FAMILY CARE at HOME

St John Ambulance Australia
Canberra Avenue
FORREST ACT 2603

Family care at home

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FAMILY CARE at HOME

SKILLS

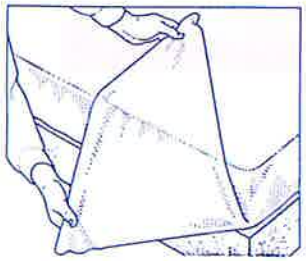
CONTENTS

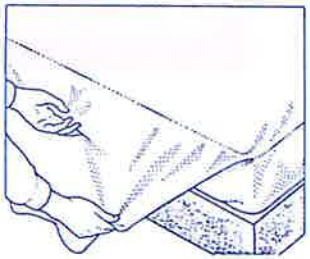
1 Making a bed

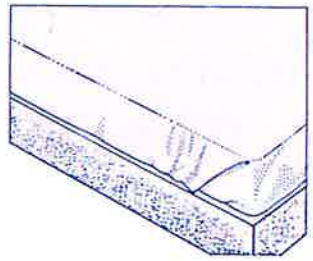
You'll need:

- one drawsheet about 1 metre wide and 2 metres long if the person is incontinent
- plastic sheeting, the same size as the drawsheet
- clean linen
- two chairs on which to place linen
- bucket for dirty linen.

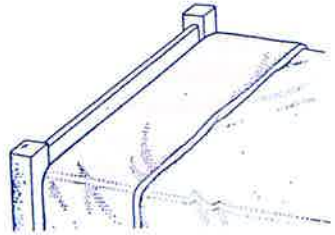
1. Wash your hands.
2. Remove used linen.
3. Place the bottom sheet in position with the centre crease in the middle of the bed and with the right side uppermost.
4. Tuck in the sheet at the head of the bed.
5. Make square or mitred corners:
   - pick up the edge of the sheet about 45 cm from the corner of the mattress
   - tuck in all the sheet which hangs down
   - tuck in the side of the sheet.







6. Pull the bottom sheet taut.
7. Tuck in the sheet at the foot of the bed and make corners.
8. Pull the sheet taut from side to side and tuck it in.
9. Place the plastic sheeting on the bed so that it will come under the buttocks.
10. Cover with the drawsheet if the person is incontinent.
11. Tuck one end of the drawsheet under the mattress.
12. Pull the drawsheet and tuck in the remainder.
13. Place the top sheet in position, wrong side uppermost, and the centre creases in the middle of the bed.
14. Make a pleat in the lower end of the sheet to allow room for the feet.



15. Tuck in the bottom of the sheet.
16. Make corners and tuck in sides.
17. Place each blanket in position and tuck in in the same way.
18. Make corners and tuck the quilt under the foot of the mattress, leaving the sides free.
19. The top sheet is turned down over the blankets and quilt.
20. Place the pillows in position.

2 Making a bed with someone in it

You'll need:

- one drawsheet about 1 metre wide and 2 metres long if the person is incontinent
- plastic sheeting, the same size as the drawsheet
- clean linen
- two chairs on which to place linen
- bucket for dirty linen.

1. Tell the person what you are going to do.
2. Wash your hands.
3. Place a chair at the foot of the bed.
4. Loosen the bedclothes all around the mattress.
5. Remove the quilt and blankets by picking up the top edge, bringing them down to the bottom of the bed, and folding them back. Place on the chair.
6. Remove the top sheet, leaving the person covered with a blanket.
7. If possible, remove all but one pillow.
8. Keeping the person well-covered with a blanket, roll him or her to one side of the bed, for your assistant to hold. If you do not have assistance, ask the person to hold on to the side of the bed and tuck a chair against it to prevent a fall.
9. Brush out any crumbs.
10. Straighten the bottom sheet, plastic sheet and drawsheet, and tuck them in tightly.

11. Ask the person to roll over to the side of the bed that has already been straightened and repeat on the other side.
12. Replace the pillows.
13. Unfold the top sheet over the person.
14. Remove the blanket from under the sheet and put it on the chair.
15. Tuck in the sheet and make a pleat at the bottom.
16. Place the blankets over the person and tuck each one in.
17. Replace the quilt and turn the sheet over it.

3 Changing a drawsheet

You'll need:

- drawsheet
- bucket.

1. Prepare the clean drawsheet by rolling it up.
2. When the first side of the bed is being made, the soiled drawsheet is rolled up close to the person's back.
3. Tuck in the clean drawsheet and place the rolled portion close to the rolled up soiled drawsheet.
4. Roll person over both drawsheets to the other side of the bed.
5. Remove soiled drawsheet and pull the clean one through.
6. Remake the bed.

