whether the breaths are quiet or noisy, shallow or deep, easy or difficult, e.g. the **effort** in breathing as in asthma or bronchitis.

GENERAL OBSERVATIONS TO BE MADE

APPEARANCE

Facial expression, for example, alert, apprehensive, grimacing, fatigued.

Weight—whether the patient is well-nourished, obese (fat), or emaciated (thin).

Deformities or other marks, for example, scars, bone deformities. Note if the patient has contact lenses, any fittings of artificial parts (prostheses), e.g. limb or an eye, or a breast in women.

Puffiness (oedema) —swelling due to excess fluid in the tissues which may occur in the abdomen, ankles, under the eyes, or other soft tissue. It may be noted in advanced conditions, such as heart or kidney disease, and may occur during pregnancy. It may be the result of a bandage or plaster applied too firmly.

THE SKIN

Colour

Flush May be due to high temperature (fever), high blood pressure, or a nervous blush.

Pallor May be due to anaemia or shock.

Bluish tinge (cyanosis) Due to lack of oxygen in body tissues. Observed most in skin of face, lips, and under the finger nails. Occurs in some heart and lung conditions, and to obstructions in airway.

Jaundice A yellow colour of the skin, white of the eyes and mucous membranes. It occurs because the bile pigments are retained in the blood, most commonly due to liver diseases.

Patients who have an unusual 'sickly' yellow colour of the skin, possibly associated with a variety of diseases, other than liver diseases, are often termed 'sallow'.

Condition

Dry or moist

Hot or cold

Smooth or rough

Rashes Vary in type —may result from allergy to drug treatment, solid food or liquids or from an infectious disease. (Note time of appearance if possible.)

Scratches and bruises.

POSITIONS

The patient usually adopts the position which is the most comfortable one his condition will allow.

The patient lies on his back with knees drawn up, attempting to relax the abdominal muscles and relieve abdominal pain.

The patient is restless and may apply pressure with his hands to abdomen indicating colicky pain.

The patient sits up and may lean forward to relieve breathlessness (dyspnoea) as some persons suffering an asthma attack or suffering a heart condition.

The patient may lie 'curled up' in bed, resents being disturbed, and shields his face from light (a condition called photophobia), indicating probable head injuries, e.g. concussion.

If person is unconscious for even a short period **a doctor must be notified.**

The patient's back is arched and head drawn back which may have been preceded by stiffness of jaw and neck indicating spinal cord and brain infections.

EYES

Observe the eyelids, whether they are puffy or smooth.

The whites for any discolouration or the presence of blood or yellowness.

The pupils are equal or unequal in size.

The presence of any discharge, watery or purulent (pus).

SLEEP

Observe the amount, length and time of sleep. The quality — whether restful or disturbed.

THE STATE OF CONSCIOUSNESS

Consciousness may be defined as an awareness of one's external surroundings. This awareness varies in different people. The differences may be described in the following way:

Alert and fully conscious.

Sleepy and slow to respond to questions, but will **readily react** to noise.

Delirious, a temporary mental upset in which a person is restless and may be noisy and incoherent.

Sleepy and responding to painful stimuli, e.g. gently pulling a hair on chest or armpit.

Deeply **unconscious** and **not responding** to any stimulus.

There are occasions when a person in the home will be required to contact the doctor about any of these conditions. Any member of the family or neighbour may for example:

Have a high temperature from **any** cause and may become delirious. Fall over and receive a knock or blow on the head. Have a 'stroke' and become paralysed.

Paralysis means the patient's muscles have lost the power to move due to an injury or disease of the nervous system.

Observe

If one side of the body is affected: **hemiplegia**

If body paralysed from waist down: **paraplegia**

Upper and lower limbs paralysed: **quadriplegia**

PAIN

Note should be made of the following:

Onset Whether sudden or gradual

Location The part of the body affected. The patient will tend to protect the painful areas.

Duration Continuous or spasmodic

Character

Smarting As in burns

Shooting As in toothache and sciatica

Stabbing As in pleurisy

Aching As in muscle and joint pains

Throbbing As in inflammation, e.g. abscess

Effect If noticeable by expression, posture, redness or swelling of the part.

Severity Often difficult to assess by facial expression. Some persons are able to tolerate more pain than others. The pulse rate may be increased but is not an essential fact.

Occurrence

On awakening, or in evening, or after a period of activity.

If relieved or aggravated by eating food.

THE DIGESTIVE TRACT

Mouth

Lips Whether cracked or dry. Usually occurs in dehydration when temperature is elevated.

Tongue Normally moist and pink. In disease it may become a dirty brown colour, furred or cracked. For example, in dehydration and fever.

Teeth and gums Note if teeth are natural or artificial, and whether gums are free from infection.

Breath Bad breath (halitosis) may be due to decayed teeth or alcohol. Some diseases cause a particular type of breath, e.g. diabetic coma — the breath smells like sweet apples.

Appetite

Notice—

Whether the patient has a good or bad appetite (loss of appetite is called anorexia).

The types of food the patient eats.

Vomiting

Note the amount, food content, type and colour, and if pain is present. Measure and record, and save for inspection.

Faeces (pronounced fee-seez) are the excretions of the bowel.

Normally brown in colour, except in infants when it is usually yellow.

Faeces is usually passed in a semi-solid state and has a characteristic odour.

One or two motions may be passed daily. Some people may use their bowels every second or third day. Providing the motion is soft and easy to pass, it is normal for that person.

Variations from normal

Constipation In most cases this is a functional condition, the motion occurring either too seldom or incompletely—

There is a longer interval between times when faeces are passed.

The faeces become hard and dry due to the excessive absorption of water from them if stored in rectum too long, e.g. person ignoring the warning to visit toilet—time may not be convenient. In this case small, hard pieces of faeces are passed but the rectum is not emptied.

Diarrhoea The passage of frequent, loose fluid bowel actions may occur for many reasons, most commonly from dietary causes or infective organisms.

Sometimes the patient has the desire to empty the bowel but is unable to do so. This causes straining and it should be reported to the doctor.

If normal bowel habits alter in any way, the matter should be discussed with a doctor.

METHODS USED TO RELIEVE CONSTIPATION AND ADMINISTER MEDICINES PER RECTUM

Suppositories A suppository is a solid, cone shaped medicated preparation which, when inserted into the rectum, readily melts at body temperature. It may contain lubricating substances or special drugs.

The purpose of the suppository, depending on its ingredients, is used to:

Relieve constipation by inducing a bowel action

Relieve asthma and migraine attacks

Relieve the pain of haemorrhoids

PREPARATION AND METHOD IF THE PATIENT IS UNABLE TO INSERT OWN SUPPOSITORY

Requirements

Small tray or plate

A household glove, or a finger stall (obtainable from chemists)

A lubricant, e.g. vaseline or olive oil

A small bowl of warm water to moisten the suppository

The suppository and cover for the tray

Heavy weight plastic piece, 60 cm by 60 cm (2 feet by 2 feet) and a towel

Bedpan and cover if patient is confined to bed

Toilet paper

Preparation of Patient

Explain simply to the patient the procedure to enable co-operation and to prevent a feeling of apprehension.

Take the tray to the bedside.

Close the bedroom door to ensure privacy.

Remove quilt, and any comfort aids present in the bed, and all but one pillow (except in special cases when lying low will increase the discomfort to the patient).

Give the patient the opportunity to empty the bladder; discard the urine.

Place the patient on the left side, resting the head on a pillow. Bend the knees, expose only the buttocks.

Place plastic piece and towel under hips to protect the bed.

Method

Put on the glove or finger stall, remove wrapping, lubricate index finger—moisten rounded end of suppository and gently insert into the rectum. Hold the patient's buttocks together for a few minutes if there is an immediate desire to empty the bowel. Ask the patient to resist this desire for as long as possible.

Save the specimen if doctor wishes to examine it (see later notes) or write results if requested. If person is unable to attend to own toilet, see to this matter and leave the patient clean, dry and comfortable.

Clean equipment.

REFERENCE AREA

AN ENEMA

The introduction of fluid into the rectum. It may only be given when ordered by the doctor and is less commonly used in the private home.

The purpose of giving an enema in the home is—

- To relieve constipation
- To prepare for an x-ray of the bowel

HOW TO GIVE A DISPOSABLE ENEMA

Disposable enemas (various types) are available from the chemist on the doctor's recommendation and should be used only according to directions.

Requirements

- A tray
- Disposable enema unit in a bowl of warm water
- Old linen, or a paper towel, on which is placed a wool swab or tissue smeared with lubricant, e.g. vaseline or olive oil
- Paper bag for disposing of container
- Cover for the tray
- Plastic piece and a towel as described for insertion of a suppository
- Bedpan and cover
- Toilet paper

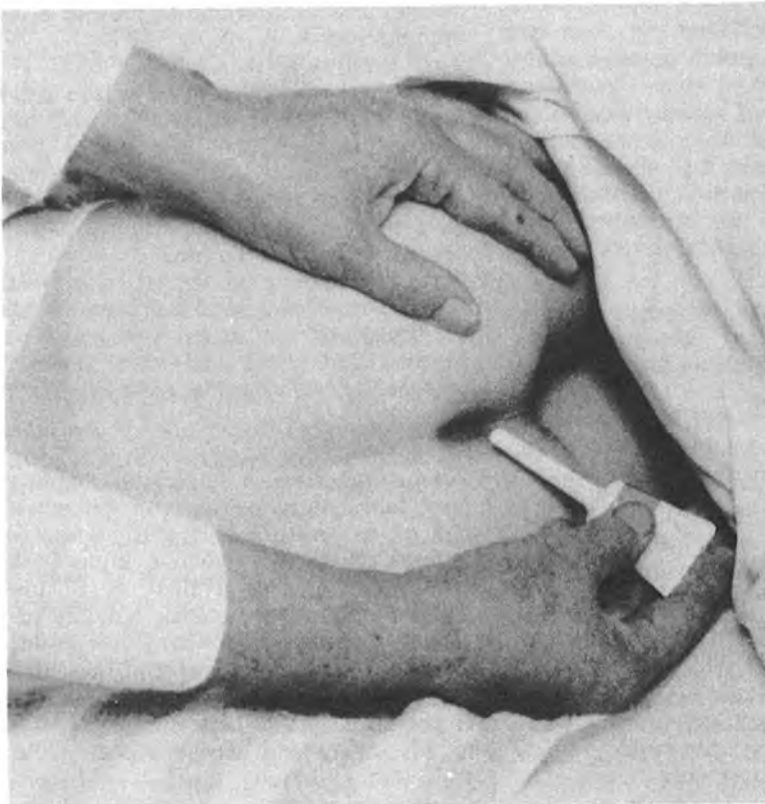


Figure 45 Method of inserting a disposable enema.

Preparation of the patient

Same as described for suppository insertion

Method

Read directions on container

Warm contents by placing container in a small bowl of warm water. (This is especially necessary with oil-based fluids to permit an easier flow)

Lubricate the nozzle and gently insert it

Administer as directed, slowly squeezing the solution out of container

When empty, remove nozzle and place empty container in paper bag

Turn patient on to back, place comfortably on the bedpan, and sit up if permitted

If the patient is very sick or distressed, the nurse should remain in the room

If a person is not confined to bed, assist on to a commode or to the toilet

On completion attend to the patient's toilet needs as described earlier

Remove and clean the equipment

ENEMATA FOR CHILDREN

A doctor will order a smaller amount to be given, however, the preparation and method are the same as for adults.

Special care must be taken to gain the child's confidence in order for the child to co-operate without fear.

Note

The home nurse should have the supervision of the sister or the doctor before giving her first enema.

The nurse must wash her own hands thoroughly after she has completed this treatment.

Method of saving faeces for examination

Remove toilet paper from pan or commode pot

Place receptacle in the toilet — covered

Label with name of patient, date, and time

Report to the doctor or the sister if **appearance** of faeces **gives cause for alarm**, e.g. if any variations from normal occur in regard to size and amount, colour, consistency or presence of any foreign matter.

Write a description of the fresh specimen for doctor to read.

Collection of faeces for laboratory tests

Doctor will provide a clean jar and the completed laboratory request form

The patient empties his bladder into a separate container

A bedpan is used to collect the faeces

The specimen is placed into the jar with the aid of a wooden spatula or a stick. (A disposable plastic spoon would be suitable.) Collect the most solid portion of the stool, which should **include any abnormalities present**.

The lid is placed firmly on the jar

Check that the jar is correctly labelled with patient's full name, the date and the word Faeces.

The specimen, with pathology request form, is sent to the doctor's rooms or laboratory without delay according to doctor's instructions.

OBSERVATION OF URINE

Urine is a waste material composed mainly of water (96 per cent), with chemical substances dissolved in it.

It is produced in the **kidneys** which are two organs situated in an area approximately level with the middle of the back. The blood passes through the kidneys and unwanted water and waste substances are extracted from it. In this way the kidneys help to keep the blood and other parts of the body healthy. The wastes are formed in the body by the work carried out by its many parts and by using the food we eat. Urine is being made all the time in healthy kidneys. It flows out of these organs down two tubes, the **ureters** which pass down the back of the abdomen to the **bladder**, where it is temporarily stored. It then flows through a short tube, the **urethra**, from its reservoir to the outside.

The act of passing urine is referred to in medical terms as voiding or micturition.

Normal

Colour Ranges from clear yellow or straw colour to deep amber

Consistency Clear or slight cloud

Quantity It is usual to pass urine every 4 to 5 hours. The amount passed in 24 hours is usually 1 to 2 litres but will vary with the individual and is influenced by fluid intake and the weather (in hot weather more fluid is lost in sweat and consequently less urine is passed)

Odour Faintly aromatic in fresh urine

Variations from normal

Colour

If dark it may be concentrated, due to infection

A bright or smoky red may be due to the presence of blood, e.g. because of kidney damage. (If a female patient, check whether menstruating)

If greenish-brown, may be due to presence of bile, e.g. in a person with disease of the liver

If green or orange, may be due to the presence of drugs

Consistency

A thick pink or white cloudy deposit can be present — this may be normal or abnormal

A very thick deposit, ropy in appearance due to pus, may be the result of infection in the urinary passages. Pus in the urine is difficult to detect with the naked eye.

Quantity — May be either

Increased as in diabetes or in chronic inflammation of the kidney (nephritis).

Decreased as in fever, in vomiting and diarrhoea and in acute nephritis — inflammation of parts of the kidney.

Odour

If offensive — due to an infection.

If sweet smelling, it may be due to **acetone** in the urine because of diabetes, excessive vomiting or fever. (The smell is similar to nail polish remover)

If the passing of urine is accompanied with pain or scalding, it may indicate that infection is present. If there appears to be reason for concern, the doctor should be consulted.

Note

Observations of urine should include any urinary disturbances, such as—

Pain or burning sensation when passing urine

Any changes in colour

The presence of a 'different' odour

Heavy cloudiness

Increased frequency, inability to pass urine or the passing of only a small amount.

REFERENCE AREA

ABNORMALITIES OF PASSING URINE

INCONTINENCE

Urine is passed involuntarily as the patient is unable to control the flow of urine from the bladder because of weakness in the muscle of the outlet. This condition is likely to occur in aged and unconscious patients.

RETENTION OF URINE

The urine is secreted by the kidneys and stored in the bladder but the patient is unable to pass it for one of the following reasons:

Obstruction due to pressure, e.g. enlarged prostate gland in man

Interference with the nerve supply in certain diseases

Following certain operations

RETENTION WITH OVERFLOW

Occurs if retention is overlooked. The bladder becomes so full that small quantities of urine are squeezed out involuntarily, giving the impression of incontinence. In some instances the patient may request a bedpan at frequent intervals, but passes **only very small amounts of urine each time** or it may be noticed that a person makes repeated visits to the toilet and may complain of discomfort. In the case of the patient confined to bed for **any reason** the repeated request for a bedpan with only small amounts of urine passed each time should arouse suspicion.

FREQUENCY

The abnormally frequent passing of small quantities of urine can be distressing because it interferes with day-time routine and night-time rest.

ANURIA

A very serious condition when the kidneys fail to secrete the urine. Any abnormality of micturition must be reported to the doctor.

At times, doctor may order fluid intake and urine output to be carefully measured and recorded and doctor consulted if there appears to be any reason for concern.

URINE TESTING

This may be required in certain conditions, e.g. in diabetes and kidney disorders. The doctor or district nurse will give instructions.

The testing agents will have clear directions for use and for reading the results of the test.

SUMMARY OF OBSERVATIONS

Remember. All the faculties of sight, smell, hearing and touch are important in observing the sick. Much detail has been included to broaden your knowledge of signs and symptoms.

No observation should be regarded as too trivial or unimportant to be brought to the attention of the doctor.



Figure 46 Main food groups.

Food for the Healthy and Sick

The person giving care will need an understanding of **basic food requirements** and what constitutes a **well balanced diet**.

The Commonwealth Department of Health provides a dietary plan suitable for Australians which can be used as a basis for planning meals for people, both sick and well.

The plan divides food into five groups.

GROUP ONE

MILK

Served in any form should be provided in the following proportions daily:

Three cups for children, expectant and nursing mothers.

Two cups for adults. (One heaped tablespoon of powdered milk, half a cup of evaporated milk, or one cup of full cream milk may be substituted.)

Milk provides **protein, carbohydrates, fats, vitamins and minerals**, especially **calcium** which is necessary for healthy growth and maintenance of bones and teeth.

GROUP TWO

MEAT, FISH, and POULTRY

One or more servings each day.

Dried peas and beans may be used in place of meat.

EGGS and CHEESE

These foods are a good source of **protein** and also contain **vitamins and minerals**, and are necessary for the growth of body tissues and their repair after injury.

GROUP THREE

VEGETABLES and FRUIT

At least one serve daily of each of—

One leafy green and a yellow-fleshed vegetable
A serving of potatoes—unless doctor states otherwise

Two serves of fruit in season

Citrus fruits, pineapple, and tomato are of good value

This group provides the body with **minerals and vitamins**, especially **vitamin C**, which is

necessary to keep the mucous membrane lining in our air passages and digestive tract healthy, and this helps to prevent infections occurring. (Because of the frequent use of garden sprays all fruit and vegetables must be washed.)

GROUP FOUR

BREAD, FLOUR, and other CEREALS

Three or more servings daily

Wholemeal varieties are better food value.

These are mainly **carbohydrate foods**. They provide **calories, fibres, minerals and vitamins**, especially **vitamin B** which helps to maintain a healthy nervous system.

GROUP FIVE

BUTTER, CREAM, and TABLE MARGARINE

One to two tablespoons. They provide **calories**, which give **heat and energy** to our body. They also provide **vitamin A**—necessary for healthy eyes. These quantities are said to be basic for the average person.

Note

In addition **water** and **roughage** serve special and important purposes for maintaining a healthy body (see next section).

HOW DO WE ASSESS

JUST HOW MUCH FOOD WE NEED?

EAT MODERATELY

The quantity of food we need depends on the amount of energy we use.

The **energy value of food** is measured in **calories**.

If we take in more calories than we require, the excess is stored as fat and we gain weight.

Excess weight is a hazard to good health and may predispose to certain illnesses, e.g. some heart conditions. Sugar and foods containing sugar, such as confectionery, cakes, sweet biscuits, and sweetened beverages, should be used sparingly. Sugar provides calories only, whereas other foods also contribute essential protein, minerals and vitamins.

FOOD CONTAINS SPECIAL NUTRIENTS FOR SPECIAL PURPOSES

PROTEIN

For growth and repair of all body tissues.

Animal proteins, e.g. meat, fish, eggs, cheese, and milk are good sources of proteins.

Vegetable proteins, e.g. peas and beans (fresh or dried), bread, and certain other cereals provide a different class of protein but are necessary in a balanced diet.

FATS

Provide heat and some energy for the body.

Animal fats, e.g. butter, cream, cheese, and milk.

Vegetable fats, e.g. nuts and vegetable oils such as olive and peanut.

Note

Margarine is a food made from vegetable fats and by law must be fortified by the makers with vitamins A and D as these two valuable vitamins are found naturally in animal fats.

CARBOHYDRATES

Mainly energy-producing foods, but provide some warmth. Two distinct groups of carbohydrate foods are:

Sugars Honey, jam and fruit, and cane and other sugars.

Starches Potatoes, flour, and foods made from flour such as bread, cakes, and pastry.

MINERAL SALTS

These are essential components of body cells and body fluids. They assist in tissue building and general growth, however, only minute amounts are needed daily.

Calcium Essential for healthy bones, teeth, and blood. Found in milk, cheese, meat, and green vegetables.

Fluoride Works with calcium and phosphorus to assist in healthy development of teeth. It is found in some drinking water. Certain areas of the world have a higher level than others. Fluoride is added to water supplies in some localities where deficiency occurs.

Iron Essential for healthy red blood cells to enable them to carry oxygen to all parts of the body. (All cells require oxygen in order to live). Found in liver, kidney, red meats, egg yolk, leafy green vegetables, and wholemeal cereals.