4 Changing a bottom sheet

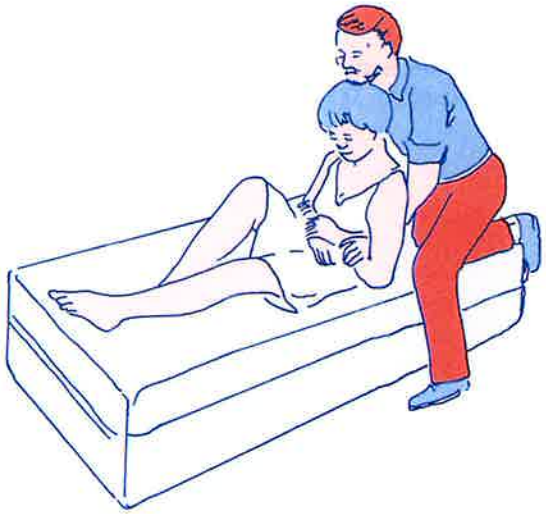
You'll need:

- clean bottom sheet
- bucket.

1. With the person lying on the side, roll the soiled sheet close to the back.
2. Place the rolled clean sheet on the bed close to the soiled sheet, making sure that its centre crease will come in the middle of the bed.
3. Tuck in the clean bottom sheet making sure that it is well tucked in at the head of the bed.
4. Roll the person over the two rolled sheets to the other side of the bed.
5. Remove the soiled bottom sheet, pull the clean sheet through and tuck in securely.

5 Sitting someone up and helping him/her out of bed

1. Tell the person what you are going to do.
2. Fold the person's arms across the waist.
3. Place your inside knee on the bed, level with the person's hip, and your outside foot on the floor in line with the person's waist.
4. With your knee bent, place both hands under the person's armpits.
5. Keeping your arms straight, sit back on your heels. Your body weight lifts the person to a sitting position.
6. With one hand supporting the back, help the person to swing his/her legs over the side of the bed.
7. Help the person put on a dressing gown and slippers.



6 Lifting someone in a low bed without a helper

1. Tell the person what you are going to do.
2. Sit the person up.
3. Place your knee on the bed, well behind the person, and your outside foot on the floor close to the bed.
4. The person should hold his/her right wrist with the left hand and bend one knee.
5. Slip your hands under the person's arms and grasp his/her forearms.
6. Carry your body weight backwards by thrusting with your outside leg until you are sitting on your heel.
7. If possible, get the person to help by straightening his/her knee.
8. The person's buttocks are now in line with your thigh.

7 Lifting someone in a low bed with a helper

1. Try to lift with a person of the same height.
2. Tell the person what you are going to do.
3. Ask the person to help if possible.
4. Stack up pillows.
5. Face direction of move.
6. Stand as close to the bed as possible, with your thighs against the bed and your front foot facing towards the top of the bed.
7. Put your hands under the person's thighs up as high as possible. Grasp the other lifter's wrist.
8. Tell the person to put his arms over your back.
9. Put your shoulder under the person's armpit.
10. Put your other hand at the top of the bed, on the side.
11. Bend your front elbow and your knees.
12. On the command to lift, straighten your arm on the side of the bed and straighten your knees.

8 Lifting someone from a bed to a chair with a helper

1. Tell the person what you are going to do.
2. Place the chair in position.
3. Sit the person up with his/her legs over the side of the bed.
4. Help the person into a dressing gown and slippers.
5. With your inside hand, grasp your helper's wrist under the person's armpits and place your outside hand flat on the bed.
6. Your outside leg should be close to the bed with the foot pointing forward.
7. Your inside leg should be a little way behind with the foot pointing inside.
8. With your back straight and your chin tucked in, bend your hips and knees.
9. Lift by pressing up into the person's armpit with your shoulder while straightening your knees and pressing firmly on the bed with your outside hand.
10. Support the person's back with your outside hand as you walk towards the chair.
11. When you reach it, place your inside foot slightly in front of the chair, facing inwards, and your outside foot at the side of the chair, facing forward.
12. Lock your feet to prevent the chair moving.
13. Place your outside hand on the arm of the chair.
14. The person should be able to feel the seat of the chair with the back of the legs before sitting down.
15. With your back straight and your knees and hips bent, lower the person gently into the chair as your elbow bends.

9 Helping someone up from a chair

1. Tell the person what you are going to do.
2. Stand slightly to one side and put one foot in front of the person's foot to prevent him/her sliding forward.
3. Make sure the chair cannot move.
4. Bend your legs at the knee and place your hand under his/her armpits.
5. Keeping your back straight, straighten your legs and bring the person into a standing position.

10 Helping someone to walk

1. Tell the person what you are going to do.
2. Stand at his/her weaker side.
3. Support the person with one arm around the waist from behind and the other hand under the armpit from in front.
4. Block the person's feet with your forward foot and prepare to use your knee to provide support for the weaker knee when weight is put on it.
5. Ask the person to move the stick forward, the weak leg forward, then the strong leg forward, until the rhythm is well established.
6. Try to finish the walk in front of the chair that the person wants to sit on, with the back of the legs touching the chair.
7. Remove the walking aid and let the person turn slightly towards the stronger side. The stronger hand should be placed on the chair arm or on the seat before sitting down.

11 Giving an oral medication

You'll need:

- tray
- glass of water, milk or juice
- medicine glass or spoon
- medication.

1. Tell the person what you are going to do. Wash your hands, and check the 5 rights.
2. If a liquid, shake the bottle carefully. Hold the glass at eye level with the markings facing you. Hold the bottle with label uppermost to prevent staining. Place thumbnail as a marker at the correct level on the glass.
3. Dispense the correct dose.
4. Recap the bottle and recheck the label.
5. Add water to the dose if required.
6. Give the person the medication and watch it being taken.
7. Rinse the glass or spoon.
8. Give the person a drink.
9. Record the dose.
10. Watch for any reaction.

12 Giving an inhalation

You'll need:

- ordered medication
- disposable cup for sputum
- lanolin or vaseline
- 1 litre jug of hot water which has been boiled and allowed to stand for 5 minutes
- bowl in which to stand jug
- two towels
- tray and tissues
- bag or bin for disposal of tissues.

1. Tell the person what you are going to do.
2. Wash your hands.
3. Seat the person at a table with the head slightly forward. Ensure that the hair is out of the way. Place a towel over the chest.
4. Lanolin or vaseline may be smeared over the lips and the tip of the nose to protect them.
5. Place the jug containing the medication and hot water in a bowl in front of the person, ensuring that it is stable.
6. Ask the person to hold a towel over the bridge of the nose to protect the eyes and direct the steam to the nose and mouth. The person should breathe in through the mouth and out through the nose.
7. The inhalant should be used for at least 10–15 minutes. Encourage the person to cough following the inhalation. It is advisable to remain in a warm atmosphere for 30 to 60 minutes after inhalation.
8. Observe the person carefully.

13 Giving a rectal suppository

You'll need:

- medication
- bedpan
- tray
- towel or underpad
- disposable gloves or a finger stall
- bag for used equipment.

1. Tell the person what you are going to do. Allow him/her to empty the bladder.
2. Wash your hands.
3. Place the person on the side with the towel under the buttocks. Tell him/her to draw up knees.
4. Warm the suppository in the hand before removing foil wrapping. This allows the suppository to soften a little and become lubricated. A lubricant such as KY Jelly may be used, but this could delay absorption.
5. With gloves on, hold the buttocks slightly apart and gently insert the suppository pointed end first, using gentle pressure with the index finger, until the sphincter muscle is passed. Ask the person to take some deep breaths to ease insertion.
6. Instruct the person to hold the suppository for the specified time, or until absorbed.
7. Record the dose on the chart.
8. If the person is in bed, a bedpan should be made available.
9. Note any results, e.g. bowel action.

14 Applying a topical medication

You'll need:

- medication
- gloves
- cotton balls or buds
- bag for used equipment.

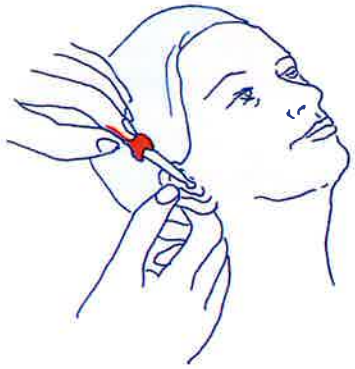
1. Tell the person what you are going to do.
2. Wash your hands.
3. Make sure the area to which the ointment is to be applied has been cleaned.
4. Select the correct medication. Check the 5 rights.
5. Do not touch the person's skin with the tube.
6. Apply the medication from the centre of the affected area towards the outside, using a cotton ball or bud or the applicator supplied.
7. Cover the area if necessary.
8. Record on chart.

15 Giving ear drops

You'll need:

- medication
- tray
- tissues
- dropper
- towel
- cotton balls
- bag for used equipment.

1. Tell the person what you are going to do.
2. Wash your hands.
3. Clean the external ear with a cotton ball. DO NOT use a cotton bud.
4. Lay the person down, affected ear up.
5. Warm the drops by holding in the hands for a few minutes.
6. Draw up the dose and instil into the outer ear.
7. Ask the person to remain on the side for a few minutes.
8. Record on chart.



16 Giving nose drops

You'll need:

- medication
- tray
- dropper
- tissues
- bag for used equipment.

1. Tell the person what you are going to do.
2. Wash your hands.
3. Ask the person to blow the nose gently.
4. Lay the person down with head lower than the shoulders. A pillow may be placed under the shoulders. Alternatively, sit the person on a chair with the head tilted well back.
5. Draw up the dose.
6. Insert the dropper about 0.5 cm into each nostril and instil the dose.
7. Ask the person to remain lying down for a few minutes.
8. Clean and sterilize the dropper after use.
9. Warn the person that an unpleasant sensation may be felt at the back of the throat.
10. Record the dose.
11. If giving a nasal ointment, use a cotton bud or the container nozzle to instil the dose. Massage the outside of the nostril to distribute the ointment.