Iodine Essential for the normal function of the thyroid gland. This gland is situated in

front of the neck and is responsible for controlling the **rate** at which we burn our body fuel. Found in fish and in some vegetables which are grown in iodine-rich soil. It is usually present in sufficient quantities in the diet except in persons living in those areas where it is deficient in the soil, e.g. in the South-East of South Australia, Gippsland, and some parts of Tasmania.

VITAMINS

Are complex chemical substances found in a variety of foods. There are many groups, each with its own function to perform. Today the public are more aware of the value of these minute chemical substances. It seems necessary, however, to enlarge on this knowledge as simply as possible as an increase in the intake of any one of these vitamins may be ordered if the doctor feels this is deficient in certain patients.

Vitamin A

For healthy development of the eyes.

Gives a high resistance to infection by maintaining a healthy lining in the air passages (mucous membrane).

Food sources Animal fats, such as milk, cheese, butter, eggs. Table margarine, fish liver oils, tomatoes, and carrots are all sources.

Vitamin B

A complex group of vitamins which are responsible for a healthy skin, nerves, blood, and a healthy digestive system.

Food sources Wholemeal cereals, eggs, liver, nut, and yeast extracts.

Vitamin C

Necessary for healthy gums and the healing of wounds.

Food sources Lemons, oranges, grapefruit, pineapple, strawberries, tomatoes, green vegetables, and new potatoes.

This vitamin is lost or diminished if food is old or if sodium bicarbonate is added to the cooking water.

Vitamin D

Necessary for strong bones and teeth.

Food sources Cod and shark liver oil, butter and eggs.

It is of interest that sunlight on the skin can cause the fat layer under the skin to manufacture vitamin D for the benefit of the body.

There are many other vitamins of which these four are the better known. Research is being carried out continually in this field.

WATER

It is needed for every chemical process in the body

It carries the digested food materials

It assists in ridding the body of wastes

Three litres (five pints) are required each day
Obtainable from solid foods as well as in beverages

ROUGHAGE

An indigestible substance found in some foods, e.g. rhubarb, celery, prunes, cereals, and leafy green vegetables. It provides **bulk** in the **bowel** and increases movement, and assists in preventing **constipation**.

SUMMARY

The diet should be a varied one as no food contains all of these ingredients.

The **amount** of food we need depends on sex, age, and occupation of the person. As a general rule, men eat more than women, older persons less than the younger age group, heavy or manual workers more than persons who sit or carry out light duties.

HANDLING AND SERVICE OF FOOD

Food should be nourishing and look attractive. It must be **clean** and free from harmful substances. These harmful substances sometimes enter food preparation. The substances may be bacteria or their poisons which produce disease.

Bacteria need suitable nourishment, moisture, the right temperature and time to become harmful.

REMEMBER

Do not let food stand at room temperature for long periods

Food is best kept hot or stored in a refrigerator
Protect food from dust and flies

Wash and cleanse eating utensils in hot, soapy water, and rinse in clean water

Handle dishes and utensils correctly, i.e. handling the parts which will not be in contact with food or mouth.

Store them away from dust in closed cupboards and drawers

If practicable, avoid preparing and serving food if you have sores on face or hands to prevent infecting food.

YOU MAY BE THE MEANS OF PREVENTING DISEASE — HOW?**By personal cleanliness**

Clean clothes, aprons, towels, dishcloths.

Eating and cooking utensils must be washed thoroughly after each use, and handled with care.

Hands washed before and after attending the patients — nails should be kept clean and short.

BACTERIA CAN BE TRANSFERRED—

From other people to the cook or food handler.

From the cook or food handler to the food, and thus to the patient and other people.

By flies and vermin.

Contaminated food causes illness. Prevention and cleanliness are the keywords in this situation and much of the responsibility rests on the person preparing the food.

FOOD POISONING

This condition occurs when a person eats food which has been contaminated by bacteria.

Either the bacteria themselves or the 'toxins' produced by them cause the sickness.

The person usually complains of stomach pains, sometimes vomits, and has diarrhoea. This may start a few hours after eating the contaminated food, but in some cases does not start until twenty-four hours afterwards. The type of bacteria which has entered the food influences this time interval.

Foods which are most commonly affected by the bacteria known as salmonellae and staphylococci are:

Meat or foods made up from meat such as pies, pasties, mince, rissoles.

Fish, especially shell fish, oysters, crabs and crayfish.

Milk, alone or in custards, creams and ice-cream.

Duck eggs, unless they are made safe by **any** of these three ways:

By boiling them hard for at least ten minutes
By frying them well on both sides

By using them only in baked cakes and puddings where cooking temperatures are high enough to kill bacteria.

(Both shell fish and duck eggs have been found to contain the salmonellae bacteria and as these can be destroyed by heat, thorough cooking renders them safe for consumption. It is wise to wash all eggs before breaking the shell.)

The treatment depends on the severity of the condition

Clear fluids, with a little sugar or powdered glucose added, is helpful in keeping the body's water balance in a healthy state.

Doctor may order other medicines to combat or relieve the condition.

FOOD FOR THE SICK

The doctor will tell the person caring for the sick the type of food he wishes the patient to have.

He may prescribe any of the following types of diets according to the sickness of the patient.

A liquid diet, soft, light or full diet. If there is any doubt as to what the doctor means, ask him to help you understand clearly just what foods are permitted. In large hospitals, before the patient is sent home, the dietician will give the advice required.

THE LIQUID OR FLUID DIET

Often required for those persons who are acutely ill. It is usual for patients on a liquid diet to have **all fluid intake** and **output** measured and recorded on a memo pad.

Nourishing fluids can be varied to encourage the person to drink and maintain the fluid balance of the body. Examples of these fluids are:

Strained fruit juices and soups

Tea and coffee

Thin custards; cooked cereals can be thinned with milk

Egg flips, prepared by beating eggs thoroughly, adding sugar, flavouring and milk.

The addition of honey or glucose powder to fruit juices or vitamised vegetables gives additional energy value.

Commercially prepared 'strained' baby foods can be added to clear broths to thicken them.

Concentrates of powdered protein or powdered milk can be added to fluids in high protein diets.

As the acuteness of the illness subsides, the patient will progress to a soft, light or full diet.

SOFT DIET

Soft, easily-digested foods of high nutritional value are permitted. Softly cooked eggs, cooked cereals, chicken, fish, bread and butter.

The usual family meal may be converted to a soft one by the use of a vitamizer or a sieve.

All raw, coarse and fat-rich foods, concentrated sweets, and condiments are restricted.

LIGHT DIET

This is a modified full diet. The serves are usually smaller.

Avoid Fried foods, cabbage, onions, spices and condiments.

THE FULL OR REGULAR ORDINARY DIET

The patient may have any food desired. It is necessary to choose food from all the groups previously discussed in order for nutritional requirements of the body to be met.

SPECIAL DIETS

Modified or special diets are often needed by patients with such conditions as diabetes mellitus, and after certain heart conditions, certain operations on the bowel and those with a 'terminal' condition. The doctor will order the diet, and help in the form of sample diets is obtainable from the Diabetic Association, National Heart Foundation, the Colostomy Club, and many other similar clubs.

SPECIAL POINTS TO REMEMBER WHEN PREPARING AND SERVING FOOD

The type of food permitted should be selected and prepared for cooking with care as to its quality and appearance.

Serve meals **attractively** and as **punctually** as possible.

See that **hot** foods are served **hot** and **cold** meals **cold**.

HOW TO CARE FOR THE SICK AT MEAL TIME

Prepare the patient **before** the meal is served.

Offer toilet facilities

See that the patient washes the hands. (Small disposable wash cloths in packs are available, if expense is not a problem for the patient.)

Position the tray **conveniently** and **safely** for the patient to reach

Give assistance, if necessary

Remove the tray promptly after patient has finished

Finally, note whether the patient has eaten the meal and write down the amount of liquid taken, if this is required.

HOW TO FEED A PATIENT

Wash your hands

Give small amounts of food from tip of fork or spoon — use spoon if patient is restless

Feed slowly — never give the sick person a feeling of being rushed

Allow enough time between each mouthful for the food to be chewed and the patient to rest a little. (Talk quietly to the patient at this time)

If liquids cannot be taken directly from a cup or glass, use a drinking straw (preferably a plastic disposable one).

Wipe the lips clean with serviette as necessary. Clean teeth as soon as practicable after meal (see notes on Mouth Care, Area 1, page 35).

Note

If person is able to assist in any way, allow them to do so.

If person is **blind** or unable to see the tray for any reason, explain what food is on the plate. This usually stimulates interest and appetite. If a polythene non-disposable tube is used as a drinking straw, it will need special care to ensure that it is **clean**.

SICK CHILDREN

When a baby or child is sick they often reject solid food.

If vomiting occurs, fluid may not be tolerated. In this condition it is better to **wait a short time** and then **offer small amounts** of cool, boiled water, strained fruit juice or lemonade.

The emphasis is on the **small amount** as it is more likely to be retained.

Fluids can be offered every half hour.

Later if milk can be taken without provoking vomiting, it is usually the best fluid to give because of its high food value. From the second day, sweetened condensed milk (30 grams mixed with 200 grams of boiled water) can be tried.

Appetite may be slow to return; however, most children will eat as they improve.

The older child can often be encouraged by

attractively-served food, or a special favourite dish which the parent knows will not aggravate the child's condition.

Persistent vomiting or a continued loss of appetite should be reported to the doctor.

FEEDING THE AGED

(See also Area Ten, page 106)

As a person advances in years, the appetite may diminish especially if activity is reduced. It is important to remember that though only smaller amounts of food are required, it is necessary to choose this food from the basic groups. More protein foods, wholegrain cereals, fresh fruit and vegetables are the protective foods the aged require. Less high calorie foods are needed.

Poor eating habits and the consequent under-nutrition can be the cause of many of the complaints of the aged person.

Some of these are: tiredness, inability to sleep, anxiety, depression.

For the aged who live alone, the reverse is often the situation they adopt as they lose interest in cooking meats and egg puddings, and they tend to eat bread and butter and cereals which are prepared ready for use and therefore require little time and attention. Companionship helps to make meal times more interesting and often stimulates the desire for food.

The 'Meals on Wheels' organisation can be of valuable service to the aged in providing one full meal per day at a minimal cost.



Figure 47 Patient prepared and in a comfortable position for breakfast. Tray is positioned securely and all items are within easy reach.

REFERENCE AREA

<i>Special Diets</i>	<i>When Needed</i>	<i>Food</i>
High Protein	Ordered for patients who are deficient in protein. Those who are recovering from serious illness. For persons who have been severely burnt. Extra protein required for building and repairing tissues.	Give milk, eggs, cheese, meat, fish, poultry Add to milk, eggs, a high protein powder.
High Calorie	Ordered for patients who are underweight. It is often advised to give smaller amounts 5 to 6 times a day.	Give the normal protective foods plus additional eggs, butter, cream and sugar to increase the number of calories. Between meals give egg flips or other milk drinks.
Low Fat	Ordered for patients who are overweight, e.g. for obesity. Those suffering from diseases of the liver (e.g. hepatitis), and of the gall bladder.	Give skimmed milk, egg white, lean meat (steamed or grilled), clear soup, small serve only of cheeses, wholegrain cereal, vegetables and fruit. Avoid fatty meats, baked vegetables, gravy, salad dressing, fried foods, pastries, egg yolk, nuts, and chocolate.
Low Salt	Ordered for patients with kidney diseases and heart diseases (to prevent oedema). High blood pressure (hypertension). In some conditions of pregnancy.	Give unsalted foods — meat, fish, poultry, cereals, bread, butter, fruit, vegetables, and sugar. Avoid all salted foods, corned meat, ham, bacon, salted butter, pickles, sauces, gravies, and yeast extracts. Cakes, biscuits, bread, spinach, carrots, and celery.
Low Residue (Low fibre)	Ordered for cases of severe diarrhoea and other conditions of the bowel and after bowel operations. Before x-rays of bowel and urinary bladder.	Give tender meat, fish, poultry, clear soups, eggs, white bread, honey, sugar, fruit juices, and tea. Avoid all food with roughage, e.g., meat (if tough and fibrous), wholemeal bread, cereals e.g. porridge, Cornflakes, fruit, vegetables.
High Residue (High fibre)	Ordered in cases of constipation, which in a chronic state may cause other more serious bowel conditions.	Give wholegrain cereals , include bread, porridge, All Bran, fruit and vegetable fibres. Avoid bland, smooth foods.

Administration of Medicines

A medicine is a substance which may be required to relieve symptoms of a disease, or to remedy other medical disorders.

Before any medicine is used in any manner, it should first be ordered by a doctor.

The doctor's **directions for use** must be followed exactly. If they are not clearly understood, say so, and the explanation will be repeated for you.

GENERAL INSTRUCTIONS FOR THE CARE OF MEDICINES

(Essential for safety in the home)

Medicines for **internal use** must be kept apart from all other preparations.

No label is to be changed or altered by any person other than a pharmacist.

No medicine, or poison, is to be transferred from one container in which it is issued to any other container. Nor may containers be used for any purpose other than for the supply issued in them.

There are '**five rights**' to remember in giving any type of medication—

Give the right **medicine**

To the right **person**

At the right **time**

In the right **amount**

In the right **manner**.

GENERAL PRECAUTIONS AND INSTRUCTIONS FOR THE GIVING OF MEDICINES BY MOUTH

Keep **all** medicines **out of the reach of children**.

The cabinet should be high and securely locked. (Special safety closures and lock cabinets are available which a child cannot open easily.)

Have a good light so that the label can be read accurately.

Keep only small amounts of medicines, especially aspirin and iron tablets; both are harmless if taken in correct proportions for age but dangerous in excess.

Do not give medicines from unlabelled or illegibly marked containers. Discard or return to chemist for advice.

Do not return a prepared dose of medicine to its container, as a mistake could be made and liquid medicines 'spoiled'.

Unused medicine should be destroyed or discarded promptly when the patient no longer requires it.

Expensive medicines, foil-wrapped or in glass vials should be referred to the doctor. If they will store safely and it is likely that the patient may require them again, he may advise you to retain them in a locked cupboard.

Medicines must be given to the patient by the person who prepares the dose, thus avoiding an intermediary or third person, and the likelihood of mistakes being made.

Find out if there is a poison centre in your State (have the telephone number at hand), or alternatively, if the Children's Hospital or local pharmacist has arranged staff to deal with all calls from parents whose children may have swallowed **or** are **thought** to have swallowed medicines.

MEDICINES GIVEN BY MOUTH may be liquids, tablets, pills, capsules, powders, and oils.

The prescription written by the doctor should be taken to the chemist shop as soon as possible.

The pharmacist, on dispensing the medicine, will label the container clearly according to State regulations. In all instances the label will show:

Name of medicine

Dose and directions for use

Patient's name

Date

Prescription number

Special directions

Requirements — will vary depending on type of medicine — usually

Small tray or plate

Glass of water

Medicine as ordered

Medicine glass, or a dish for tablets

Paper tissue

Teaspoon for stirring sediment mixtures

Drinking straw (only in those instances when liquids cannot be taken from a glass)

HOW TO PREPARE THE DOSE ORDERED

Read the label **three times** to ensure you have the correct medicine.

Before removing medicine from the cabinet

Before removing the medicine from the bottle or pack

Before returning container to cabinet

These are check points to prevent mistakes.

Prepare the prescribed dosage as follows:



Figure 48 The correct method of measuring dose of liquid medicine.

LIQUIDS

These may be clear, clouded, or with a light or heavy sediment; syrup or oils.

Check the label

Take the bottle in one hand, label against palm. This prevents staining the label during pouring. Place index finger on bottle top and **invert** the bottle, several times, to ensure thorough mixing of the mixture.

Remove the cap or cork and place **top side down** on the tray. (This keeps the inside clean.) Hold the medicine glass in the other hand so that the markings are facing you, and raise to the level of your eyes.

Place your thumb nail **at the mark** of the dosage required.

Re-check the label

Pour out an accurate amount of the medicine. Wipe the bottle rim with a paper tissue or a damp cloth, and replace the top securely.

Check the label (third and final checkpoint). Return to cabinet and **lock** the door.

Unless otherwise stated, **dilute** the medicines with an equal amount of water.

Take to the patient on a small tray
Stay with the patient while the medicine is taken
Assist if necessary

Add a little water to the glass to ensure that the entire dose has been swallowed

Offer a glass of water

Wipe lips if the patient unable to do so

Wash glass in hot soapy water, rinse thoroughly and dry

SPECIAL NOTES

Cough syrups (linctus) are usually given without water. They are the only medicines allowed to be left at the bedside to be sipped as required for cough. **Only one dose** should be poured into glass. (An overdose of these syrups could have serious consequences.)

Iron mixtures are given through a straw to prevent staining the teeth — iron is more commonly given in tablet form.

Oily substances are better given from a warmed glass so that oil will run smoothly. (A small square of bread may be given to eat to remove the oily taste, unless bread is not permitted for any reason.)

Malt extracts, cod liver oil and paraffin emulsions are given directly from a spoon.

Sediment mixtures require stirring at bedside.

Vitamin supplements. When these are ordered for infants, they are usually measured with a special dropper attached to the bottle top.

Care must be taken to hold the dropper in a vertical position and draw up only a small amount. This prevents the fluid flowing back into the rubber bulb, which may perish and cause contamination of drops.

Aperients are best avoided under ordinary conditions. They may, however, be prescribed To relieve constipation if dietary measures fail. Prior to investigation of special conditions of the bowel.



Figure 49 Giving tablet and medicine to a convalescing patient.

Comparative measurements for liquids

Approximate dose equivalents: millilitres (ml) to fluid ounces

Millilitres	Fluid ounces
15 ml	$\frac{1}{2}$ fl oz
30 ml	1 fl oz
100 ml	$3\frac{1}{3}$ fl oz
150 ml	5 fl oz
500 ml	$17\frac{1}{2}$ fl oz
600 ml	20 fl oz (or 1 pint)
1000 ml (1 litre)	35 fl oz

TABLETS AND PILLS

Appear similar, but pills usually have a harder outer coat of sugar preparation and take longer to be absorbed.

The required number are shaken out of the container on to a teaspoon or into a small dish. The spoon or dish is placed on the tray or plate to take to the bedside. The patient takes the tablet and places it on the front of the tongue and swallows it with water.

If tablets are to be halved, they are cut with a sharp knife or may be broken between the fingers if a 'break line' is present on the tablet.

CAPSULES

These are powders or oils contained in a gelatine case. They are a convenient way of taking unpleasant medicines. Shake out the required number and give in the same manner as tablets.

POWDERS

Those which are prepared in paper packs are simply shaken from the paper on to the back of the tongue and swallowed with a glass of water. It is often easier to take if a mouthful of water is swallowed first to moisten the mouth.

Powder in jars is either measured into a calibrated medicine glass or in a spoon. Dip spoon into jar and take out more than the required amount, draw the edge of a knife across the spoon, allowing the excess powder to fall back into the jar. Add powder to a glass of water and stir well before taking to the patient.

SUGGESTED TIMES FOR THE GIVING OF MEDICINES

Once a day It must be given at the **same time** each day — usually in the morning unless it is a sedative.

Twice daily They are given in the morning and afternoon, twelve hours apart — 8 am and 8 pm are often convenient times for home routine, **unless** otherwise stated.

Three times a day With no other instructions, give at eight hourly intervals — 6 am, 2 pm and 10 pm.

Four hourly Give at 2 am, 6 am, 10 am, 2 pm, 6 pm, 10 pm

It should be clearly **understood** whether the doctor wishes the patient to be disturbed at night.

Before food Give one hour before meals

After food Give one hour after meals

With food That is during a meal

At night To induce sleep — the time depends on the habits of the sick person and the doctor's orders.

GIVING MEDICINES TO CHILDREN

It is important that the adult has an understanding of the needs of children.

Approach the bed in a friendly, confident manner. If the medicine has an unpleasant flavour, tell the child.

If for any special reason the child cannot take the medicine in the usual way, the tablet or pill may be crushed, or the capsule emptied, and mixed with a teaspoon of jam.

Liquid medicine can be emptied into a favorite glass.

Praise the child after the medicine has been swallowed.

A drink of water or cordial should follow the administration of the medicine.

Most medicines are flavoured especially to prevent these problems of unpleasant taste.

GIVING MEDICINES TO HELPLESS PATIENT

The overall rules for preparation of the dose are the same as mentioned previously.

Place a tissue under the chin to protect bed-clothes. Gently, but firmly, support the head whilst giving the medicine.

Slide one hand under the top pillow and raise both pillow and head simultaneously.

After the drink of water has been swallowed, lower the head, wipe the lips, and replace the patient in a comfortable position.



Figure 50 Preparing to place drops in the patient's right eye and illustrating the requirements.

OTHER METHODS OF GIVING MEDICINES

Into the rectum (Area Two, page 47) eyes, nose and ears. By steam inhalation (Area Six, page 79), injection, oxygen inhalation (Area Four, page 64).

INTO THE EYE

These may be ordered as drops or ointments.