17 Giving eye drops

You'll need:

- medication
- tissues
- tray
- dropper
- bag for used equipment.

1. Tell the person what you are going to do. Absolute cleanliness is essential. Your hands should be washed thoroughly and a 'non-touch' technique should be used.
2. If necessary, clean the person's eyes with warm sterile water or weak saline. Swab each eye from the inside to the outside with a clean moistened swab.
3. If possible, sit the person down and stand behind him/her.
4. Select the medication and check the 5 rights.
5. Draw up the correct dose.
6. Tilt the person's head back and gently open the lower lid.
7. Instil one drop only in the pouch formed, being careful not to touch the eye with the dropper.
8. Wipe any drainage with a tissue.
9. Repeat the process as required.
10. Record the dose.
11. Observe any reaction to the medication.
12. If using an eye ointment, hold the tube parallel to the eye. Squeeze a thin ribbon of ointment along the inside of the lower lid. Ask the person to close the eyelid and gently roll the eyes around to distribute the ointment.

18 Taking a temperature

You'll need:

- tray
- thermometer
- jar of water and one of disinfectant if thermometer is not disposable
- swabs
- bag for used equipment
- pad and pen.

1. Tell the person what you are going to do.
2. Check that he/she has not had hot or cold drinks or food, been smoking, or had a hot bath or shower in the last 10 minutes.
3. Wash your hands.
4. Pick up the thermometer (not from the bulb end).
5. Shake the mercury down to 35°C.
6. Place the thermometer either:
   - under the tongue for at least 2 minutes
   - under the armpit for at least 10 minutes.
7. Tell the person to close the lips and not to talk, if measuring the temperature in the mouth.
8. Remove and wipe the thermometer.
9. Read and record the temperature.
10. Wash the thermometer in cold water.
11. Store the thermometer in disinfectant at correct strength and for the correct time, as stated on the bottle.

19 Measuring the pulse

You'll need:

- watch
- pad and pen.

1. Tell the person what you are going to do.
2. Wash your hands.
3. Locate pulse point.
4. Feel the pulse by placing two or three fingers upon the artery, exerting light pressure. Do not use your thumb.
5. Count the rate for one full minute.
6. Record the rate, the rhythm (regular or irregular) and the strength (weak or strong).

20 Measuring respiration

You'll need:

- pad and pen.

1. Measure respiration without telling the person.
2. Count the rise
3. Record rate, regularity and character of breathing.

21 Sponging an ill person in bed

You'll need:

- plastic cup
- small dish for cleaning teeth
- washbowl and water
- toiletries
- two large towels
- two wash cloths (one each for face and body)
- clothing.

1. Tell the person what you are going to do.
2. Wash your hands.
3. Ensure privacy.
4. Close windows, and warm room if necessary.
5. Towels, toiletries and clothing should be placed within easy reach.
6. Offer the person a bedpan.
7. Remove all upper bedclothes, except a blanket; night attire; and any supports such as a bed cradle and sheepskin.
8. Wash and dry all areas of the body thoroughly, noting any signs of pressure sores or injury to the skin. This procedure should be carried out from one side of the bed:
   - place one towel under the person's head and neck to protect the pillow and one across the chest
   - wash, rinse and dry the face, neck and ears, using a face cloth
   - place a towel lengthwise under the arm to protect the bed linen and another alongside for drying before washing the arms and hands. If possible, wash hands in bowl
   - turn the blanket down to below the person's waist and wash the chest and abdomen. Dry thoroughly
   - wash the groin and genital area, if the person is unable to do this

- empty the bowl and replace with clean water
- wash the legs in the same manner as the arms
- if possible, bathe each foot in the wash bowl by bending the knee and gently immersing the foot in water
- dry the feet thoroughly, especially between the toes
- turn the person on the side, and wash and dry the back and bottom.

9. Check the skin for any areas of redness, blisters or bruising. If necessary, carry out any special care of the skin, and massage the back with a soothing cream.
10. Change the bottom sheet and replace the night attire. Replace sheepskin, bed cradle and top linen.
11. Place the person in a position of comfort.
12. Clean teeth, brush hair and shave if male.
13. Remove all equipment.

22 Washing an ill person's hair in bed

You'll need:

- shampoo and conditioner
- face washer
- brush and comb
- plastic jug
- low chair
- two buckets (one each for clean and used water)
- plastic sheeting to protect linen and floor
- small pillow or rolled towel covered with plastic
- hair dryer.

1. Tell the person what you are going to do. Wash your hands.
2. Close all windows and make sure the room is warm.
3. Place the buckets on the floor on the plastic sheeting.
4. Place the rolled towel or pillow under the neck for support, with plastic sheeting under the shoulders forming a trough into the bucket.
5. Fold the upper bed clothes back to the waist and replace with a small blanket.
6. Ensure that the person is comfortable.
7. Pour warm water slowly from the jug over the hair, using the face washer to protect the eyes.
8. Pour some shampoo over the head and work it into the hair, gently massaging the scalp with the fingertips.
9. Rinse hair, apply conditioner, and then rinse well.
10. Squeeze water from hair and wrap in towel.
11. Gently move the person down the bed and sit up if possible.
12. Comb and dry hair.
13. Leave the person comfortable and the room tidy.

23 Giving a bedpan

You'll need:

- bedpan
- toilet paper
- bowl of water
- soap and towel.

1. Tell the person what you are going to do.
2. Wash your hands.
3. If the bedpan is metal, rinse it out with warm water and dry it.
4. Cover with a cloth or paper towel.
5. Close the bedroom door, for privacy.
6. Turn back the top bedclothes, and remove any extra pillows, books, etc.
7. Ensure that clothing is free of the pan.
8. Ask the person to bend the knees and raise the buttocks, using one hand to assist.
9. Slide the pan underneath with the wide end towards the person's waist. Another assistant may be needed.
10. Assist the person to sit up, if allowed. The back must be adequately supported by pillows.
11. If allowed, leave the person alone, with toilet paper and a bell within easy reach.
12. To withdraw the pan, remove supporting pillows and lower the person.
13. Ask the person to bend the knees. Slip one hand under the back and remove the pan.
14. Put the pan on a chair and replace its cover.
15. It may be necessary to turn the person on to one side to make sure that the buttocks are clean and dry.
16. Bedclothes should be rearranged and the person made comfortable.
17. Provide a bowl, soap and towel for hand washing.
18. Remove and empty pan, checking first for any abnormalities such as blood in the urine.
19. Wash your own hands thoroughly.

24 Giving a urinal

You'll need:

- urinal
- cloth
- bowl of water
- soap and towel.

1. Tell the person what you are going to do. Wash your hands.
2. Cover the urinal with a cloth.
3. The urinal should be warm if not made of plastic.
4. If the person is very ill or has little control when passing urine, the urinal should be placed in position.
5. If possible, allow the person to sit up with the legs over the side of the bed, or to stand up.
6. If required, measure and record the volume of urine passed.
7. Empty and rinse the urinal.
8. Wash your own hands thoroughly.

25 Dressing a wound

You'll need:

- tray
- sterile scissors
- antiseptic
- bandage or plaster
- bag for soiled dressings
- bowl containing disinfectant for soiled instruments
- a disposable dressing pack containing the following – sterile bowl, cotton wool swabs, gauze, paper towels, 3 pairs of forceps
- a good light.

1. Tell the person what you are going to do.
2. Gently turn the bedclothes back and expose the wound.
3. Wash your hands and scrub your nails.
4. Place the sterile articles close by you and add the antiseptic.
5. Remove the bandage or tape holding the old dressing in place.
6. Wash your hands well.
7. Using one pair of forceps, remove the soiled dressing and place in the bag. If the forceps are disposable, place them in the bag. If not, place them in the bowl containing disinfectant.
8. Place a sterile towel on the side of the wound nearest you.
9. Using a second pair of forceps, the wound is then cleaned with wool swabs dipped in antiseptic. Using each swab once only, the wound should be cleaned from the inside to the outside. Discard used swabs and forceps as described above.
10. Apply the dressing using a third pair of forceps. Secure the dressing with tape, bandage or elastoplast.
11. Dispose of soiled dressings and swabs by burning.
12. Wash all other equipment, and sterilize for further use.
13. Wash your hands thoroughly.

26 Sponging a feverish patient

You'll need:

- clean night clothes
- bowl of tepid water
- 2 face washers
- 3 large towels
- thermometer.

1. Tell the person what you are going to do.
2. Remove the blanket and top sheet.
3. Place a large towel under the person.
4. Sponge the arms, hands, legs and feet for 15 to 30 minutes, and pat dry.
5. Take the person's temperature. If it has fallen by 1°C, do not sponge further. If not, sponge the chest and back.
6. Dress the person in clean night attire.
7. Remove towels.
8. Make the bed and ensure that the person is comfortable.
9. Take the temperature again after 30 minutes.

St John Ambulance Australia

1 STAYING HEALTHY

WHAT IS GOOD HEALTH?

Good health is a total concept that includes physical, emotional and social wellbeing.

When we are not functioning adequately in a physical, emotional or social capacity, ill health may be experienced.

In order to maintain a state of good health, a healthy lifestyle should be adopted.

WHAT IS ILLNESS?