The purpose

To treat an eye infection or disorder

To soothe irritation and relieve pain

To dilate the pupils for doctor's examination

Special care which may be required

If the lids are stuck together with discharge, they must be cleaned gently before medication is carried out.

A weak solution of salt and water can be used with safety. One **half a teaspoon** of salt into 600 ml (one pint) of **water**, room temperature is satisfactory.

Swab from the inner angle of the eye outwards to prevent infection of the non-infected eye. Drop swab into a paper bag.

If the eye requires covering, an eye pad may be obtained from the chemist.

Remember

Strict cleanliness is essential

Be gentle

Avoid touching any part of the eye with the dropper or ointment tube

If cotton wool swabs are used to wipe the eye, they are best **slightly moistened** to prevent small pieces of wool fluff coming in contact with the eyes.

Requirements

A small tray or plate

Drops prescribed by the doctor

Eye dropper (if there isn't one attached to the bottle top)

Clean face tissues or cotton swabs

Small hand towel to place about shoulders and under the chin.

Method of instilling the drops

Have the patient sit or lie in a comfortable position facing a good light.

Check the bottle label. Note the **expiry date** and/or **rejection time** of some eye drops.

Hold the dropper vertically so that no medication goes into the bulb.

Draw the required amount into the dropper — if both eyes are to be treated draw up enough to do both eyes without the need to return the dropper into bottle.



Figure 51 Illustrating the angle of dropper as drops are about to be inserted in the left eye.

Stand at back of patient or a little to one side. Ask the patient to tilt the head back a little and to keep still.

Steady the hand holding the dropper by placing the little finger and side of the hand against the temple and cheek.

Gently lower the bottom lid with the other hand, using a tissue or cotton ball, and ask the patient to look upward to the ceiling.

Hold dropper a little above the eye and **gently squeeze** the bulb, dropping the prescribed number of drops in the lower lid, slightly off centre towards inner corner of eye.

Tell the patient to close the eye, so that the drops are distributed over the surface of the eyeball.

Wipe away any medication or tears from the cheek.

Any drops which remain in dropper should be emptied on to swab or tissue and discarded.

Should the dropper accidentally touch any part of the patient's body, it **must** be cleaned in hot, soapy water, rinsed and placed in cold water and brought to boil for thirty minutes

before it is returned to bottle. This prevents contamination of the remainder of the drops in the bottle.

It may be necessary to make a note of the time at which the drops are instilled. The memo pad should be used. In any case the **condition** of the eyes should be noted, especially **note** whether the eyes react in any way to the drops, e.g. if any redness in or around the eye or any swelling occurs, it will be necessary to report this to the doctor.

Eye ointments

Are usually dispensed from a tube.

The ointment is squeezed gently from the tube into the cupped lower lid.

Should the ointment be required to be placed on the lids it is applied **gently** with a cotton wool applicator **after** the lids have been cleaned.

Note. Some drugs will cause a stinging sensation, and the vision becomes blurred. The patient should be cautioned against squeezing the eyes shut tightly, using pressure with the fingers or rubbing the eyes, as this will only aggravate the unpleasant sensations.

INTO THE NOSE — DROPS

The purpose

Nasal drops may be ordered by the doctor to relieve such conditions as difficulty in breathing and inflammation.

Equipment

Bottle with prescribed medication

Medicine dropper (if one is not attached to bottle top).

Paper tissues

Method of instilling nasal drops

Check the label on the bottle of medication.

Ask the patient to rest on the bed without a pillow, the head tilted well back.

Draw up amount required by gently squeezing the bulb of the dropper.

The dropper should be inserted for a distance of about half an inch.

Insert drops into both nostrils.

The patient remains in the head-back position for a few minutes so that the liquid will not run out.

Some of the liquid may run back into the throat and have an unpleasant taste.

Hand the patient some tissues or wipes in case expectoration is necessary.

Children should be held firmly but gently so that the delicate lining of the nose will not be damaged with the glass dropper.

INTO THE NOSE — SPRAY

Special 'puff bottle' nasal sprays are in use for nasal congestion caused by hay fever or the common cold. Directions are on the bottle.

INTO THE EAR

In home care the doctor may order ear drops for the following purposes:

To soften wax prior to removal by a doctor (olive oil is commonly used).

To relieve pain and to treat infection.

Equipment

As for nasal drops, **but** substitute ear drops.

Method

The patient can sit or lie down as required by circumstances.

Cover the neck and shoulder on the affected side with a paper tissue.

Draw up the required amount of fluid (commonly 2 to 4 drops).

Ask the person to tilt the head slightly to the opposite side.

Gently pull the ear lobe backwards to straighten the ear canal.

Insert the drops, which are at room temperature unless other directions are given by the doctor.

The dropper is held only at the entrance to the ear and should **never** be inserted further into the canal.

The drops are usually left in for several minutes before the patient straightens the head. Dry the outside of the ear as necessary.

Should the person requiring the ear drops be confined to bed, it may be necessary to place a piece of cotton wool **lightly** over the external opening.

Note. The **inside** of the ear canal should **never** be probed as this could perforate the ear drum and cause other more serious conditions to occur.

REFERENCE AREA**GIVING INJECTIONS IN A PRIVATE HOME**

If it is necessary to have medicine given by injection, it is clearly the responsibility of the doctor, the hospital or special clinic nurse, or the district nurse to give the patient and/or relative clear directions on just **how** this is to be done.

For this reason the actual preparation of the dose has been omitted from this area. The guide below could be used to ensure that the person receiving instruction understands what is required to successfully carry out these tasks.

Occasional injections

In the home they are best given by utilising the readily available **disposable** equipment. The use of such equipment for this purpose is desirable because—
It eliminates the time-consuming home disinfection procedures (see Area Eight).
It assures that syringe-borne diseases, such as serum hepatitis, are not passed from patient to patient.

The time saved in injection preparation permits more time for other nursing care and household tasks.

Individual packets of disposable spirit swabs are usually available from local chemist shops. These are used to clean the skin at the injection site and the top of the container of the medication.

Note: Syringes and needles must be destroyed and discarded immediately after use. This must be done in such a way as to ensure the needle does not come in contact with another person as serious infections (as mentioned above) may develop.

Frequent injections

The continuous use of disposable injection equipment could prove too expensive for the person having daily or twice daily injections over a long period. For example, the person who is a diabetic.

The following points would need to be emphasised and explained in detail:

The person would be encouraged to have a certain saucepan for the sole purpose of cleansing the equipment.

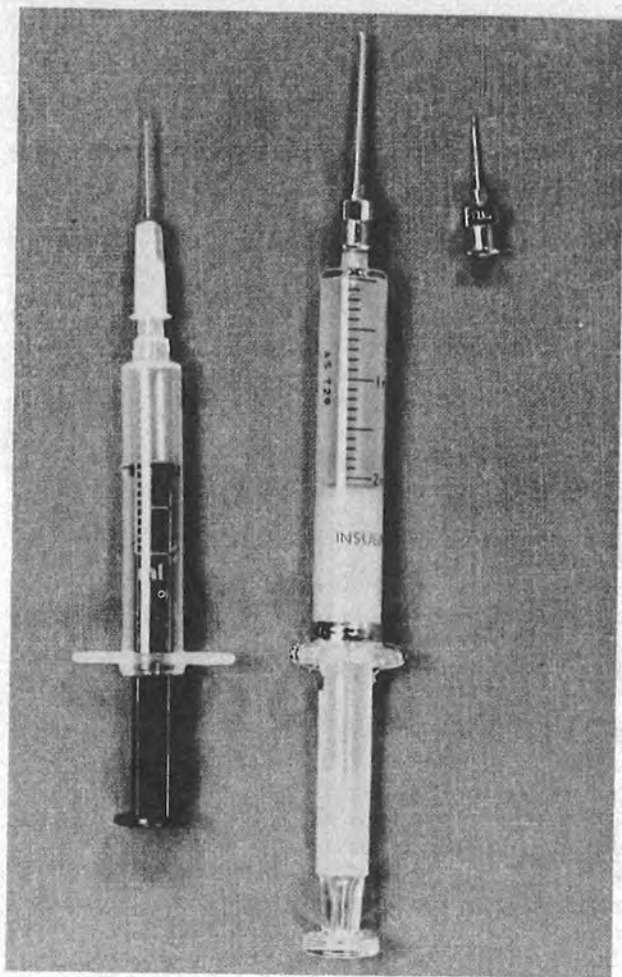


Figure 52 Left: a disposable syringe; right: glass syringe and needle.

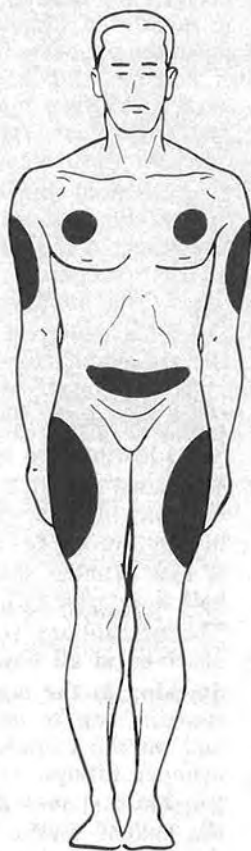


Figure 53 The areas shaded in blue are most suitable for insulin injections.

Special instructions regarding the dismantling of the syringe, its cleaning and disinfection is required. How to assemble it and **use it immediately without contamination** is also necessary.

An understanding of the syringe used and special marked dosage lines is essential. The areas for a **safe injection** is explained.

The possible dangers of giving injections would need to be explained, but without worrying the patient unnecessarily.

In conclusion, safe injections can be given in the home provided adherence is given to the basic principles and techniques.

Of Special Interest

The person with diabetes is usually given special and clear explanations of their condition. The type of insulin to use, the syringe best suited for the person's use, to ensure accuracy of the dose, and the sites for injections (see Figure 53). Learn to use each site on one day of every week.

The Diabetic Association provides a booklet which covers the injection needs and many other aspects of care needed to maintain good health. It explains what to do should sickness occur and how to prevent any complication arising.

OXYGEN THERAPY AT HOME

Oxygen is a normal constituent of the air we breathe, it is essential to life. Inability to breathe in sufficient air, or to absorb the oxygen in that which is inhaled may mean the patient will require additional help to receive this life-sustaining substance. It may be used in certain forms of lung disease to increase patient comfort and activity. Oxygen must be regarded as a **drug**, and this along with all medications has specific use. As well as benefits, it also has side effects which with **incorrect administration** may be dangerous.

It is essential that the doctor give clear instructions on its usage, and that these are fully **understood** by the **patient** or the **person** responsible for giving the oxygen. Treatment is aimed at raising the oxygen content of the blood by increasing the oxygen percentage of inspired air (normal air contains approximately 21 per cent). This increased level (22 to 42 per cent) **must be determined by the doctor**. Oxygen is supplied in cylinders either through a hospital or directly from one of the gas manufacturers. Because it is contained in cylinders **under pressure**, special valves and flow meters are required to regulate the oxygen supply. These are obtainable from the same sources.

Strict instructions apply to the use of oxygen

The mode of giving oxygen and the flow rates used must be directed by the doctor. Not only must the equipment be looked after and cleaned, but also attention should be given to the patient's mouth and nose toilet.

A new cylinder should be obtained **before** the one in current useage is less than half to quarter full.

The precautions relating to **flammability** and **explosiveness** of oxygen must be observed **at all times**, especially when it is being used.

Smoking in the area is dangerous. Not only should the importance of the non-smoking ban be emphasized by a 'No Smoking' notice placed on the room door and on the cylinder, but also the dangers of allowing grease and oil near the cylinder fittings. (Oxygen and grease under pressure cause an explosion.)

Emphasis should also be placed on the dangers of wearing nylon clothing by the patient (static sparks), of electrical fittings and appliances being used near the flow, of using flammable fluids for back care, and allowing spark-producing toys in the area.

Because cylinders are bulky and heavy, they should be positioned near the bedside in such a way that the doorway is unobstructed should an emergency arise. Explosions have occurred when cylinders have toppled over and the valves damaged or the cylinders fractured. Provided they are attached to a fixed structure such as a bed or cupboard, this risk will be minimised.

METHODS OF GIVING OXYGEN AT HOME

Nasal Cannula

This technique is very useful in that it can be worn just inside the opening to the nose without obstructing the mouth.

Treatment may thus be given whilst the patient is eating and drinking. The feelings of suffocation some patients feel whilst wearing a face mask are also eliminated. The amount of oxygen delivered to the patient is determined by the flow rate from the cylinder.

Venturi Mask

Masks of this type are constructed so that oxygen delivered from a cylinder is diluted with room air. Using the flow rate specified on the mask, constant percentages are delivered to the patient.



Figure 54 Oxygen being given by a nasal cannula. Note safety notice attached to cylinder.



Figure 55 Inhalation of a bronchodilator through a nebulizer attached to an oxygen mask for a patient with respiratory distress.

Masks are available that supply 24, 28, 35 and 42 per cent oxygen. Whereas the amount of oxygen delivered to a patient via a nasal cannula is **variable**, that provided by this type of mask is **constant**.

Other types of masks may be ordered by the doctor, however, they are only used for certain conditions. Again a prescribed amount of oxygen required must be strictly adhered to.

Trolleys are available, if required, to make the cylinder portable to enable certain patients to transfer from the house to the garden.

OBSERVATIONS DURING OXYGEN THERAPY

Deterioration in the patient's condition should be interpreted as a need for re-assessment of the patient's condition by a doctor, rather than to give an increase in the oxygen level.

The presence of increasing drowsiness, increased irritability, sweating, a rapid, thready pulse or coma, may indicate that too much oxygen is being given (or that the patient's lung condition is deteriorating).

SPECIAL DRUGS TO BE USED IN CONJUNCTION WITH OXYGEN

Drugs to relax the bronchial airway (bronchodilators) may be prescribed on occasion to be given as a fine mist to be **inhaled**.

This drug is breathed in at certain intervals, e.g. four to six hourly, and also for a specified time (one to two minutes), and this time **must not be exceeded**. The apparatus for this is called a **nebulizer** and is attached to the oxygen mask. The drug is inserted into the nebulizer, a sufficient amount of the solution (usually two to three millilitres) must be inserted for adequate misting to be possible. To be operating effectively, the nebulizer must have oxygen flowing through it at a prescribed rate (e.g. ten litres in one minute), and must have clouds of mist coming from it which are to be inhaled by the patient.

Note: The standard procedure for **cleaning** all apparatus as directed by the gas manufacturers must be carried out **daily**.

Summary: In addition to the abovementioned, there is various other sophisticated respiratory equipment available, such as ventilators (respirators) and ultrasonic nebulizers. The use of these requires detailed instruction by the doctor.

Bandaging

Roller bandages are seldom used in hospitals or doctors' surgeries as newer methods of keeping dressings in place have been introduced, and adhesive dressings are available in different sizes, and are easy to apply. However, as they are often the only type of bandage, real or substitute, available in the home at short notice, some guidance in regard to their use needs to be included in this manual.

Material bandages such as cotton, flannel or crepe can be used.

The length Usually 4 to 6 metres (6 yards approximately).

The width Varies in size of the limb in both children and adults. The most versatile widths are from 5 to 10 cm (2 to 2½ to 3 inches).

THE USES OF A ROLLER BANDAGE

To keep dressing and splints in position

To control bleeding (by helping to maintain pressure over a bleeding part)

To provide support

To restrict movement

To help limit oedema (swelling)

In order to have **complete control** over the bandage during its use, it must be **tightly** and **evenly** rolled before commencing.



Figure 56 Rolling a bandage by hand and showing the head of bandage and free end or tail.

The photograph shows how this can be done at home without the use of a bandage winder.

RULES OF APPLICATION FOR APPLYING A ROLLER BANDAGE

Select the bandage of suitable size and length for the part to be bandaged.

Put the person in a comfortable position, and the limb in the position it is to remain in when bandaged (e.g. if an arm is to be supported with the elbow bent it must be bent before the bandage is applied).

Stand or sit opposite the person for all except head bandages, when it is easier to stand at the back.

Hold the head of the bandage uppermost and in the **right** hand when bandaging a **left** limb and vice versa.

Commence with an oblique turn across the **front** of the limb to fix the bandage. Continue to bandage from **below upwards** and **within outwards**, not allowing more than 5 to 10 cm (2 to 3 inches) of bandage to be unrolled at one time.

Each layer of bandage is to cover two-thirds of the previous layer.

Bandage with **firm** and even pressure so that the dressing and bandage will be **secure** and yet **not restrict** the circulation of blood.

Note: If the circulation of the blood is **restricted** because the bandage is **too tight** there may be:
An absent pulse below the bandage

Swelling of the part

Either a bluish tinge or a pallor of the exposed ends of the limbs

Numbness of the part

Pain may be present

If any of these signs are present, the bandage must be loosened and re-applied comfortably.

Two skin surfaces must not rub against each other as friction and soreness will occur.

These areas (armpit and groin) should be padded with soft wool.

Finish on the outside of the limb, tidily and securely, avoiding pressure over the bony prominences. Adhesive tape or a small safety pin can be used when bandage clips are not at hand.

Bandages are named by the method used to apply them.

The following examples demonstrate the correct methods of applying the bandage to particular areas of the body.

SIMPLE SPIRAL

This bandage is used for parts of the body which are of uniform thickness, such as the fingers or the wrist. The bandage is carried obliquely around in a spiral fashion, each turn covering two-thirds of the preceding one, and the edges are kept parallel.

Simple spiral bandaging to fingers

Place the forearm with the palm down and fix the bandage by two circular turns around the



Figure 57 How to commence arm bandage using an oblique turn.



Figure 58 First turn anchored securely in position.

wrist, leaving the end free for tying off afterwards. Carry the bandage obliquely over the back of the hand to the base of the finger to be bandaged. Take one spiral turn to the base of the fingernail and then cover the finger by simple turns. Carry the bandage across the back of the hand to the wrist, complete with a straight turn around the wrist and secure. If more than one finger is to be bandaged, take a turn around the wrist between each two fingers.

REVERSE SPIRAL

Figure 59 Showing the simple spiral, then reversing the bandage as the arm becomes wider.



Figure 60 Bandage complete and secured on the outside of arm.



REVERSE SPIRAL

Is used in bandaging parts of limbs where, owing to its varying thickness, a simple spiral will not lie evenly, such as the arm and the leg.

Reverse spiral of the forearm

Apply one or two simple turns around the wrist. The upper edge of the last spiral is fixed with the thumb in the mid-line of the limb.

Reverse the bandage and bring down and around the limb. Reverse the bandage immediately above the former fold, the bandage covering two-thirds of the previous turn.

Repeat these reverses as far as necessary and complete the bandage with one or two spiral turns around the limb. This method is also used for bandaging a leg.

FIGURE OF EIGHT

Is used for bandaging at or in the neighbourhood of a joint such as the **elbow, knee or heel**. Figure of eight bandage to the elbow. Bend the elbow at right angles. Lay the outer side of the bandage on the inner side of the joint and take one straight turn. Carry the bandage over the elbow tip and around the limb at the elbow level. The second turn encircles the fore-

arm, the third the arm. Continue these turns alternately below and above the first turn. Where the limb bends, i.e. the flexure, there should be the width of the bandage only. This means that at this part each turn of the bandage lies over the previous one. This not only prevents 'pull' on the limb, but prevents pressure on the underlying blood vessels. Finish above the elbow.

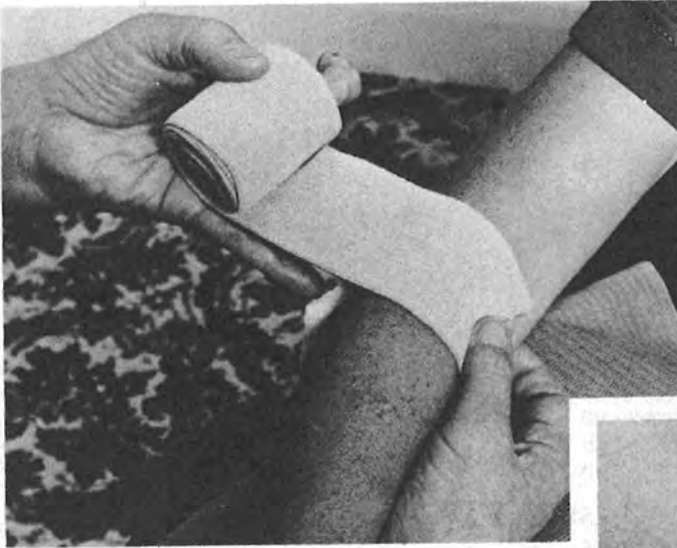


Figure 61 Start on the inside flexure of arm.

Figure 62 Third turn of figure of eight.