Most people have experienced some minor health problems. Many experience chronic health problems, yet manage their condition by taking certain precautions and respecting the limitations imposed by their illnesses.

An individual's health must be considered in terms of total functioning. For example, following a stroke, a person may have a physical disability which will interfere with emotional and social wellbeing. The person will undoubtedly be anxious and may require lengthy hospitalization and rehabilitation. These factors interfere with normal contact with family and friends and in the work situation.

Even in the case of minor illnesses such as influenza or a gastrointestinal upset, a person's mental outlook and interactions with other people are affected. Similarly, an emotional problem such as anxiety may affect the appetite, digestion and other physical functions.

Illness is a personal problem because it affects the individual's ability to work and function as usual. It is also a social problem because others such as family and friends are affected.

WHAT ROLE DOES OUR ENVIRONMENT PLAY?

The environment in which we live consists of:

- the physical environment (natural and manmade elements)
- the social environment.

People are influenced by their environment and influence the environment of others. Changes are constantly occurring within the individual, in the home, the community and the wider environment.

There are many aspects of our interaction with the environment that may cause community health problems. Society is becoming increasingly aware of the dangers of radiation and chemical pollution of food, water and the atmosphere. We appear to be a lot more conscious of the mental strains and stresses that are also present in the community and that influence individuals in different ways.

Increased individual responsibility and public awareness of environmental factors responsible for motor vehicle accidents, coronary heart disease, stroke, chronic lung disease, a number of cancers, accidental poisoning and suicide could prevent many of these occurring.

Many health problems are related to personal behaviour. Quality of life could be improved if individuals avoided hazards such as alcohol, tobacco and other harmful drugs.

Economic factors also contribute to physical and mental illness. Poverty results in inadequate housing, clothing and food — our basic physical needs. Emotional stability, social factors and personal interactions are all put under strain. There is evidence to suggest that in affluent societies, diets contain many elements which contribute to arterial disease and other degenerative conditions. These include fats, carbohydrates, excess salt and caffeine.

Staying healthy should be the aim of individuals and the community — healthy living is living life to the fullest.

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St John Ambulance Australia

2 ILLNESS

A family affair

With escalating costs of health care, and increasing shortage of hospital and nursing home beds, and changing community attitudes, many people with illnesses or special needs are being cared for at home.

Whilst all people have the same basic needs, some conditions place special demands on the caregiver. Adequate support services are necessary to maintain high quality care, to ease the caregiver's stress, and to prevent the person's premature admission to institutional care.

WHAT SUPPORT SERVICES ARE AVAILABLE?

Specialist support services operate between hospitals and homes, providing specific education, treatment and facilities. Voluntary organizations and self help groups also play a significant role in community health. Information on these groups is available from your doctor or Community Health Centre. Their phone numbers are listed in the white pages of your telephone directory.

EPILEPSY FOUNDATION OF VICTORIA

ALCOHOL & DRUG FOUNDATION

THE ASTHMA FOUNDATION VICTORIA

MS

AQA VICTORIA

Independent Living Centre

National Heart Foundation of Australia

AUSTRALIAN KIDNEY FOUNDATION

GENESIS

The Deaf-Blind Care Association

2.1 Voluntary organizations provide community health support services

WHAT CHANGES IN LIFESTYLE MAY BE EXPERIENCED?

When caring for a family member at home, the caregiver and the family may experience dramatic lifestyle changes as new situations occur or responsibilities are relocated.

Family routine is frequently interrupted. Careful planning is necessary to meet the needs of all family members. Not everyone can readily adapt to new and sometimes stressful situations.

Social trends in Australia have been towards a home being shared by parents and children, and rarely with other relatives. In some cultures, living in an extended family group is the accepted lifestyle. However, for those for whom an extended family group is a new experience, stress may exist, particularly if changes have included sharing a bedroom, with little opportunity for privacy.

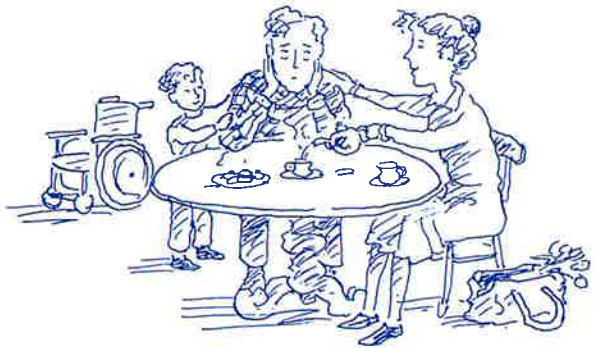
Changes in personal relationships are also likely to occur. Families need to develop good communication channels, know each others' strengths and weaknesses, and strive to understand each other. Loss of independence often leads to anger, frustration, and resentment. These feelings may be directed at the caregiver.

WHAT HELP DOES THE CAREGIVER NEED?