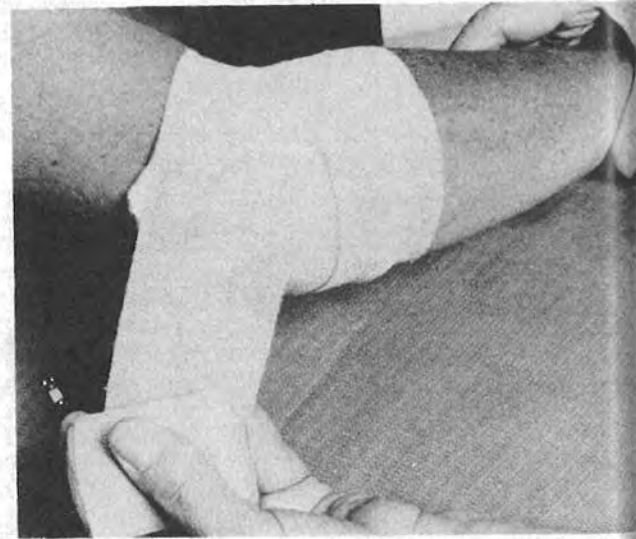
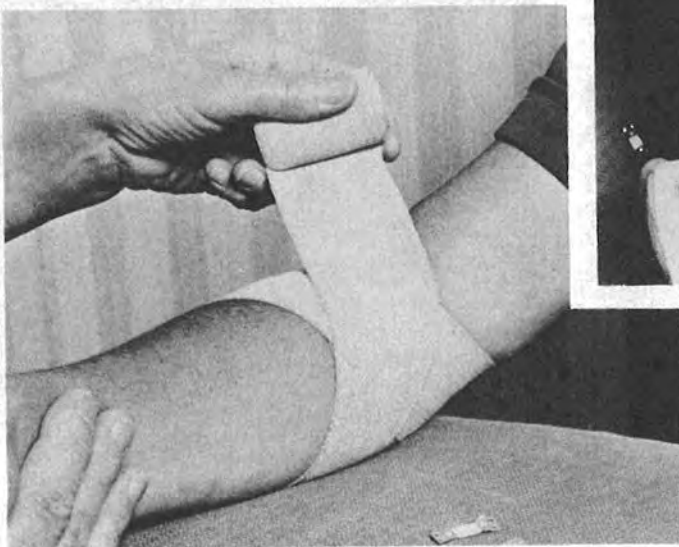


Figure 63 Correct method of placing bandage in flexure of elbow.

Opposite page
Figures 67-68 Showing a modification of figure of eight and a spica, suitable also for the foot.

SPICA

Is used as a modified figure of eight in which one turn is much larger than the other, useful for bandaging the shoulder, groin or thumb.

Spica of thumb bandage

The forearm is placed with the palm down. Take two turns around the wrist and carry the bandage over the back of the thumb. Encircle

the thumb with one or two straight turns with the lower border level with the root of the thumbnail. Carry the bandage back over the hand and around the wrist. Repeat figure of eight until the ball of the thumb is covered. Complete the bandage with one straight turn around the wrist, and finish on the outside and centre of the wrist to avoid bony parts.

Figure 64 Start of bandage and showing dressing. Palm is shown upwards for purpose of illustration only.

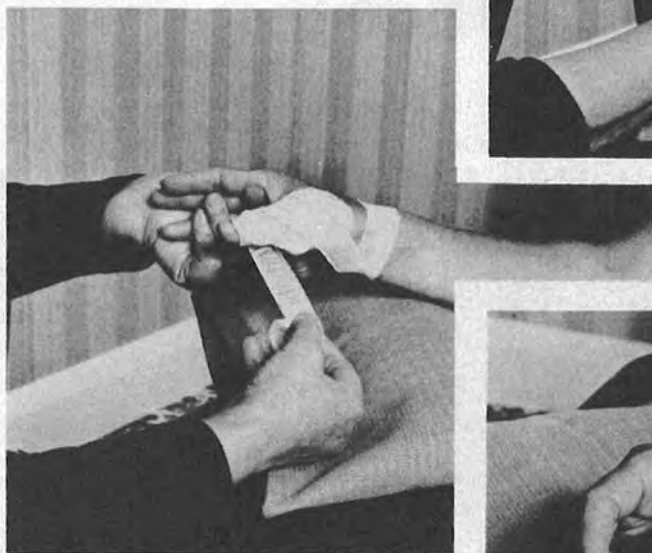


Figure 65 Simple turns of bandage to anchor dressings before carrying on a spica back to wrist level again.



Figure 66 Complete thumb spica.



TUBULAR GAUZE

Used instead of a bandage, is a very useful and simple means of keeping dressings in place. A special applicator is required and is made in metal or plastic. This and the gauze bandage

in various sizes can be purchased from chemists and chain stores. It is most useful for fingers and is neat in appearance and, with a little practice, is easy to apply. Other limbs can also be bandaged efficiently with various size gauze and applicators.

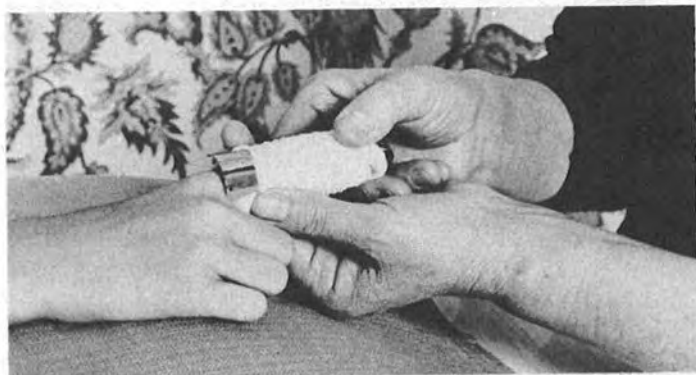


Figure 69 Commencement of finger bandage with required length of gauze fitted onto applicator.



Figure 70 Applicator withdrawn from finger and tubular gauze twisted prior to refitting applicator for further coverage.

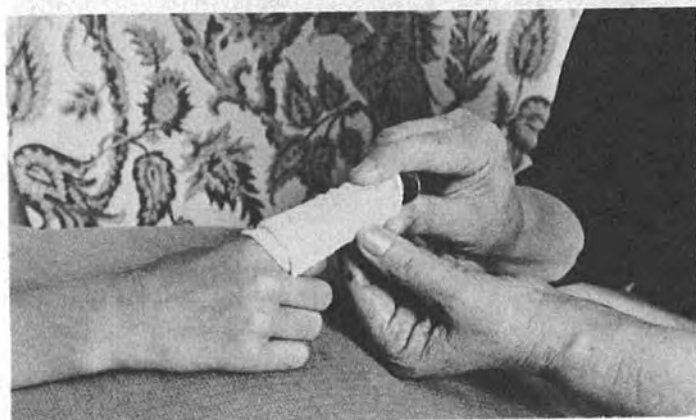
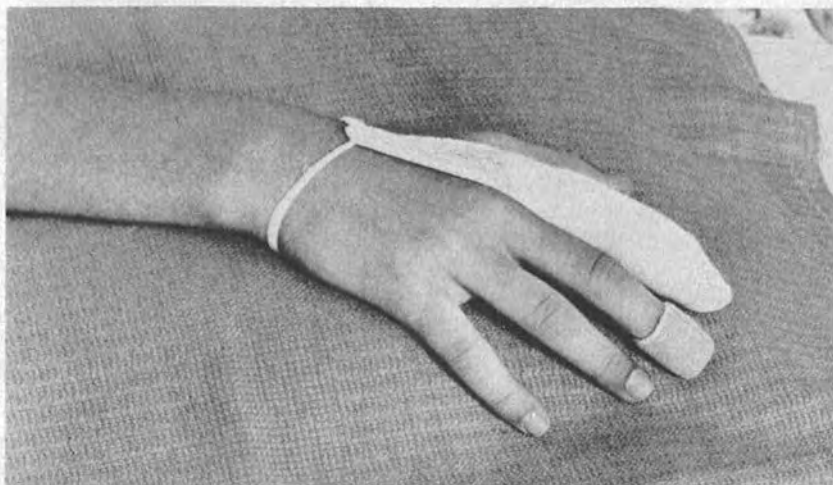


Figure 71 Final application of gauze.

Figure 72 Bandage complete — gauze cut and tied around the wrist.

NOTE: ONE FINGER WITH A STRAIGHT ADHESIVE PREPARED DRESSING.



ELASTICISED TUBULAR NET BANDAGE

A comfortable method of keeping dressings in place. It can be cut to fit special parts of the body, such as head, shoulder, chest, abdomen, and thigh and limbs.

It is easy to apply by being stretched over the hands and pulled on over the part.

It is light and strong and allows freedom of movement.

It is obtainable in several sizes, and directions for use are included in packet.



Figure 73 Elasticised tubular net bandage being applied to keep hand dressing in place.

Hazards in the Home

Accidents of an unforeseen nature are likely to occur in and around the home. As these may often be of a serious nature, which may cause prolonged disability, it is imperative that people must be aware of possible dangers, and do all in their power to **prevent** them.

Parents of young children have a special **responsibility** to check the **safety** of their environment. For this reason certain selected and more prevalent dangers are brought to the attention of the reader. It is not intended that all possible dangers have been included.

As each part of the home presents its own particular hazards, living areas have been mentioned according to their particular danger.

INDOORS

THE KITCHEN

This may be a very dangerous room as most activity seems to be centred here.

Always turn **handles** of saucepans and other cooking containers **inwards** to prevent children and yourself from knocking them off the stove and causing burns or scalds. A stove guard is available to afford protection from this type of accident.



Figure 74 Stove guard

Containers with **hot** food and drinks must be placed in the **centre** of the table out of reach of toddlers.

Place mats are less likely than the dangling ends of a table cloth to be pulled off the table, with the risk of sharp and pointed cutlery falling and causing injury.

Electrical cooking appliances are dangerous if their **cords** are allowed to **dangle**. **Hook** them up out of reach **or**, if practical, have **short cords** for toasters and electric jugs which have just sufficient length to pass from appliance to socket.

Electrical sockets should be closed with 'dummy plugs', which are difficult for the small child to remove. This applies to **all** rooms. Sockets are available with inbuilt safety shutters, with or without neon light indicators.

THE BATHROOM

Never leave a child **alone** in the bathroom. Always put cold water into the bath **before** adding hot water. This lessens the risk of burning and scalding.

Non-slip mats should be placed in the bath to prevent accidental slipping by any age group. (This is also mentioned in an earlier section.)

The **medicine cabinet** (wherever situated) should have a childproof lock — or a padlock. Special safety closures for medicines are now available. Do **not** store unwanted medicines.

All bath-cleaning agents and skin perfumes should be securely locked out of reach of the child.

THE LAUNDRY

Never leave a child **alone** in the laundry whilst the washing machine is in action, or if buckets or tubs of water are in use for any purpose.

The ironing **cord** should be looped up out of **reach** to prevent the iron, whether hot or cold, being pulled down on to the child causing serious injury. Cord holders can be attached to ironing boards.

All soaps and detergents must be **locked** away.

THE LOUNGE

If floor rugs are in use they should have **non-slip** backing attached. This will prevent the risk of falls in all age groups.

The fire or radiator should be **guarded** to prevent burns.

The night attire of children should be of a **non or low flammable** or special burn-proof material and be of the firm fitting track suit design. Flowing nightdresses and gowns must be **avoided**.

Cigarette lighters (or matches if they must be used) should not be left lying within reach of children of any age group.



Figure 75 Firm fitting, track suit type pyjamas lessen the risk of children being burnt.

THE BEDROOM

The practice of leaving medicines or tablets in an easily accessible place, such as the dressing table, or in handbags, must be avoided to prevent accidental drug overdosage in children or in confused elderly people.

Cot styles must be thoroughly checked before purchase. The side-bars can be a danger if they are so spaced that a child's head can be thrust through them and possibly cause strangulation. The anchorage of the cot sides needs to be of a reliable secure type.

GENERAL COMMENTS ON OTHER INDOOR HAZARDS

Ladders should be positioned safely for inserting ceiling light globes, high dusting, or hanging curtains. It is dangerous to step on to chairs or the end of a table top.

Plastic bags should be destroyed or if required for future use they should be stored where young children cannot reach them as suffocation may occur if the child pulls the bag over its head.

Toys should not be left lying about on the floor or on stairs because they may cause falls. Stairs should be guarded by gates.

Before purchasing any toys, parents, relatives or friends must be certain their selection is a safe one and suitable for the mental and physical development of the child.

Avoid purchasing toys of materials such as glass, celluloid, and fur as these could splinter or burn easily. Toys containing plant seeds and those with buttons or beads stitched on for eyes can be chewed, causing sickness or choking.

All play material should be kept in a safe condition.

Firearms must be dismantled and ammunition should be stored separately in a safe place and **locked out of reach**.

OUTDOORS

THE TOOL SHED AND THE GARDEN

All tools, weedkillers, insecticide sprays, kerosene, and any other dangerous items must be kept locked away at all times. They must be labelled correctly.

None of these **poisons** should be transferred to cool drink bottles.

If it is unavoidable that the garden rake or fork be left temporarily, their prongs should be embedded in the ground.

Avoid standing ladders against walls or trees for children to climb or play upon.

Swimming pools or garden pools must be adequately screened. Steps or ladders attached to pools should be unhooked and removed or be covered in some secure way. (Accidental drowning of your own or other people's children must be prevented.)

Old refrigerators, used as play houses or cubby holes, must have the door removed, and be placed on even ground so that they will not topple over.

Barbecues, incinerators, hot ashes, and burning rubbish should be guarded by a responsible adult.

Kerosene must never be 'thrown' on to a smouldering fire.

Rubbish bin lids must be a firm fit so that children cannot remove them and play with the rubbish. Broken glass and china must be wrapped with thick layers of paper and tied securely. This will also help to protect the garbage collector from cuts.

CARS

Never leave children **alone** in a car.
They may play with the gears.
Never leave ignition keys in the car.

On **hot** days it is **dangerous** to life to leave infants in this situation.

A child restraining device is essential to prevent the child being thrown from the seat should the car brake suddenly. Standards Association of Australia approved seat belts, with webbing and webbing straps for bassinets, are on the market.

Check the glove box to ensure it is free of tablets or matches.

Make sure the children are in the house when **backing out** the family car. Always look in the rear vision mirror to ensure no other person or animal is in the way. Back the car out **slowly**.

Cigarette lighters, which may be activated by a child and dropped on to the floor or the upholstery, should be removed if a hazard is possible.

Summary: It will be seen that each adult person has a responsibility to be alert to possible dangers and to do all in their power to prevent accidents to their own family and other people.

Inflammation

The Latin meaning of the word inflammation, 'Inflammo' — 'I set on fire' — aptly tells us the reaction of the body tissues to any irritant.

An irritant is anything which causes the tissues to respond in any way which can be seen by the onlooker or felt by the victim.

The irritants can be either:

Living Pathogenic (disease causing) micro-organisms such as those which cause tonsillitis, pneumonia, boils, and many other conditions.

Non-living

Foreign bodies A splinter

Friction Stiff or high coat collars

Pressure Tight shoes

Heat Sunburn

Cold Frost bite

Chemicals Garden sprays

When any of the above conditions are present the person's body responds in either a local or constitutional (general) way.

LOCAL EFFECTS

Redness

Heat

Swelling

Pain

Limited or loss of movement

These effects are brought about because the blood vessels in the area dilate (widen) causing the part to become **red and hot**. The widened vessels hold more blood and some of its fluid seeps out into surrounding tissues and causes the part to **swell**.

This swelling causes pressure on the nerves in the area which results in **pain**.

The pain prevents **free movement** of the part.

CONSTITUTIONAL RESPONSES

These take place in the body:

A high body temperature, a fast pulse and respiration rate

Hot, dry skin due to the fever

A furred tongue and bad breath

A feeling of nausea, which may progress to vomiting

Loss of appetite

Headache, listlessness, and inability to sleep

Aching joints

Less urine is formed in the kidneys, therefore less passes out of the bladder.

Any of the following may be the **result of inflammation**:

Either the condition resolves itself (i.e. disappears with a minimum of scarring)

Pus formation occurs

The area heals, forming a tough fibrous scar tissue

Death may occur

THE TREATMENT OF INFLAMMATION

LOCAL

Rest, preferably in elevated position. Relieves swelling and throbbing. An arm may be put in a sling, or rest on a pillow; leg supported on sloping pillows or cushions.

Application — **Heat**: hot baths, infra red lamp, medicated plasters, **Cold**: ice packs.

Doctor may need to open and drain the part if inflammation causes an abscess to form. In this case **special care** with dressing the part to prevent re-infection is **essential**. Antiseptic lotions may be required for cleaning the areas.

CONSTITUTIONAL OR GENERAL

Rest in bed, with periods of getting up to go to bathroom and toilet.

Personal hygiene. Special attention to skin and mouth is essential to prevent complications developing.

Diet. Light and nourishing, high protein, with special vitamin-rich foods and additional roughage to prevent constipation.

Copious fluids, fruit juices — cold, if temperature is high.

Medicines

To relieve pain

To combat infection

To induce sleep if necessary

To introduce additional vitamins, if required.

Special record. Observations regarding temperature, pain or discomfort, bowel actions, and the passing of urine should be noted.

TREATMENT USING HEAT OR COLD

HEAT

Applications of heat have brought relief to patients over the years for many reasons—

It has a soothing effect

It relaxes muscles

Eases tension

Relieves pain

Promotes healing

Provides warmth

Heat treatments are either **dry or moist**.

Moist heat is usually more penetrating than dry heat as a wet substance conducts heat faster than a dry substance.

DRY HEAT TREATMENTS

ELECTRIC PADS OR BLANKETS

These provide warmth without weight. They should be used according to the maker's directions.

Care should be exercised to see that they do not become moist. (Blankets not attached to a transformer should not be used for an incontinent patient.)

The **pad** is convenient for applying heat to **one part** of the body only. It should not come in contact with the skin, but have a washable cover, which can be removed and washed as required. The cover should also be removed to check the pad is not defective.

The **blanket** spreads warmth to all parts of the body. It should be set to required heat by its regulator switch.

Both these articles should be carefully switched off and removed from wall plug by gripping the plug at the end of cord attachment. The hands must be dry.

HOT WATER BAGS

Another means of applying local heat.

Requirements

A water bag in good condition and a suitable thick cover large enough to completely cover the bag.

A kettle or jug for pouring water.

A cloth to wipe any moisture from outside of bag.



Figure 76 Correct method of pouring hot water into a water bag to avoid scalding.

Method of filling the bag

Lay bag on a flat surface and expel any air. Pour hot water into bag until it is about **half full** and allow water to show in the neck. This expels any remaining air.

The stopper is then screwed into the bottle.

Dry outside of bag. Check to see that the bag is not leaking and place it in the cover. **Apply bag to part.** One or two blanket thicknesses should be placed between bag and the patient. Refill as necessary to maintain the right degree of warmth.

Care of the bag when not in use

It is emptied and hung up to drain.

Allow it to become filled with air and then add stopper. (This keeps the inside surfaces from sticking together.)

Note

Heat should not be applied to the abdomen for pain unless ordered by the doctor.

Precaution must be taken to prevent burns from water bags.

INFRA RED LAMPS — USED ONLY UNDER MEDICAL ORDERS

More commonly used today as they can be purchased much more reasonably or hired for a minimal cost from most chemist shops.

They are of value for use in treatment of deep-seated muscular and joint pain, and the person with the frequent backache obtains much relief by its careful use.

They can also be used to assist in healing of wounds. The doctor is consulted before its use and his directions must be carried out with care as this type of heat can be dangerous if not carefully handled.



Figure 77 Positioning infra-red lamp on to the affected part and exposing only the area to be treated.

How to give treatment with the lamp

Turn the lamp on to heat it.

Place patient in a suitable and comfortable position, with inflamed area exposed and the surrounding area covered.

The skin must be dry.

The lamp is focused with the element parallel

to the part to be treated. It should feel comfortably warm on the patient's skin: 50 to 80 centimetres (20 to 30 inches) is a safe distance for most makes of lamps.

The treatment should be no longer than five minutes for the healing of wounds, or twenty to thirty minutes for muscular and joint pains. Check with the patient at least twice during these periods to ensure the warmth is not causing any distress. On the completion of the procedure the area is covered and the patient made comfortable.

The area should not be exposed to draughts for at least one hour.

This treatment is usually carried out two or three times daily.

MOIST HEAT TREATMENTS

STEAM INHALATION

A medicated steam inhalation has a local effect on the tissues of the respiratory tract. It is prescribed for hoarseness, a sore throat, coughing, or difficulty in breathing. The warm, moist and medicated air and steam tend to soften and make less sticky the secretions and they are therefore easier to cough up or blow from the nose. In chest conditions, coughing should be encouraged after the inhalation in an attempt to clear the lungs.

Requirements and preparation

A jug of approximately half a litre (or one pint) capacity or preserved fruit tin (or similar) washed thoroughly and its edges turned in smoothly.

A round bowl or tray on which to stand the jug or tin.

A small hand towel to be wrapped around the inhaler tin to prevent the risk of burning or scalding. (This towel can be brought up a little higher than the edge of the tin so that it can be held over the bridge of the nose to prevent scalding the eyelids.) Alternatives are a thick paper bag placed over the tin with the corner cut off obliquely, or a heavy sheet of newspaper to make a funnel.

Paper tissues and a paper bag to dispose of them.

A protector for the hair of women (a shower cap will do). A wrap for the shoulders, if necessary.

Hot water

The drug to be inhaled (friars balsam, menthol crystals or any special prescription.)

How to give an inhalation by steam

Explain the procedure to the patient if there has not been any previous experience with inhalations, emphasising the need to be as still and careful as possible.



Figure 78 Patient managing her own medicated steam inhalation. Note the position of the towel over the nose to protect the eyes from steam.

Prepare and protect the patient and the table top when used.

Extra pillows may be needed to support the back and head if the person is confined to bed — otherwise they sit at a table.

Boil the water. **Allow the steam to escape for a few minutes.**

Stand jug or tin in a bowl and pour in water. Add the drug in ordered quantity.

Cover and carry to the bedside.

Place the bowl containing the jug at a comfortable height. Ask the patient to place his **nose and mouth** over the opening in the towel and inhale the steam. A little lanolin smeared on the lips is soothing. The eyelids should be closed to prevent any escaping steam from smarting the eyes.

It is usually necessary for the patient to raise the head from time to time.

After approximately 6 to 10 minutes, remove the equipment.

Do what is necessary to leave the patient comfortable.

The container can be washed and dried and any stain removed with a little methylated spirit on a piece of cotton wool.

Note: If the patient is very sick, elderly, or is a child, the inhalation should be strictly supervised. The container is supported by the person giving care thus preventing accidental scalding.

SPECIAL STEAM INHALATIONS FOR CHILDREN

This is often used in the home if the child is suffering from bronchitis, laryngitis, a cold, or other respiratory ailments, but always under the direction of the doctor.

A kettle of boiling water may be placed in the sick room and kept simmering on a portable heater (an electric frypan is an excellent substitute). In any case great care must be taken to keep these away from the bed and clothing. The steam can be allowed to fill the room to produce humidity, or if a **special medication** is ordered, it will be necessary to make an improvised tent by draping the bed with a blanket or a sheet **covered by plastic**. Allow sufficient area open for viewing. Direct the steam through a newspaper funnel, **away from the child's face or other exposed parts** to avoid scalds. Saturate a large egg-sized piece of cotton wool with the amounts of the prescribed drug and pin it in the inside of the paper funnel and the steam will pass through it on its way into the cot tent.

Remember: The child may be afraid, the presence of its mother is essential for reassurance and to provide adequate protection and supervision.

HOT, MOIST COMPRESSES OR FOMENTS

The length of time that hot compresses are to be used and the extent of body surface to be treated will determine the choice of equipment. Soft woollen fabrics, heavy flannel or pieces of blanket are the best items and most homes will have some of these. This material holds the heat better than cotton, which absorbs more water, and there is a greater danger of being burned.

Requirements

A saline solution is most commonly ordered for hot compresses. To make this solution, add one teaspoon salt to half a litre (one pint) of water, bring to boil and simmer in a covered container for thirty minutes.

Clean compress material folded to required size (make two). They must be large enough to completely cover the area to be treated. Each piece should be made three or four layers thick to be more effective.

A foment wringer, made out of strong, old linen, double thickness, 50 cm (20") long.

A bandage, made out of a strip of old sheeting, or a towel, to hold the foment in position. Safety pins to secure.

A piece of waxed paper, plastic or aluminium foil to fit inside bandage. It **must** be **wider** than the foment or compress and helps to retain the warmth **and** protects the area beneath.

Medication, if ordered.

A paper bag in which to place the foment to be removed.

An improvised bed cradle may be necessary if the patient is confined to bed to protect the limb from the weight of the bed clothes.

How to apply the compress (if the skin is unbroken)

Fold the material into three or four thicknesses. Wrap it in the wringing cloth.

Place in a small bowl, and pour boiling water over it and cover it entirely.

Place on a tray, with safety pins and other requirements, and carry to the bedside.

Wring out very tightly, making sure that no water remains to burn the patient. Undo the wrapper and lift out the compress.

Shake quickly three or four times to remove the steam.

Apply it to the area to be treated.

Quickly cover with plastic or substitute, and cover both with the bandage or outer wrap. In order to keep up a sustained period of heat, the compress is changed in five minutes and then again in ten minutes. Thereafter, it is changed every 10 to 15 minutes for the length of time ordered.

Note

If the skin is sensitive, the area can have a thin layer of oil or petroleum jelly (vaseline) smeared over it.

Sometimes inflamed or infected parts can be treated satisfactorily with hot saline baths instead of the use of fomentations.

SPOON FOMENTS

May be ordered for relief of inflammation of the eyelid.

Requirements

A jug

A wooden spoon

Thick material to pad the bowl of spoon and cover it. The cover is tied securely to the spoon handle.

Towel to protect the patient's clothing.

Boiling water.

To prepare and administer the foment

Place the padded spoon in jug and cover with boiling water.

Sit person in a comfortable position, whether in or out of bed.

Protect the clothes with a towel.

Press the spoon against side of jug to remove excess moisture.

Hold the spoon as close as possible to the eye without touching it. The lids should be closed. As the spoon cools, repeat the heating process and continue for 5 or 10 minutes.

This is repeated three or four times daily.

The padding should be replaced daily.



Figure 79 Spoon foment to the eye showing the pad of the spoon held close to the eye without touching the lid.

COLD TREATMENTS

Cold is used to lower body temperature, to reduce inflammation and swelling, to control haemorrhage, and to relieve pain. The effect it has on the area is to constrict the blood vessels and to reduce the flow of blood to the skin and nearby areas of tissue.

ICE COMPRESSES

Requirements

Small piece of towel to be used for compress (e.g. hand towel or a man's handkerchief as a substitute).

A bowl with ice chips.

Methylated spirits but **not** if the area to be treated is **near the eyes**.

Waterproof protector (plastic piece) for bed. A towel.

Small tray to hold articles and a cover if the patient is confined to bed.

How to apply the cold compress

Position patient comfortably

Protect clothing or bed linen

Moisten hand towel in cold water to which one



Figure 80 Patient managing own cold compress to the ankle. Shown on table is the flexible and reusable ice pack.

part methylated spirits is added to each three parts of water. Methylated spirits is an evaporative fluid and speeds up the cooling process. Place ice chips in centre of moistened towel and fold over.

Change the compress when it feels warm to the patient, or every three minutes.

Continue in this way for about fifteen minutes, then wait.

After one hour, if no skin reaction has occurred, the application of the cold compresses can start again.

Continue changing the compress as required for approximately twenty minutes in each hour. Discard any soiled compress

Note

This treatment may be needed for 24 to 48 hours in certain conditions, but **not** during the night, **unless** condition for which it is used occurs at night, e.g. bleeding — see special points to remember.

The patient may be able to change the compresses if requirements are at hand.

ICE COLLAR OR PACK

Suitable for treating a nose-bleed, or bleeding from the tonsil bed after removal of tonsils.

Requirements and preparation. The same as for ice compresses.

Towelling should be of sufficient length to wrap around neck.

Note

New flexible ice packs which contain a gel can now be purchased in sets of two. They can be kept in a freezer without losing their flexibility and are able to conform readily to the part applied.

It is wrapped in a cloth or a towel and placed on or around the part to be treated.

In this way a cold compress is prepared ready for immediate use when required.

These packs are durable and can be used many times. The pack can be cleaned with soap and water and stored in the refrigerator.

REMEMBER

Special points to remember about the use of heat and cold treatments

They should be used only if ordered by a doctor, **unless** in the case of cold treatments for any **emergency bleeding**.

In patients who have poor circulation, are diabetic, or are paralysed, those who are very young and aged persons need special observation and care to prevent any complication occurring, e.g. reaction of skin to heat or cold, such as:

Sensation of numbness in part

Blanching of skin

Reddening or blistering due to sensitivity to heat from any cause.

Those who have frequent treatments may develop a degree of tolerance which could be harmful to their tissues.

Every precaution should be taken to ensure that the area is not burnt or suffers a frost-bite.

Any sign of damage to the tissues must be reported to the doctor immediately.

Infection and How it is Spread

INFECTION

The entry of disease-producing micro-organisms or bacteria (germs) into the body, causes them to develop and multiply, and give off poisons known as toxins, which cause many of the symptoms of disease.

The word infection is taken from the Latin 'Inficio' meaning 'I taint'.

CROSS INFECTION

Means the spread of micro-organisms from one individual to another. Some infect wounds, producing pus — this is known as **sepsis**. Others affect the whole of the body, as in measles, mumps, and many others.

CONDITIONS NECESSARY TO SPREAD AND ACQUIRE INFECTION

In order to thrive and multiply organisms need warmth, moisture, nourishment, and some require oxygen.

Certain organisms die if exposed to air for even a short time, others (e.g. tetanus) can survive in a dormant state for months or years, awaiting suitable conditions for multiplication. The human body can provide a suitable place for these organisms to produce harmful effects. In order for this to occur **three conditions** must be present.

1 They must enter the body of a **susceptible host**, i.e. a person whose body is in a state of health in which the organism can do harm.

2 They must enter into the body through the **proper channels** (route) by either:

INHALATION (breathed in with the air). This is a common means of entry, resulting in respiratory infections and subsequent spread.

INGESTION (swallowed in contaminated food or water) giving rise to bowel infections.

INOCULATION (through a break in the skin). A cut, a prick from a rose thorn, a pin or other sharp pointed objects, or from an insect or animal bite — all of these may cause a skin infection to develop.

Note

While the skin remains unbroken it is a perfect barrier against the entrance of bacteria.

3. The organism must be present in **sufficient numbers** and be **virulent enough** to cause harm.

THE METHOD OF SPREAD

Personal contact

Direct physical contact — hands, kissing, intercourse.

The **hands** may contaminate bedclothes, clothing, toilet articles, reading and writing materials, toys, light switches, door knobs, toilet fittings, bell and food.

Polluted air

Droplet infection. Organisms from the nose and mouth may be expelled during talking, coughing, sneezing, and expectorating.

Dust particles. This includes any dust in the surroundings, particularly fluff from bedding materials, clothing, wound dressings, bandages, and the floor.

Carriers

These are living things which harbour virulent organisms in their bodies unknowingly, and spread them everywhere.

Human carriers. People who are immune to a particular infection, but carry the bacteria in their bodies and transmit them to others who are not immune, for example—

Diphtheria carriers harbour bacteria in their throats.

Typhoid carriers carry the infecting organism in the urine and faeces. Careless or faulty sewage disposal could contaminate water supplies and so infect a whole area.

Insect carriers

The house and blowflies are particularly dangerous because of their filthy habits if they are not controlled. Fine **wire screens** at windows and doors are necessary to stop their entry into the home.

Parasites. The female Anopheles mosquito, prevalent in tropical areas, spreads malaria.

PREVENTION OF INFECTION

This is achieved by **avoiding** or **removing** any conditions which will encourage growth of bacteria such as—

Physical removal of the organisms
Their destruction

PHYSICAL REMOVAL OF BACTERIA

By thorough and efficient cleanliness.

THE HOME

Bathrooms and toilets can be cleaned, using a household disinfectant with a hypochlorite base (as in bleach).

Avoid raising dust, by using a vacuum cleaner or carpet sweeper, if available. Dust furniture with a **lightly dampened** chamois, wettext or soft cloth.

Garbage bins must be cleaned and kept covered with a firmly fitting lid. Wastes should be wrapped in newspaper before being placed in bin.

Garden should be free of rubbish to prevent flies and mosquitoes breeding.

THE PERSON

Scrupulous hand care is essential

The hands are the most likely part of the person to become contaminated. They must be washed often (see notes on hand washing).

Good health

Because of the comparatively high standard of living in Australia, every citizen should be able to maintain a reasonably high standard of health, if the following health 'rules' are maintained:

Regular meals based on a balanced diet

Do not over eat nor over drink

Regular exercise

Sufficient rest and sleep

Mental activities suitable for adequate relaxation

DESTRUCTION OF BACTERIA

Bacteria are destroyed by the process of **sterilization** which simply means the removal of harmful bacteria from various objects. It is difficult to sterilize satisfactorily in the home. The following means, however, will make articles safe and free from harmful bacteria.

Heat Moist and dry (boiling water, domestic pressure cooker, oven)

Chemicals As recommended by pharmacist

PREPARATION OF ARTICLES PRIOR TO DISINFECTION

All articles must be thoroughly cleaned prior to disinfection — dried blood and pus must be washed off, and any grease carefully removed.

METHODS OF DISINFECTION

HEAT

Moist — boiling water, steam

Dry — oven

Boiling water

Place articles into a clean saucepan so that they are **completely covered** with water. Small items such as forceps (or substitute), syringes and injection needles are best put into a sieve with a handle. This is then placed into the saucepan, which is covered as completely as possible with its lid.

Bring to the boil and **boil gently** for thirty minutes. This is the ideal time in which most types of organisms are killed. During the boiling time **do not add** any additional articles to the saucepan as it will interfere with the sterilization procedure. Lift the sieve from the saucepan, empty the water carefully and replace sieve temporarily back on to the saucepan.

Assemble the syringe, handling the plunger by the handle only and the needle by its butt end.

Larger items used for **dressing wounds** can be lifted from the saucepan with a pair of household tongs which have been boiled in the saucepan, with only their handles above the water level. It is imperative that the handles of the tongs are allowed to cool or that a cloth is used before using them for lifting.

Steam

Place articles into pressure cooker and when pressure is established leave for fifteen minutes. Prepare and handle articles with the same care as mentioned previously.

Oven

Articles such as small packets of cotton wool swabs, lint or dressings, are placed in a metal container with the lid off. This is then placed in the oven for one hour at 160°C (430°F).

Note

An article is either **sterile or unsterile**, never partly sterile. It becomes unsterile **immediately** it is **contaminated** (touched or comes in contact with unsterile parts).

When using **chemicals**, ensure each item is **covered completely** for thirty minutes with a reliable disinfectant, e.g. those with a chlorhexidine base.

SIMPLE DRESSING TECHNIQUE

Purpose of dressing

Protect **the wound** from further injury

Prevent contamination

Hasten healing by—

Keeping edges of the wound close together

Local application of drugs

Absorb any discharge or bleeding

Apply pressure to the area

Prepare the patient

Have the patient sitting or lying in a comfortable position with the area exposed and part supported.

Adequate light on the part of the body to be attended.



Figure 81 Adhesive conforming dressings suitable for small injuries.

DRESSING A WOUND, SMALL CUT, OR LACERATION

Requirements

Small bowl containing salt and water

Cotton wool balls (swabs)

Small, plain, gauze-covered dressings

(The latter two articles are obtainable in prepared packs from a chemist shop or general store.)

Or

A small adhesive dressing of suitable size and shape.

The small 'butterfly' types can act as a temporary stitch to small wounds to hold skin edges together. Safety pins or adhesive tape if a bandage is needed to hold dressing in place. Paper bag for soiled swabs

Method

Wash hands thoroughly and scrub under nails, preferably under running water.

Dry on a clean towel.

If forceps are available, use to hold swabs. Eyebrow tweezers or a spring peg (boiled), can be used as a substitute.

Do not touch the wound with the fingers.

Moisten the swab in saline, squeeze against edge of bowl to rid excess moisture.

Wipe the swab from top to bottom of the wound, then discard.

Take a clean, moistened swab, wipe slightly to the left of the centre line, from top to bottom — discard swab.

Repeat this process on both sides of wound, wiping from the wound site outwards so as not to contaminate the wound from dirt on the area around it.

Use each swab for one wipe only.

Apply dry dressings and bandage or adhesive strip dressings.

REMEMBER

Bacteria needs moisture for growth.

Cotton wool is not to be placed directly over a wound as its fluff adheres to its raw surface.

In some cases soaking the wound in a bowl of saline may be necessary because of the dirt. The friction of the flowing water will remove grit. One teaspoon of salt to half a litre (one pint) of water makes a normal salt solution.

Dry with swabs as described above and apply a dry dressing and secure it in place.

IF A WOUND OBVIOUSLY NEEDS MEDICAL ATTENTION

Cover with a piece of clean linen or combine dressing. (A combine dressing is one which is made of a pad of wool surrounded by gauze, and can be cut to required size. A clean sanitary pad is useful.)

Bandage firmly to control bleeding. (Small wounds are better stitched — sutured — as this hastens healing.)

The edges can be pulled together temporarily with strapping, and a dry dressing applied and kept in place with a bandage.

Note

The area must be completely dry or the strapping will not stick.

The doctor will decide if the wound requires a small area left open to drain any fluid which may accumulate in the area.

All homes should keep a small first aid kit ready for emergency.

For reference

New individual prepared packs of steri-wipes are available for cleaning wound areas.

There are two distinctive types available at present. One wipe is impregnated with an aqueous chlorhexidine and cetrimide solution for cleaning wounds. The other is impregnated with chlorhexidine and alcohol for drying the wound after the cleansing.

Both of these would be useful in busy casualty rooms as time would be saved as each pack simply requires tearing off at its end and is ready to be lifted out and used.

Infectious Diseases

Infectious disease — communicable disease — are terms used in relation to disease caused by minute organisms harmful to human beings, and which show their own peculiarities in specific signs and symptoms, such as rashes, flushed complexion and in many other ways, and can be passed from one person to another.

In the past, this type of disease has caused many deaths, e.g. **influenza** killed millions of people in a world-wide epidemic in 1918 - 19. Influenza is prevalent in Australia in autumn and winter months, and the so-called **Asian type of influenza** in 1957 and 1970 killed many.

The knowledge is available to prevent many infections, with the exception of most of those caused by viruses.

A health-conscious community will use this knowledge fully. To know of the methods of prevention is one of the duties of everyone.

MEANS AVAILABLE TO PREVENT INFECTION AND ITS SPREAD

Immunization, e.g. diphtheria, whooping cough, poliomyelitis, tetanus, influenza (some strains), measles, typhoid and allied fevers, and small pox.

Control of disease-carrying insects.

Food — pure and carefully preserved and stored (see section on food).

Care in contact with people carrying infectious disease.

Control of entry of disease into a country by regulations called quarantine.

Other measures of a more general nature depend upon all members of a community developing a 'hygiene conscience'. This means thorough cleanliness with hands and the rest of the body, with clothes and with substances expelled from the body such as sputum and droplets from the nose and mouth, urine and faeces.

REMEMBER

The prime step in controlling any infections is **cleanliness**.

As it is the hands which come in contact with contaminants, it is obvious that scrupulous

hand care becomes a prime necessity. Soap and water still remains the most valuable means of preventing spread of infection.

IMMUNISATION

Is readily available and should be used after consultation with a **doctor or health authority** for the following conditions:

Babies Whooping cough, diphtheria, poliomyelitis, tetanus, measles, smallpox.

School children Poliomyelitis, diphtheria, influenza, tetanus, rubella (German measles) for girls.

Adults Should maintain immunization after their primary course of injections, by booster injections against tetanus, influenza, diphtheria, poliomyelitis. Immunization for poliomyelitis is by three doses of Sabin vaccine, which gives a lifetime protection.

If the primary course has never been given, arrangements should be made for the person to be immunized without delay.

People at risk (doctors, nurses, airport staff, and their families and others who are in contact with the following diseases) should be immunized against smallpox, tuberculosis, and typhoid.

Other protection may be called for if a person is travelling outside Australia. Advice about this can be obtained from doctors, health authorities, shipping and air travel agencies.

FEVER

A symptom characterised by an increase in temperature — the patient becomes flushed and hot. It is associated with many infections and has a similar pattern irrespective of the cause.

In some of the more common infections, the fever will be detected by touch and confirmed by using a thermometer. Other symptoms are: General aches of muscles and joints, headaches, poor appetite, thirst, disturbed sleep.

In the more severe conditions, shivering and sweating occur. Then the symptoms of the specific disease will be added to these features. The cause needs to be identified and often medical aid is necessary to find or confirm this.

GENERAL TREATMENT OF FEVER

Rest and reduced physical activity. (It does harm to try and 'work' a fever out.)
 Clothing for comfort
 Avoid chills
 Give plenty of simple varied fluids
 Food in liquid or semi-liquid form

Frequent face and hand washing to promote comfort and, if necessary, assistance with body washing.
 Mouth care as previously described
 Special treatment for special conditions will be called for

REFERENCE AREA**WHEN THE FEVER IS ASSOCIATED WITH AN INFECTIOUS DISEASE AND THE PERSON IS NURSED AT HOME**

The aim is to prevent the spread of infection to other persons by:

Excluding as many persons as possible from visiting, especially those who have not suffered from the same infection.

Avoid any unnecessary close contact with the sick person, e.g. do not sit on the sick patient's bed.

The hands **must** be washed thoroughly before entering and after visits to the sick room.

Note

A bowl of disinfectant for the person giving care is required in the bedroom. The hands are washed in this and dried on a small hand towel, which is changed frequently. (It is preferable to use disposable towels, if available. These can be discarded into a large paper bag in the sick room and disposed of at intervals by burning.) It is recommended that advice of a qualified pharmacist be sought regarding choice of a disinfectant.