Circumstances vary with each particular situation and people all react and cope differently. When a crisis occurs, or in a short-term caring situation, most family members are supportive and willing to assist. However, if a prolonged need for care exists, the responsibility may rest with one or two people.

Those who are not directly involved with day-to-day care may be unaware of any problems. Whilst it may appear that the caregiver is coping well, he/she often feels depressed or isolated, and may become tired, frustrated and overwhelmed by the demands and constancy of the situation.

The caregiver needs to recognize and accept his/her limitations and seek assistance. A stressful situation can be eased by dividing and sharing responsibilities. Help can be provided through an extended family structure which includes friends, neighbours and voluntary support groups.



WHAT SPECIAL NEEDS DO PEOPLE FROM OTHER CULTURES HAVE?

People from non-English speaking backgrounds may experience problems as a result of communication difficulties and a lack of familiarity with Australian society and available services. Language and cultural differences may contribute to reluctance in seeking medical assistance. An interpreter or a family member may be able to assist with communication. Services are provided by official health interpreters and health and welfare professionals working in the ethnic community. In addition, many government health agencies produce multilingual publications.

Some cultures accept ill health as part of normal life and do not readily accept well-meaning intervention by others of different cultures. Similarly, in many cultures, caring for the disabled, the aged and the infirm is seen as a family responsibility. It is important that cultural differences are respected.

WHAT SPECIAL CARE IS NEEDED FOR THE DYING AND THE BEREAVED?

Terminal illness places greater stress on everyone than a temporary condition. An important part of caring for a terminally ill person is in relieving stress wherever possible. Acceptance of death by the ill person, family and close friends takes time and careful counselling. A deep, loving relationship provides solid support in facing death and it helps if those involved are able to freely discuss pains and fears.

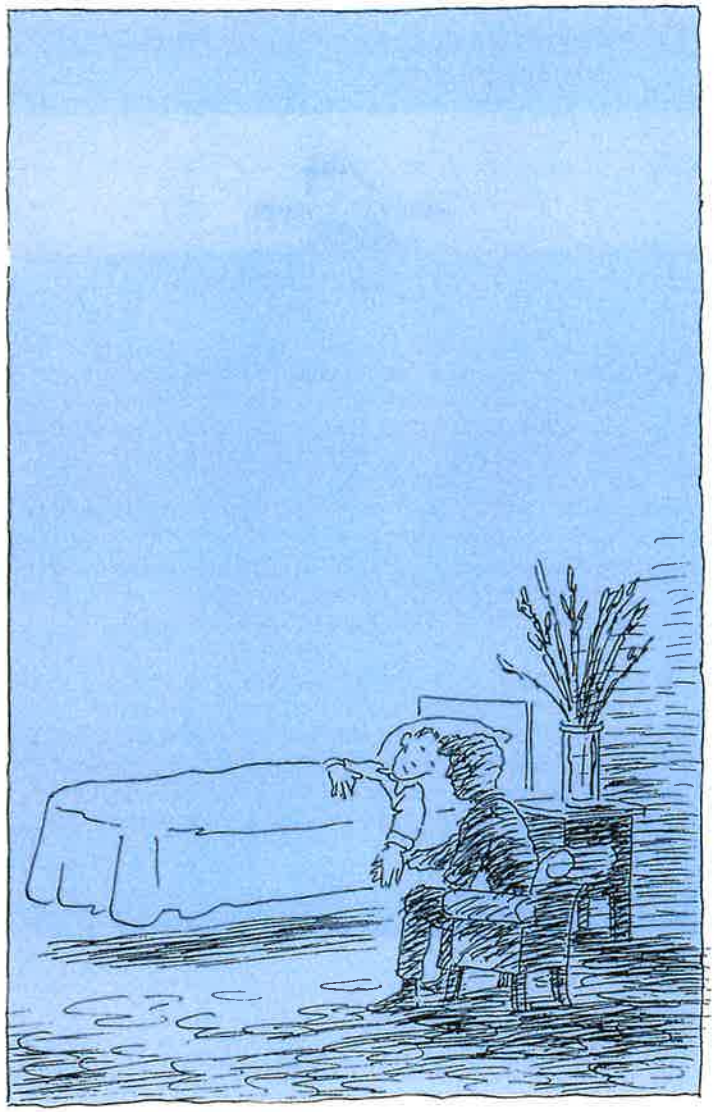
The spiritual needs of a dying person must be considered as well as physical and emotional needs. Many people find their religious beliefs give strength and courage in facing death calmly and with dignity. Some religions and cultures require specific ceremonies at the time of death, and these customs must be respected.

The dying are not always adults. Repeated visits to clinics and hospitals can be distressing for children, especially when they see other children getting better and going home. Support is available from voluntary groups, e.g. Camp Quality.