Use disposable handkerchiefs (tissues) which can be safely destroyed after use. A paper bag can be attached with adhesive materials to the side of the bed frame and changed as required.

Persons suffering from infections themselves **must avoid** attending the patient, especially if they have such complaints as a cold, influenza, sore throat or diarrhoea, as sick persons are susceptible to these infections because of their lowered resistance. When they are infected the results are severe and in some instances serious complications have been known to occur.

Wear a 'coverall' apron when attending the patient. It must be removed before leaving the room and hung up, with the clean side inwards.

The dishes are washed thoroughly and separately in hot water, rinsed and dried to avoid transmitting infection. (They must be washed after the dishes of the other members of the family have been washed.)

Linen should be boiled if possible (for example in gastro enteritis, soaked overnight in a disinfectant solution) and then laundered in the normal way. A qualified pharmacist's advice should be sought about the choice of disinfectant used.

SOME SELECTED COMMUNICABLE DISEASES

Acute respiratory infections. There are two broad types of these conditions: The common cold, influenza.

COMMON COLD

There are a very large number of viruses which cause the common cold. In fact, each succeeding epidemic is often due to a different virus from its predecessor. This makes protection difficult at the present time.

The condition is readily spread by any effort which forcibly expels air from the nose or mouth such as loud speaking, laughing, coughing or sneezing. For this reason a person with a cold should keep his distance from all non-infected persons. The use of disposable tissues instead of handkerchiefs is helpful in preventing the spread of infection.

The symptoms of a cold vary, but usually include sneezing, nasal discharge, sore throat, and a cough.

The duration varies but averages about two weeks. The discomfort is quite marked, and the efficiency of the victim is impaired, so that everything that can be done to stop the spread should be carried out, e.g. avoid crowded areas and take care with handling and disposal of secretions.

The treatment

Reduced activity is necessary — bed rest if possible

Plenty of fluids are required

Small amounts of food should be given frequently

INFLUENZA

An infection which attacks the upper and lower parts of the respiratory tract. It is due to a variety of influenza virus strains and these change with epidemics. It is possible for influenza virus vaccines to be prepared when a particular virus has been identified.

Influenza may be very serious because it can prepare the way for many other bacterial infections and may lead to pneumonia.

The symptoms of influenza are of a fever, with a sore throat, dry cough, husky voice, and general loss of interest and drive.

The duration varies with the severity of the epidemic at the time.

The treatment Rest in bed — fluids in a very good supply — light diet.

Avoidance of violent coughing efforts, if possible.

Limit talking, no smoking, attention to medical advice, which is usually needed in severe conditions.

Care to prevent spread, as with the common cold.

WHOOPIING COUGH

Is an infectious disease due to bacteria, and is spread easily by the cough (droplet infection). Although it may attack at any age, most cases occur in children under five years.

It can be prevented to a large extent by vaccination in the early months of infancy.

Medical aid is needed to supply treatment for the condition and to help cough. Like some other infectious diseases it starts as an infection in the upper breathing passages and has the appearance of a severe cold.

After this stage has lasted about one week, then the **spasmodic cough** which is the essential feature of whooping cough develops. The cough occurs in bursts of rapid barks and no breaths are taken in until the end of a spasm and then there is a long intake of air which often produces the 'whoop'. As this spasm ceases, there is often vomiting. (The effort of coughing and the shortage of air causes a bluish tinge to the skin.)

In the spasm, the child usually has to sit up to help breathing. The coughing spasms increase in frequency from day to day for some two weeks. It takes four to six weeks for the **untreated condition** to clear up.

The treatment

If fever is not present, then the child can be dressed and allowed out of bed — if feverish, keep in bed. Cough provoking factors such as dust, smoke, and excitement should be avoided. If vomiting occurs then **small amounts of bland food** must be given frequently.

DIPHTHERIA

Is a disease due to the diphtheria organism. Spread is by direct contact, or by objects in contact with the patient. This organism produces a localised infection usually on the throat. From this area a very potent and damaging toxin (poison) is absorbed into the blood stream. This toxin will cause severe damage to the nerve supply of the heart and muscles.

The disease causes a rapid development of a white patch on one or both sides of the throat. It usually has a shiny surface, and may go on extending quickly over one or two days. The glands (special nodes of tissue) in the upper neck may be enlarged.

If this condition is suspected, then medical treatment is essential.

Early treatment with an anti-toxin is necessary.

It is a disease which can be prevented by immunizations which should be started in infancy and renewed by booster doses during school life. It is because of intensive immunization campaigns against diphtheria which have been carried out in most civilised communities that diphtheria is a rarity today.

MEASLES (1)

Is a virus caused disease. One attack usually prevents more attacks.

It is spread by direct contact with the sick — by coughing secretions from the nose and throat.

Fever occurs approximately ten days after an unprotected person has been in close association with another who is developing measles, and lasts for about four days.

At the start the appearance suggests a severe cold with a harsh cough and sore eyes, which 'water' for several days and are uncomfortable in bright light.

The rash shows in the mouth and on the face and quickly spreads to the rest of the body. It consists of isolated pink to red spots which enlarge and run into each other. Later it goes brown and slowly fades and there is a fine shedding of the surface layer of the skin.

The treatment

Patients are usually cared for at home, staying in bed for as long as they are feverish.

Whilst the fever persists and a cough is present, varied liquids should be frequently and freely offered to prevent dehydration.

The eyes need bathing each four hours, and light in the room should be shaded. Medical supervision will be needed in the treatment of measles. This is especially so if the attack is severe and/or complications arise.

Possible complications of measles

Bronchitis, pneumonia, sinus infection, otitis media (ear infection), enteritis (small bowel infection), encephalitis (inflamed brain tissue), conjunctivitis.

Measles is a disease which it is hoped will be prevented, or the severity of the symptoms reduced, because of recent advances in producing a suitable vaccine which gives protection to those who are immunized. The body's reaction to this new strain of vaccine is mild and the results good.

MEASLES (2)

Rubella (German measles) — a virus caused disease contracted by direct contact. It has an incubation period (time of contact until symptoms occur) of fourteen to eighteen days. One attack usually prevents further attacks.

Because of the danger to the unborn child should the mother contract Rubella early in pregnancy, school girls are now immunized against this condition, to eliminate the possibility of its development later in life. (The chief dangers are to the infant's eyes and ears.)

The common feature of the condition is the presence of a small-sized (pinhead) rash over the body and the enlargement of the glands at the back of the head and neck. These are usually tender.

The rash lasts about three days and the patient may feel vaguely unwell.

CHICKEN POX

Virus caused disease and very easily spread by means of nasal secretions, clothes, and direct contact, and has an incubation period of two weeks. Further attacks are very rare.

A rash appears early in the condition, usually more abundantly on the trunk, or covered parts of the body. It consists of small red spots which change into small blisters in a few hours, and then they form small areas of pus and this is soon followed by a scale. Fresh crops of rash develop for several days. The rash is likely to be very itchy and if scratched leaves a scar.

A soothing lotion or cream may be put on the spots themselves and this helps relieve the itch (e.g. calomine base agents).

It ceases to be infectious once the rash has dried and formed scales.

It does not call for further treatment, other than moderate rest.

MUMPS

Virus caused disease and contracted by direct contact. The incubation period is about eighteen days. It causes swelling of the glands, which produce saliva.

The glands **in the front of the ears (parotid) and behind the jaw** are the ones affected. The condition may also affect the testicles in the male or the ovaries in the female, and pancreas in either sex. The affected glands are swollen and tender. The person infected may have headaches and is liable to vomit. Fever is present.

The treatment

The patient can usually be cared for at home with rest and a soft diet. Warmth (a hot water bag, adequately covered) to the involved glands makes the person more comfortable. If concern is felt, then medical advice should be obtained.

POLIOMYELITIS (Infantile Paralysis)

Due to a series of polio viruses and it is spread by people suffering from a very mild poliomyelitis infection, who are not ill, and therefore unknowingly spread the infection. It is a disease for which immunization has had excellent results in Australia since 1956 — as the condition is now rare. A vaccine, given by mouth, is the current practice to produce an immunity to this condition. If people are prepared to keep the level of immunization in the community high, then it can be expected that the present state of affairs will continue.

The patient complains of headache, general tiredness and stiffness of the neck and back. Poliomyelitis is a disease which shows **a few days of fever before muscular paralysis starts** in various muscles of the body. The symptoms vary from person to person.

If the swallowing or breathing muscles are affected, then the condition demands extreme care. It is a condition which calls for **medical care from the start**.

INFECTIOUS DIARRHOEA

This may be due to large range of organisms which in most instances are spread by infected food material.

The food in turn may have been affected by **careless handling** by a person suffering from the condition themselves, or by **infection carried to the food by flies** which have had contact with excreta, or by **dust** which has blown from an area where excreta has been deposited. Thus food, fingers, flies, filth, and fomites (inanimate objects such as books and toys) are the media for spread.

The symptoms are those of abdominal pain and frequent loose bowel actions and sometimes vomiting.

The treatment in the **less severe instances** consists of boiled water to which salt (a quarter of a teaspoon to the pint) and a little strained lemon juice has been added—avoid hot drinks. Semi-solid foods, e.g. maizena, blancmange, strained or similar foods (exclude fruit and vegetables) may be given until the condition improves.

Note on fluids. Boiled water (prepared as previously stated) should be given in sips only. As the patient responds, larger drinks can be given, and the total volume increased as the patient shows that he can tolerate it. The addition of glucose to the fluids **in serious conditions**, and later the resumption of normal diet should be **as advised by the attending medical practitioner**. Usually no food is given for at least twenty-four hours.

Prevention lies in—

Strict care with food

Strict care in disposal of excreta in sewerage or septic tanks

Careful washing of hands after attending to the patient

Patient's own attention to personal hygiene

INFECTIOUS HEPATITIS

This is due to a virus type of organism for which **medical care is essential**.

It affects only a few people at a time, except in institutions, where a larger group of people may be affected.

To prevent the spread within institutions, patients and staff are given serum containing antibodies—gamma globulins—which are a help. The condition is associated with infection in the liver and produces jaundice (yellowness of the skin and whites of the eyes), dark, tea-coloured urine, and pale coloured faeces. The patient complains of feeling hot, has a lack of appetite, nausea, tiredness, and sometimes abdominal discomfort. The spread is by way of excreta and contaminated food and milk. Care with excreta is essential, and thorough hand washing must be carried out by the home nurse after she has attended to the patient, and by the patient after toilet visits.

The diet may contain a very small amount of fat until the faeces return to a normal colour. The patient rests until the colour of the skin and urine are normal. (Another type of hepatitis is now being seen in drug takers who share the same syringe, e.g. serum hepatitis.)

SKIN INFECTIONS

Boils are an example which are due to bacteria called staphylococci. They are spread from one part of the skin to adjacent areas or to other people. The chief agents responsible for spreading the infection are the patient's fingers or clothing of any type which can come in contact with the infected area.

The area involved is red, swollen and tender, usually in a circumscribed fashion. After a few days the centre forms pus which is usually discharged on the surface of the skin. Then fresh boils can develop around the original site.

Treatment lies mostly in prevention of spread

The boil should be protected from all forms of pressure and must never be squeezed because of the risk of spreading the infection more deeply. In fact, the less a boil is disturbed, the quicker it subsides.

Local application of a skin antiseptic, e.g. Gamophen Soap helps to keep the surrounding tissues clean.

Thorough washing of the hands with plenty of running water is necessary. Any dressings must be placed on paper or in a paper bag and burned immediately.

All clothing (day and night) in contact with boils must be sterilised by:

Boiling cottons, washing and ironing woollens, soaking synthetics in disinfectant. This should be done daily. Washing machines often do not heat water sufficiently to kill staphylococci.

Bathing must be by showers. Baths will spread infection from one part of the body to another. Bathroom cleaning is essential to prevent spread to others in the house.

Gonorrhoea and syphilis are common infections spread by sexual intercourse with an infected person.

Factors influencing the spread of the disease: Promiscuous behaviour, carelessness in the use of drugs and alcohol, leading to alteration in behavioural patterns. Abnormal community conditions such as prevail during war time. Lack of health education of members of the community.

GONORRHOEA

An infection where the symptoms are discomfort in passing urine and the presence of a white or yellow discharge. In the male the discharge is from the urethra, in the female it is from the urethra or vagina. Local spread through the internal genital passages will occur if the condition is not treated. **Prompt medical treatment** is needed. The eyes and the anus can also be infected.

SYPHILIS

An infection where the organisms multiply first at the site of transference, and an ulcer is produced. Then the spread is by way of lymph and blood vessels to all parts of the body so that multiple areas of infection occur, usually in two phases. The first is three to six months after the original infection, and the second is several years later. These effects can be serious if not treated. The infections, besides being generalised, can be passed on to a developing infant.

Treatment again needs to be prompt and must be expected to take some weeks. It is usually carried out in clinics specially set up for this purpose.

RINGWORM

A contagious infection of the skin caused by a fungus. It is spread by direct contact with infected persons or animals — especially cats, dogs or cattle. Any materials in contact with this condition can be a means of spread, e.g. the backs of theatre seats, barbers' clippers, hats or clothing, hair from infected persons or animals. There is no known immunization.

The condition commences with a small pimple, then spreads outwards leaving a scaly patch, and **if on the scalp**, baldness.

On the body infection shows a characteristic ring-shaped lesion.

On the feet — scaling and cracking of skin, and if between the toes (tinea) blisters are present.

Doctors order certain agents to be placed on lesions after cleaning. These usually depend upon the part of the body affected.

Included in this area for the sake of convenience, but **not** an infectious disease, is the condition of tetanus.

TETANUS

It is caused by the entry of tetanus organisms through a break in the skin, such as a puncture wound (e.g. a nail in the foot) when there is contamination with soil or dust, and is spread by animal and human faeces. It may also occur in others ways, e.g. criminal abortion.

It is prevented by immunization of everybody at risk, for example small children who play in the garden, soldiers, gardeners, and anyone at risk in street accidents, which, in effect, means everyone. Thorough washing of a wound at the time of injury will help prevent infection in the minor wounds, which are often neglected and are common causes of the condition.

The indications of the occurrence of tetanus are the development of severe spasms of muscles, which usually occur in one area at the start and become widespread as the disease develops. This happens about a week to ten days after the time of entrance of infection.

If suspected, the condition calls for medical observation and in severe cases **very intensive care**.

It is easier to prevent this disease than to treat it.

A RIGOR

A sudden chill accompanied by severe shivering, rigor sometimes occurs before feverish conditions develop. The body temperature rises and remains high until sweating commences and causes a gradual fall in temperature. A rigor usually lasts about twenty minutes and typically has three stages, cold, hot and sweating. In the **cold stage** the patient complains of feeling cold and begins to shiver, often so violently as to cause the bed to shake. The patient's colour is pale bluish in appearance.

The temperature may rise to about 40° to 40·4°C (104° to 105°F). This is difficult to record because of the vigorousness of the shivering, but if any attempt is made to use a thermometer it should be placed carefully under the armpit and held in position.

The **hot stage** The skin is flushed, hot and dry and the patient complains of thirst and headache. The temperature of the body continues to rise and the pulse becomes rapid.

The **sweating stage** The skin becomes wet because of the profuse sweating, the temperature falls, and the pulse becomes slower.

Treatment

Cold stage Place extra blankets on the patient and give a hot drink if the shivering is not so severe that spillage will occur and cause injury.

In the **hot stage**, remove the extra blankets, give cold drinks, apply cold compresses to the forehead. It may be necessary to give a cool sponge.

Watch for the **onset** of the sweating stage when all **cooling agents** must be **stopped** immediately.

The sweat can be wiped away with warm towels, the clothing and bedding changed and the patient left to rest. The temperature will, as a rule, fall gradually. Occasionally, however, the fall is sudden.

Care For Special Groups of People

REFERENCE AREA

EMERGENCY CHILDBIRTH AT HOME

The normal duration of pregnancy is forty weeks. However some mothers may commence labour earlier than is expected. If during her pregnancy she has visited her doctor and the ante-natal clinic (most commonly under the direction of the Maternal and Child Health Centres) she will be well prepared, both physically and mentally for her confinement.

During this time she learns to know and understand the changes she may expect and will be able to recognise when 'something different' occurs. **Her doctor should be notified** if any of the following conditions arise:

Persistent and severe headaches; blurred vision; puffiness of her face, hands, feet or legs; chills or fever; vaginal 'spotting' or bleeding, or a watery discharge before baby is due.

Fortunately most pregnancies progress without cause for alarm. If, however, an emergency birth appears imminent, the mother who has been well prepared, will be more confident and able to help the person assisting.

Labour Is the work the uterus (womb) does to allow the baby to be born and the placenta (after-birth) to be expelled now that it is no longer required to nourish the baby.

RECOGNITION OF THE ONSET OF LABOUR

The **symptoms** are caused by the **contractions of the uterus** and are usually—

Regular rhythmical pains

A low backache

Discomfort in the lower abdomen

A vaginal discharge of blood-stained mucous, called a 'show'

Sometimes a gush of water escapes because the membrane (bag) containing the baby breaks—this can occur either early or late in labour.

This is the commencement of—

STAGE ONE

May continue for several hours, especially in a woman's first pregnancy. This allows time for her to be transferred to hospital and her doctor or midwife's care.

During stage one the contractions of the uterus cause the birth canal to dilate.

The cramp-like pains increase in frequency and last for longer.

The show of blood-stained mucous increases.

If, however, contractions are very frequent, every one to three minutes, it is well to prepare for the delivery at home, particularly when the prospective mother has had more than one child.

Preparation

Notify the doctor The mother should be made as comfortable as possible in a suitable room.

The area beneath her body should be protected by a large plastic piece, or by newspaper. These should be covered completely by an old sheet or pieces of linen.

Boil three, nine inch strips of household tape or ribbon pieces for a minimum of ten minutes, longer if time allows. These will be needed to tie the cord.

If the event is taking place in an outback area where help will not be available for hours, soak a pair of scissors in medicinal alcohol or methylated spirits in readiness for cutting the cord.

Prepare a cot by covering the mattress with a napkin. (A pillow could be used as a substitute for the mattress.

If no cot is available, a laundry basket, a drawer (emptied), or a strong cardboard box, prepared in the same way, will do. Place it on the floor in an area protected from draughts.

Fold a blanket into three to cover the top half of the mother's body.

A napkin and a small, old, clean blanket or a shawl to wrap the baby in, should be prepared ready for use if time permits.

STAGE TWO

This is the time when the 'bearing down' period begins, and eventually the baby is born.

The cervix is fully dilated (opened) and with each contraction the mother's desire to 'push down' is very intense.

She must be encouraged to rest between each contraction.

If she is lying on her back, it is helpful for her to bend her knees, draw them upwards and grasp them firmly as she pushes.

She has a natural tendency at this time to lift her head from the pillow and lean forward, and hold her breath.

This bearing down process will continue until a **bulge appears** in the perineum. (The area between the front and back passages.)

HOW TO MANAGE FROM NOW

Leave the mother on her back, especially if no other assistance is available.

Check to see her head is comfortably supported on a pillow.

Keep her covered as much as possible to prevent undue exposure and chilling. If bowel movements occur during contractions, wipe the area gently with soft, old cotton material.

It is essential to wipe from **the front to the back** to prevent contamination of the birth canal.

DURING THE BIRTH

Ask the mother to 'stop pushing', keep her mouth open and pant, i.e. take short breaths, so that the baby may emerge **slowly**.

Most babies are born head first — the face looking backwards. However, sometimes parts of the body, such as the buttocks, foot or an arm, may appear first — in this case the doctor must be contacted again and informed of this condition.

Support the head as it appears by placing your hand against it **gently**, then after it is delivered, support it in your palms. The head may rotate whilst you are supporting it.

If there is a membrane over the baby's face, it must be torn.

If the cord is around the neck. This may become an **emergency**. Ease it up carefully and quickly over the baby's head or down over the shoulders. The cord may be **too tight** to move up or down, in which case there is a risk that **the baby's airway will be constricted**. Place two ties around the cord two inches apart and tie firmly, cut between the ties and free the cord — **Do not use force**.

Do not leave the mother to look for ties or scissors if not prepared as stated earlier, because the baby may be born very quickly at this stage. Obtain them as soon, as possible after the birth.

Under no other circumstances should the cord be cut as early as this. See later notes on blood volume.

Wait — after the head appears there is a slight pause, then the shoulders and the rest of the body pass to the outside.

Grasp the baby under the armpits gently, but firmly — it is very slippery — and lift it up towards the mother's abdomen. **Do not stretch the cord**.



Figure 83 Baby held securely whilst mother washes scalp carefully and firmly to prevent cradle cap.

WORMS

Threadworms may occur in the toddler and the older age groups.

Prevention is by teaching and supervision of personal cleanliness. The anal area is very irritated, scratching transfers the eggs of the worm to the finger nails, and if care is not taken, the eggs are passed into the mouth and swallowed with food. Special medicines are available and must be taken as directed by the doctor or the pharmacist. If the condition is allowed to persist, the child becomes thin and is easily irritated.

SUMMER HINTS

Babies feel the heat and should be protected from extreme heat. You can help your baby in hot weather by—

Giving extra fluid Plenty of fluid (boiled water, fruit juices, between ordinary foods).

Keeping baby cool Place cot in the coolest room in the house, in an airy position, not directly in front of a cooler or a fan. Light clothing, no more than a napkin and cotton singlet is all that is necessary.

Frequent cool bathing or sponging.

Watch out for a change in the weather and add extra clothes if cool change comes.

Protecting the skin Avoid hot sun and drying winds or else use a sunburn or zinc cream frequently when outside.

Do not let the napkin rub the skin. Change it when wet.

Let skin 'breathe'. Do not use plastic pants, see heat rash.

Shade eyes and head when out of doors; wear a bonnet or hat.

Call the doctor if the baby appear ill.

A high temperature of the body can be serious in a baby.

Toddlers are very active — arrange quiet occupations for them and encourage a rest period each day.

Travelling in the coolest part of the day Prepare well beforehand. Dress the child lightly. Carry a damp washer and plenty of napkins. Keep food cold, heat bottles **only** as needed.

If travelling by motor car, allow adequate time for rest periods.

CONVULSIONS

Spasms of the muscles which usually occur suddenly.

Children may have a generalised convulsion when the temperature is high.

At the onset of a cold or teething problems, a throat or ear infection, digestive upsets.

Certain immunizations can also cause some children to convulse.

Signs At the beginning of a convulsion, if the child is old enough to be standing and/or walking about, there is a loss of consciousness and a falling to the ground.

The **special signs** are then noticed. These are: Twitching or violent convulsive movements.

The eyes turn up, or to one side, or roll about.

As the convulsion continues, the skin may develop a dusky bluish tinge (cyanosis).

The treatment

Loosen the baby's clothing about the neck, the chest and waist.

Ensure the airway is clear so that normal breathing will continue — prevent inhalation of vomitus and mucous by tilting the child in a slightly head-down position.

Cool the baby Place a cold cloth on the forehead and put the trunk and limbs into a tepid bath.

An alternative is to wet a towel and cover the babe up to the shoulders and direct a fan on it.

Always seek medical advice.

BABY SITTING

Taking care of another person's child is a serious matter. Children are parents' precious possessions and the baby sitter is entrusted with them.

Things you must know—

Contact your employer personally, find out duties, hours of work, rate of pay, and if any extra work is to be done.

Age of child or children and their temperaments.

Where to find food, bottles, torch, change of clothes, extra rugs, and first aid supplies.

Telephone numbers of parents, doctor and neighbour; what to do about incoming calls.

What time the children should go to bed.

Always keep the outside doors locked.

Have television or radio volume down so that you will hear the faintest cry or call.

Guidelines for the baby sitter

I will

Take my job seriously and fulfil it to the best of my ability.

Respect the privacy of the home.

Be patient and kind with the children in my care, yet firm if necessary.

Carefully follow instructions left by the parents. Not ask friends in or make free use of the home. Check frequently on the children to see that all is well.

Not leave the house for a second.

Call the parents if an emergency arises and if I cannot contact them, I will call a neighbour or the doctor.

I will not look upon this task as a means to earn easy money — it is a position of trust.

INJURIES TO TODDLERS

These may be many and varied in nature. Toddlers frequently fall as they become more venturesome. Damage to the child's limbs may be apparent during bathing and dressing, as the child may show a reluctance to move a limb, cry or express pain in other ways on movement. If there is any reason to suspect any injury, the child should be taken to the doctor or to a hospital.

If the toddler's teeth are broken in a fall or knock, examination by a dentist is essential.

CONVALESCENCE FOLLOWING MAJOR SURGERY

The treatment at home is a continuance of that begun in hospital and the person responsible for the patient's care will do well to obtain sufficient knowledge of the patient's condition and any special treatment or care necessary after discharge from hospital.

The length of time the patient requires to stay in hospital varies according to the severity of the operation, healing power of tissues, and the person's general response to the operation.

Many patients are discharged with wounds which will require dressings and may need to return to the doctor's surgery for stitches to be removed.

The basic requirements for these patients are the same as for all patients.

Primarily the patient should be dealt with in terms of how he sees his own situation, but he must be **encouraged to do most things for himself and not play the role of an invalid** — spending the greater part of twenty-four hours in bed.

For suggested daily routine, refer to previous sections on this, and also on bathing, nutrition, medicines, and general observations of urine and faeces.

SPECIAL ADDITIONS to these sections are suggested below:

BATHING

The wound may be sealed with a spray or waterproof strapping to enable the patient to shower, or, if necessary, to be washed in bed.

DRESS

It is much better for the person's morale to dress fully in comfortable clothes and shoes than to stay in night attire. Dressing fully may be reached in stages over a day or two so that fatigue will not occur.

NUTRITION

It suits most households for the convalescent to remain in bed until the family is off to school and work, so that breakfast is often served in bed on a tray. It could be carried in by one of the younger members of the household. Special foods and fluids may be required to assist in the regaining of strength and to encourage normal kidney and bowel functions.

REST

Short rest periods during the day and adequate sleep at night are necessary to restore well-being. If unable to sleep or if the patient complains of pain or discomfort, doctor should be notified.

WOUND CARE

This must be attended to as directed on discharge from hospital. If sealed with a spray, this may need reinforcement if it happens to crack or lift.

The spray dressing is applied from the pressure can, holding it about 8 inches from the wound. The patient should be encouraged to look at the wound and grow familiar with the technique of dressing, particularly if dressing is to be continued for a prolonged period: maybe a lifetime as with a permanent colostomy (a condition where the bowel contents are discharged on to abdominal wall).

Disposable sterilized packs of wound dressings can be purchased from any chemist.

Dressings are done in manner described in Area Eight, page 84. The doctor should be notified if any sign of the following occurs:

Infection of wound, with redness, heat, swelling or pain, or

haemorrhage — where the dressing becomes stained with bright red blood.

If the patient is to return to the doctor's surgery for the removal of stitches, see that ample time is given that morning for preparation in order to arrive at the surgery in adequate time. The patient should not be worried or hustled on arrival at the doctor's rooms.

PHYSIOTHERAPY

Encourage the patient to continue with deep breathing exercises every four hours during the day and at night, if awake.

If a heavy smoker, encourage to cut down on daily number. The doctor and physiotherapist will have advised the patient on the importance of this prior to operation and again on discharge.

Exercise of muscles and joints must be attended to daily to prevent weakness and stiffness of limbs.

The patient should be encouraged to do a little more each day, e.g. light household chores: drying the dishes, preparing vegetables, hosing the garden, or taking gradually longer walks.

OCCUPATION

Some patients may be inclined to sit and worry about the future. Try to avoid this by encouraging discussion of thoughts. Listen to any expression of anxiety as sharing troubles lessens

the burden, and you may be able to help by making practical suggestions.

Friends should be permitted to call to stimulate interests. Reading, sewing, knitting, sketching, designing, and the viewing of television will help to fill in long hours of the day.

Do not allow the convalescent to remain in any one position for too long a period; remember that pressure sores will develop if pressure is prolonged or joints become stiff.

Fatigue should be avoided by limiting activity in any one day.

RETURN TO WORK

Doctor will direct when the patient is ready to return to work. Much will depend on the type of work done in the past and if this is to be continued.

Until the doctor advises that full function of the part operated upon has returned to normal, or as near normal as possible, the person giving care should prevent any heavy lifting and straining or strenuous exercise.

CARE OF THE LIMB IN A PLASTER CAST

Plasters may be applied to a body because of broken limbs, other injuries and disease.

Directions for care are usually given to the patient who is to go home after the plaster has been applied. This care will follow these general lines.

Keep the plaster cool during the drying period.

This will not take very long. **Heat must not be applied as the plaster will steam and cause burns and swelling.**

If told to rest, limbs should be supported on pillows so that they are higher than the level of the trunk.

During this time the fingers and/or toes should be opened and closed in an attempt to grasp the plaster. This 'pumps' out the swelling.

Report **immediately**, day or night, to the doctor or the casualty department of a hospital if you notice in the fingers or toes any of the following: Marked swelling, marked blueness or whiteness (not eased by elevating the limb)

Severe pain

Inability to move fingers or toes

Numbness or loss of feeling

Report any looseness or softening of plaster, which should be attended to as soon as possible.

Note: The plaster must be kept dry at all times.

Then hold the baby downwards to help drain any fluid out of the mouth and nose. This is best done by grasping the ankles firmly with one finger between them, the other hand supports the head and shoulders.

Lay baby by the mother's legs with the head slightly lower than the body. Wipe mouth and nose to clear the airway.

The babe usually cries soon after birth, should it not do so after one to two minutes then it will be necessary for the helper to breathe into the baby by covering its mouth and nose and **gently** breathing out. When the baby's chest rises, remove your mouth and watch the chest lower itself. Immediately breathe in again. Repeat this sequence until baby's breathing starts naturally.

Smacking the baby is **not** necessary, nor should it ever be handled roughly.

STAGE THREE

This is the stage when the placenta is expelled.

The mother is still lying on her back, the baby between her legs and a little away from the perineum.

When a contraction occurs she will usually expel the placenta.

This may take ten minutes or much longer — **be patient**. Reassurance at this time may be necessary.

Note how much blood is lost and measure it if possible by collecting in a dish. Show this, the placenta, and any membrane pieces to the doctor.

(The placenta is rather like a liver in appearance with a cord attaching it to the baby.)

The cord at first looks round and blue. Later it turns pale and becomes thinner as the blood stops pulsating through it **towards the baby**. It is essential no attempt is made to tie or cut the cord until this has occurred as the volume of blood which flows to the baby represents an **essential part of its blood volume**.

THE CORD AND ITS CARE

After pulsation of the cord has finished, usually about five to ten minutes or possibly a little longer, it may be cut if necessary, that is if it will be some time before the mother and baby can be transferred to the hospital.

Tie the cord **firmly** in three places.

First tie Approximately four inches from baby's navel.

Second tie A further two inches from the first, towards placenta end.

Third tie Two inches from the second tie, i.e. a distance of eight inches from the babe.

A cut is made between tie two and three. Thus there are two ties on the baby's side. The cord end is covered by a sterile dressing if available, if not by a firmly folded piece of linen, which has been washed and ironed, and held in place by an improvised bandage around its end.

During transfer of the mother and baby to the hospital, the cord ties should be **rechecked to ensure no bleeding has occurred**.

Re-tie securely if necessary.

Note

If in an emergency the cutting of the cord has been necessary as mentioned earlier, constant observation to ensure no bleeding has occurred is essential to prevent danger of death.

If the transfer of the mother and baby can be arranged within a **short time** after the birth, the cord need not of necessity be tied and cut. The placenta can be wrapped separately and placed **close to the baby (no pull on cord)**. The hospital staff must be told of this and they will then attend to the matter.

THE MOTHER'S COMFORT

She will need a refreshing wash and a clean sanitary napkin placed securely in position. Check it for any further blood loss from time to time. **Save** the 'loss' for doctor's inspection. A hot drink will help her to relax. Check her pulse and respiration and make a note of this for the doctor.

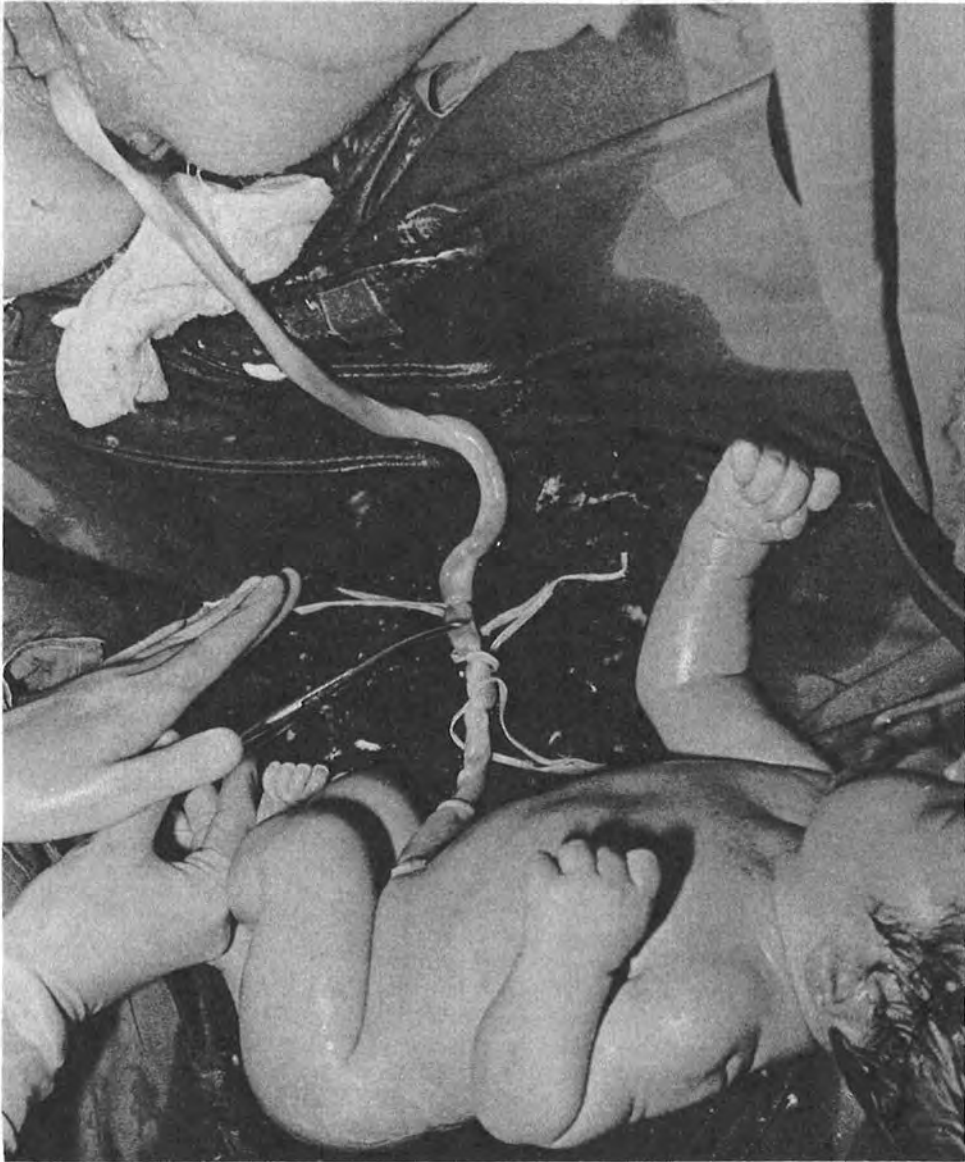


Figure 82 The cord ready to be cut between ties two and three. It is still attached to the placenta (after birth) and can be seen passing through the mother's vagina.

SOME PROBLEMS OF BABIES AND YOUNG CHILDREN

'The formative years of your child's life are from 3 to 7. As character develops you — the parent — must learn to satisfy your child's emotional needs, cope with tantrums and tensional problems and to recognise and nurse mumps, measles and other childhood illnesses. All parents want to learn what is best for their child.' This quotation is taken from one of the small 'Instant Books' ('Your Child from 5 - 7, Development, Health and Problems') compiled by the late Dr John S. Covert, F.R.A.C.P., and Dr Clair Isbister, F.R.A.C.P., D.C.H. (Mothers and Babies Health Association in South Australia and New South Wales respectively). It is printed in Australia and New Zealand and is inexpensive to buy.

Maternal and Child Welfare Departments in each State provide free literature on pre-natal care, and on preparation for the baby's future needs.

The following section will cover **some of the problems** which may confront the mother and her new-born baby or child.

DIETARY PROBLEMS AND GASTRO ENTERITIS

Feeding, vomiting, and diarrhoea are best dealt with by seeking expert advice from doctor or baby health sister. Effects of these conditions are exaggerated during hot weather. They are more common among bottle-fed babies.

All food should be stored in a cool place (refrigerator if possible).

Wash hands before preparing or handling the baby's food or attending to the baby — see earlier section on Hand Care, page 35.

If diarrhoea continues for a day or contains blood, the doctor must be notified (see Area 3, Feeding Sick Children, page 57).

A house which is clean and free from flies helps to prevent these conditions arising.

HEAT RASH

A fine, pink, spotty rash seen mainly on the face, neck and upper chest. It may last for only a few hours, and after fading away, the skin feels rough to touch. The rash usually appears in the hot weather and is often worse on the side of the body on which the baby was last lying. It may, however, occur in any season if the baby is feverish from any cause.

Try to prevent its development by keeping the baby as cool of possible during a heatwave by bathing it in tepid water several times a day.

One tablespoon of bicarbonate of soda added to the water is very soothing. Special 'prickly heat' dusting powder can be used to afford relief.

SORE BUTTOCKS

May develop during time of teething or if baby has thrush. It may also be caused because the baby is left in a wet or soiled napkin, or because of the incorrect washing of napkins, especially if harsh powder soaps or detergents are used. Napkins should be changed as soon as possible after wetting or soiling and placed in a covered bucket. They should be rinsed under running water and cleaned with a brush if necessary, boiled (using soft soap flakes) and rinsed thoroughly. Should boiling of napkins not be possible, a special agent ('Nappy San') or similar can be used to soak the napkins in and then proceed as directed on the packet. Soothing creams can be applied to sore areas.

THRUSH

A condition caused by a fungus. It appears like small fine spots of milk which usually appears in the mouth — on the tongue, inside the cheeks and on the lips. Rarely it may be seen on the buttocks. If spots are due to thrush they cannot be brushed off with a face tissue and may easily bleed. Strict cleanliness in handling of teats, dummies, teething rings and spoons to prevent infection is necessary. The application of Aqueous Gentian Violet 1-1000 is usually ordered by the doctor and it effects a rapid cure if painted on areas, three to four times daily, after feeds. The clothing must be protected from purple stains, however, should they become marked, methylated spirits will easily remove this stain. Other agents may be ordered and should be used strictly according to the instructions.

CRADLE CAP

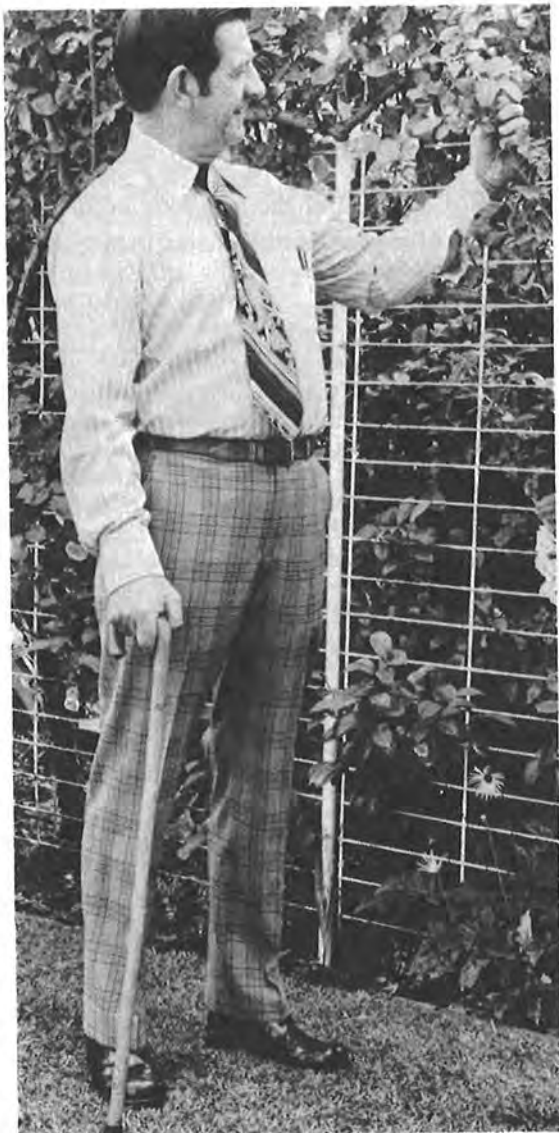
Is a condition caused by oil from pores of the scalp and dust settling on top of the head and forming a thick crust. This can be **prevented** by a gentle but brisk massage of the scalp each day when bathing the baby. A face washer or a small towel may be used over the flat of the hand. If this condition persists, it is treated by applying **slightly warmed** vaseline or paraffin at night, which is washed off next day with soap and water, rinsed well and thoroughly **dried**. Repeat until the scalp is clear.

REHABILITATION

The philosophy of rehabilitation nursing is that **patients are people**, living with families and in communities, and their physical and emotional needs and social status must be considered when **planning** the rehabilitation programme. Illness, 'whether acute or chronic, imposes

problems of adjustment on both the sick person and his family.

The extent of the adjustment depends on the severity of the patient's condition, and will vary according to the cause of the condition, e.g. a 'stroke' or a vehicle accident. Partial or



Figures 84-85 Showing the patient using a walking frame to improve physical condition by exercise and progressing to a walking stick with consequent improvements in mental outlook.

complete paralysis of limbs and sometimes impairment of vision or mental faculties may occur.

Preservation of the functions and abilities which the patient has, and **prevention** of complications commences at onset of the condition, whatever it may be. This is primarily the responsibility of the rehabilitation team which consists of doctors, nurses, physiotherapist, speech therapist, occupational therapist and social worker, and dietician. **Re-training care**

is then extended to members of the family, guided by experts.

At the home the district nurse may need to visit at first to show the person giving care how to carry out any personal needs that the patient is unable to do for himself. This will include all that is necessary to maintain a clean and comfortable body as described in earlier sections of this book.

The patient **must** be encouraged to do as much as possible, within limits of his capacity, e.g.



Figure 86 Patient recovering from a 'stroke' uses a wheel chair and is able to prune shrubs.



Figure 87 Progressing to using a four legged walking cane with the affected arm supported in a sling. This is an improvement in independence.

washing and drying face, brushing hair, putting on and removing clothing, feeding and later shaving.

Exercise is important to prevent stiffness of muscles and joints. At first it may be simply 'passive' movements carried out by the person giving care, who will be responsible for moving the limbs three or four times each day. Later the patient will become more active and carry out the movement with little or no help.

The National Heart Foundation has printed booklets on the range of movements which are simple and gradually increase in effort for the benefit of persons who have suffered heart conditions and 'strokes'. These booklets are given to patients or their relatives on discharge from hospital. They are also available (without charge) to other interested persons.

The Australian Physiotherapy Association has also printed, and issues a pamphlet which will answer many questions regarding this aspect of the rehabilitation programme.

With patients who have suffered a 'stroke' or paralysis from any cause, the **re-training** can be made easier by the use of aids, e.g. reading aids, leg, arm or body braces, four-legged walking canes (quadricanes), special attachments for beds for raising up into a sitting position (simple but strong rope pulleys are very useful if attached securely to foot of bed). The social worker, physiotherapist or occupational therapist will visit homes and make suggestions for rails in bathrooms, and ramps for wheel chairs, should this be necessary. Learning how to get into and out of a wheel-

chair requires patience and practice (see Area One, Lifting and Moving Patients, page 21).

The activity programme must not be overdone as rest is essential to recovery. Anxiety about the future may cause sleepless nights, a nourishing drink at bedtime may help and possibly eliminate the necessity for sedatives.

Other problems of incontinence and constipation have been discussed briefly earlier, and any other help can be given by members of the rehabilitation team.

In the case of youths and young people, **education** should be re-commenced as soon as possible. Time should be set aside for special television and wireless sessions to be viewed and heard.

The Education Department will be able to assist with correspondence lessons. A visit from the school teacher would be beneficial and should be encouraged as it may help the child's work and progress.

The ultimate level of rehabilitation is reached by help of excellent services in the community, such as associations for different disabilities, e.g. muscular dystrophy, diabetes, and others.

Day Centres and Sheltered Workshops help to return the patients to a level where they are able to carry out work and earn a salary which helps to provide a sense of social security and the emotional security which goes with the knowledge that they are useful and needed.

Telephones with special adaptations and a hand support for use to dial the number are now available.

This allows the handicapped person to be able to cope with certain aspects of work and social life.

LIVING WITH THE ELDERLY PERSON

Statistics readily assure us of the simple truth that more and more people are living to reach old age. Complete books have been written to deal with 'Care of the Aged', 'Nursing Older Persons' in home and in hospital. Further reading in these areas will prove rewarding to those who have the responsibility and pleasure of sharing life with older persons.

Because of the differences in upbringing, i.e. educational, social and economic backgrounds, the needs of the older person will vary. This section will give a simple, overall view of how to assist in keeping the older person healthy and happy.

The **total needs** of a person include **emotional and physical needs**. Essential to this is the comprehension of the uniqueness of each person as an individual.

Studies on ageing have pointed out that the satisfaction of many needs is denied to older persons because of loss of friends, status, health, attractiveness, and social roles.

Little note is made of the wisdom born of years of experience, because in competitive society the individual sense of worth has been maintained through achievement.

EMOTIONAL NEEDS may be highlighted because of changes in the realities of life.



Figure 88 The young reaping the benefits of living with an older, helpful person.

Retirement, physical and/or mental infirmities, death of marital partners, less responsibility for others, financial insecurity, all gnaw at the emotional health of the aged.

Reactions to these changes may cause confusion, hostility and development of fears.

It is essential that the aged person should be permitted and encouraged **to participate in helping others** in the neighbourhood or to be active in some organisation.

Social interests can be maintained by contact with others. This aspect of helping to maintain good emotional health should not be overdone as rest, privacy and time to think are very necessary.

In three generation family units, the younger members need patience and understanding when the aged fail to fully grasp the importance or excitement of their activities. There may be the need to explain that the grandparents are interested in their activities but sometimes forgetful.

If depressive conditions develop — the family doctor should be notified. He may order certain medicines to be given. Many medicines are ordered for different conditions in the aged. Care must be taken to observe any physical or mental reactions which may cause concern. (Remember, these reactions may be due to medicines.)

For example:

Talking or calling out loudly at night. A night light helps to prevent a sense of loss of bearings

and provides security on awakening, and for visiting the toilet.

Loss of appetite.

Dizziness on sudden change of position or on any movement. Clear walking areas are of help in preventing falls from this condition.

Any of these problems should be brought to the attention of the doctor.

PHYSICAL NEEDS. Physical performance reflects the combined capacity of the different organs of the body working together.

As age progresses, there is usually a decline in body functioning, until in some cases, a point of **recognised disability** occurs.

Should an older person not be already aware of what is necessary to know and do to improve health, it can be taught, perhaps at a slower rate than for a younger person.

Changes do not occur at the same rate or intensity in each individual.

Important areas of care which may need to be taught are:

CLEANLINESS

If a person is too feeble to bath alone, a relative or friend should assist. Older persons often wish to bath but are afraid of exposing themselves to the risk of falling. Folding wooden seats can be obtained to fit in the bath so that the person can sit in comfort and free from fear.

Social workers can assist in this by arranging with the Red Cross or Medical Hiring Agency to obtain the seat for as long as required.

CONDITION OF THE FEET

Observation of their condition is desirable and careful trimming of toe nails necessary. Skin between toes should be dried thoroughly. Note also if oedema (swelling) is present and, if so, the person should rest on the bed with feet raised on three pillows. Comfortable, well-fitting shoes prevent tired legs and lessen risk of slipping.

EXERCISE

If this is regular and can therefore be more easily tolerated it is essential to prevent undue strain on muscles and joints. A walk in the garden, to the shop or park, can also be helpful in keeping the person more interested in his surroundings.

FOOD

In preparing meals for older persons, it is necessary to provide adequate nutrients for age — a **high protein diet** is one which prevents wear and tear of body cells and provides the material for repair of worn out and damaged cells. Bread and butter and a cup of tea should be avoided as a full meal because of its limited nutritional value.

'Meals on Wheels' provide one full meal per day to persons who can no longer manage to prepare and cook for themselves. Recently, frozen meals have been introduced.

SOME THOUGHTS TO CONSIDER ON SERVING MEALS TO THE ELDERLY

Does he really enjoy his food?

Does he remember some foods which he once favoured — do you give them to him now?

Can he eat steak in comfort? Does he need his denture checked?

How much milk does he use in food and drink?

Does he eat the vegetables and fruit that supply him with the necessary vitamins and prevent constipation? (See notes on Nutrition, page 54.)

Who does the shopping?

What comes home in the shopping bag?

How is the food prepared, if at all?

A careful and tactful enquiry may solve many nutritional problems. However, good nutrition in old age has its base in good nutrition in early life. In many instances set attitudes, food aversions and intolerances (real and imagined) make the job especially difficult, but patient perseverance is rewarded by improvement in

skin, eyes, and general appearance of aged relatives and friends.

BOWEL ELIMINATION

May present problems for the older person. A good diet with the addition of fibre foods, such as wholegrain cereals, and attention to an adequate fluid intake is essential. Exercise (unless not possible because of infirmities) is also helpful in preventing constipation and possibly faecal impactions in the rectum.

Impactions. When faecal impaction is diagnosed by a doctor or a trained nurse, it is treated by manual removal, which means a gloved finger is inserted in the 'back passage' and the mass of faeces broken into small parts to be removed. This procedure must be carried out by a trained and skilled person **after** an **adequate explanation** has been given to the patient.

BLADDER INCONTINENCE

This is a common problem in the aged caused by weakening of the sphincter muscle control, due to loss of muscle tone and the slower response of the elderly to stimuli. Incomplete bladder emptying leads to infected urine which increases incontinence. This will vary. It may be a 'straight-out-incontinence' or 'social incontinence' which is manifested by a sense of 'urgency', i.e. when the desire to empty the bladder is first recognised or realised, the person has difficulty in reaching a toilet soon enough. This causes embarrassment, which in turn interferes with the person's social life — thus the term. Because of its very nature, help is not sought early.

Women find it helpful to wear a sanitary pad, although this may well be inadequate for some, or a special appliance can be obtained for both sexes, in which case clear directions on its use and cleaning must be given.

It is essential that **adequate fluid** (at least six cups or glasses daily) should be taken in order to prevent concentration of the urine, which will act as an irritant.

In the home, if the older person has problems in reaching the toilet soon enough, a commode could be provided or else he should be assured that a member of the family will assist him to the toilet, if called to do so. This latter does have obvious drawbacks as the dislike to inconvenience others is usually present in all people.

MEDICATIONS

Relatives must know of the dangers of giving medicines without the knowledge of the doctor, e.g. aperients, pain relievers or sleeping tablets. There are innumerable medicines available at the present time. It should not be presumed that because a medicine appears to have cured one member of the family, or a friendly neighbour, it will have good results for all.

When the elderly become ill, they are often given a complexity of medical instructions with numerous combinations of medicines which they (or any nurse) find hard to fit in between normal nutrition. This fact should be checked with the family doctor. He may not be aware that the patient is still taking tablets which he ordered for some other ailment some time previously. Sometimes he may order a higher potency drug to be taken once daily and which will have the same effect, or two or three tablets to be crushed together and given in jam, honey, ice cream or custard.

Confusion will often occur if the patient or relatives do not understand for what special condition they are taking each tablet or medicine dose, and what each one is expected to do.

It is better with patients who are very old and still live alone to try and relate their tablet taking to a daily occurrence, e.g. take this red tablet when you have your breakfast, or three times a day at meal times. Once-daily medicines may be related to a known daily habit, e.g. put the white tablet with your porridge spoon. This may help the elderly to remember to take their tablets or to remember whether they have taken them. The family doctor may suggest other helpful ideas.

CONFUSION STATES

These sometimes occur in the aged because of medications which do not 'agree' with their bodies. Often the demand by relatives to keep the elderly 'quiet' at night can cause mental

confusion, or a higher potency sedative than necessary may contribute to confusion or depression. Use of a night light will lessen or prevent confusion states during darkness. Poor nutrition may also be another contributing factor.

SUMMARY

Research in this subject has caused it to be noted that most of the needs of the elderly are actually the needs of all from birth to death. These are centred in the need **for love, security and satisfaction, i.e. someone to love, somewhere to live, and something to do.**

The chief enemies of old age are the fear of being dependent on others, loneliness, and isolation. Without new experiences to give pleasure, memories of the past predominate and drive the present into discard and lead to premature senility.

In Australia, community services, including Councils for the Ageing, are helping to eliminate some of the problems of the aged and can provide any additional information required in this area.

Groups, such as church organisations, over sixty clubs, Pensioners League, and Widows Club help to lessen loneliness by visits, reading, making a cup of tea, and having a little chat.

Questions that could be asked of each group with responsibility to care for the elderly are: How do we define personal care services?

Do 'home-makers' find limits to the personal care that they can give?

How much supervision does the person giving care need?

What type of additional instruction is required, not only to give care but also to understand and cope with problems related to illness?

We need the perception to recognise needs, the vision to plan, and the courage to carry out the plan.

What are you doing to assist positively in helping the aged in your area?

CARE OF THE DYING IN THE HOME

Attention must be directed to making the patient as comfortable as possible.

Even though there may be little which can be done by the person giving care, the sick room should be visited frequently.

Kindly and sympathetic consideration towards both patient and relatives may do much to lessen the sadness of the situation.

The person giving care should endeavour to bring to the bedside any person whom the patient would like to see.

When the patient's religious counsellor is to visit the home, suitable preparation should be made.

The patient's room should be light and well ventilated. Shield the patient's eyes from glare. Do whatever can be done to give the room a cheerful look, e.g. add a vase of flowers.

Unpleasant odours may be kept down by using a modern deodorant spray sparingly.

THE PERSON GIVING CARE WILL NEED TO

Wash the patient and change night attire and bed linen as frequently as required to keep the patient dry and comfortable.

Keep the mouth clean and moist. Special mouth care is usually necessary every two to four hours.

Give frequent sips of water whilst the person is conscious. As the state of consciousness declines, moisten lips with a swab.

Change the position of the patient about every two hours, support the trunk and limbs well, and remember that lying on the back may not always be the most comfortable position — the patient may not be able to complain.

Keep the patient covered and warm.

Bathe the patient's eyes to prevent dryness. This may occur if there is a tendency for the patient to be lying with the lids open. Close the lids gently as often as necessary.

Attend to the needs of the bowel and bladder. Encourage the relatives to stay in the room to relieve the sense of loneliness. Remain in the room when relatives leave.

Ensure that conversation is carried out in a normal way as whispering can cause misinterpretation and/or anxiety to the patient.

WHEN THE PATIENT DIES

The eye lids are gently closed.

Notify the doctor.

Remove all but one pillow, straighten the body and cover with a sheet.

Clean and replace dentures, if necessary.

Roll a bath towel and place under bottom jaw to keep mouth closed.

Prepare articles required for **care of the body after death**. For example, towels, washers, soap, night attire (or shroud) if relatives have prepared for this.

The undertaker will advise or attend to any other aspects of preparation for burial.

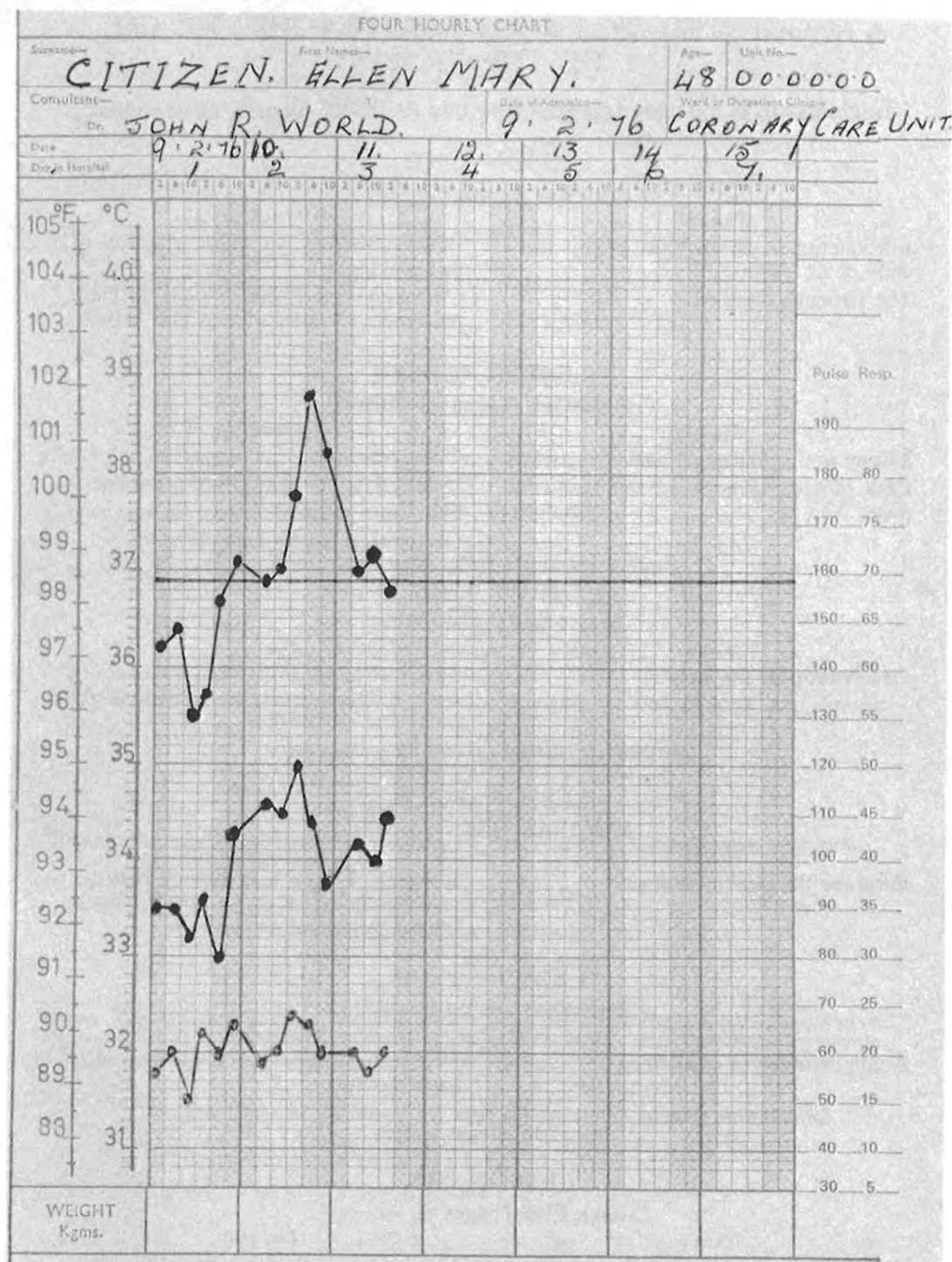
After the body has been taken by the undertaker, the room should be cleaned, bed aired and remade, and the room left as fresh as possible.

Note

Many people know they are going to die (i.e. they have a terminal illness) and would like to talk about this to someone.

It is undesirable that the conversation be 'steered' into other topics. This is especially important in the case of near relatives as there may be many things the patient would wish to have attended to before the condition becomes worse and death occurs.

When the patient knows of impending death it is often a mistake to avoid talking about it. One must of course be attentive to and guided by the trend of the patient's remarks.



Appendix 1 An example of a patient's temperature, pulse and respiratory chart showing how it is used in many hospitals. On the original, the temperature is charted in black, the pulse rate in red, and respiration in green.

A SUGGESTED SYLLABUS FOR TEACHING CARE OF THE SICK

Each lesson is a period of **two hours** and excludes all reference areas

LESSON ONE

Area One (pages 13 - 20)

<i>Theory</i>	<i>Practical</i>
Introduction — to include briefly the aims of St. John	Demonstration and class practice of bed making
The patient's comfort	Changing bed linen, patient in bed, placement of comfort aids and bedpan

LESSON TWO

Area One (pages 21 - 23)

<i>Theory</i>	<i>Practical</i>
Lifting and moving patients	Class practice
Care of special parts of the body — pages 32 - 36	Demonstration of washing a patient
	Skin care, mouth toilet
	Class practice of mouth toilet

LESSON THREE

Area Two (pages 40 - 50)

<i>Theory</i>	<i>Practical</i>
Observation of the sick	Demonstration and class practice of using a thermometer and checking the pulse and respiration

Directions to students on re-reading this Area

LESSON FOUR

Area Three (pages 53 - 57)

<i>Theory</i>	<i>Practical</i>
Food for the healthy and sick	Revision, Lifting and moving patients, and repeat use of thermometer, checking the pulse and respirations

LESSON FIVE

Area Four (pages 59 - 64)

<i>Theory</i>	<i>Practical</i>
Administration of medicines	Demonstration and class practice after each section

Directions to students on pre-reading Area Six, pages 74 - 76 which may not be taught in class sessions

LESSON SIX

Area Five (pages 68 - 73)

<i>Theory</i>	<i>Practical</i>
Revision of all preceding theory (pages 13 - 64)	Bandaging demonstration and class practice after each application
Students question period	

LESSON SEVEN

Area Seven (pages 77 - 82)*Theory*
Infection and its spread*Practical*
Treatments using heat and cold
Class to practice where practical

LESSON EIGHT

Area Eight (pages 83 - 85)*Theory*
Infection and its spread*Practical*
Disinfection
Dressing a wound

LESSON NINE

Area Nine (pages 86 - 87)*Theory*
Infectious diseases
Means to prevent spread of infection
Fever and its treatment*Practical*
Revision of wound dressing
Revision of temperature, pulse and respirationDirection to students for pre-reading Area Ten, pages 98 - 100,
'Some problems of babies and young children'

LESSON TEN

Area Ten (pages 98 - 108)*Theory*
Discussion on selected sections
Students question time*Practical*
Revision of bed making and comfort aids
Bandaging practice

LESSON ELEVEN

Practice answering of written questions Revision — students own selection

WEEK TWELVE

Examination — Written
Practical

Note. This syllabus has been prepared to cope with small to medium sized classes. Should it be considered necessary, week twelve could be used for further revision with the examination to follow later.