The thought of a child with a potentially fatal disease can cause extreme anguish and pain for the parents and other children in the family. While infants and toddlers have little or no understanding of what death means, older children do. They need to discuss their anxieties and feelings openly with their parents and others. They will require parental love and understanding in order to cope with the loss of a brother or sister.

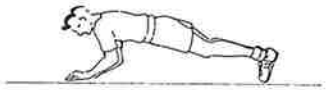
Following the loss of a child, including miscarriages and neonatal deaths, special support (available from a number of voluntary groups) and professional counselling are advisable.

In a changing society, it has become expected that people will continue with their usual routine following a family bereavement. However, recognizing the grieving process is important. Each person requires time to work through this process.



HOW CAN THE CAREGIVER COPE WHEN PROBLEMS ARISE?

- Problems need to be discussed and solutions found. Ignoring a problem tends to make it worse. Talking may reduce strain and help put things in better perspective. As well as family and friends, the family doctor, visiting nurse or a voluntary support group may be of assistance. Other professional help, e.g. from a social worker or a lawyer, may also be appropriate.
- When facing a series of problems, deal with each one separately. The overall situation may appear insurmountable, but broken down, it may become manageable.
- Arrange for some time for relaxation and recreation. Hobbies and interests outside the home may help in diverting the focus of attention from a stressful situation.
- Organize respite care if the situation is very demanding. For a caregiver to continue in the role, it is essential to have some time to maintain physical and emotional resources.



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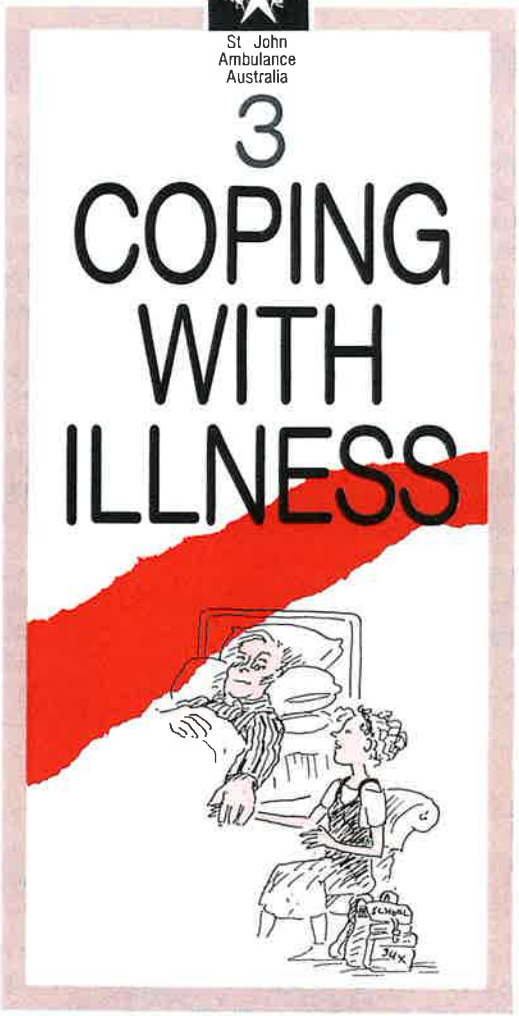
3
COPING WITH ILLNESS



Illness may provoke a variety of emotions and reactions. There is a similarity in the methods people use to cope with stress and anxiety, and how they react to ill health.

A variety of defence mechanisms develop as a response to illness and as a method of coping with that illness.

Anxiety

Anxiety is an emotion that we all experience. It is a normal reaction to stress or a threat, whether real or imagined. The perceived threats of illness or possible hospitalization, the thought of pain, the worry of trying to be brave about the outcome of the illness or the thought of being a burden on someone, can all generate anxiety. It may be aggravated by domestic and financial problems, and lack of explanation by the health care provider.

Anxiety affects people physically as well as mentally. These effects may include a rapid heart rate, clammy skin and increased perspiration. The mouth may become dry and sometimes the person may feel nauseated. The effects on personality may include withdrawal, talking and joking excessively, constant complaining and crying.

The means of coping with anxiety, whether successful or not, will vary from one person to another. Encouraging the person to talk about his/her worries and feelings may help reduce the burden. Listening and understanding can provide comfort.

Denial

Denial is a common response to ill health. The person may pretend that the symptoms of illness do not exist. Persistent headaches or the appearance of an unusual lump may be ignored. Sometimes denial complicates the recovery process. For example, a newly diagnosed diabetic may ignore a new diet.

As a coping mechanism, denial may sometimes be advantageous. It may enable the person to momentarily forget the presence of a terminal disease.

Dependence

Some ill people may be very dependent and demand constant attention. For example, the chronically ill may become comfortable with their situation. The illness reinforces the 'sick role' they have adopted. It is often difficult to change this role. The person should be encouraged to try to live as normal a life as possible.

Depression

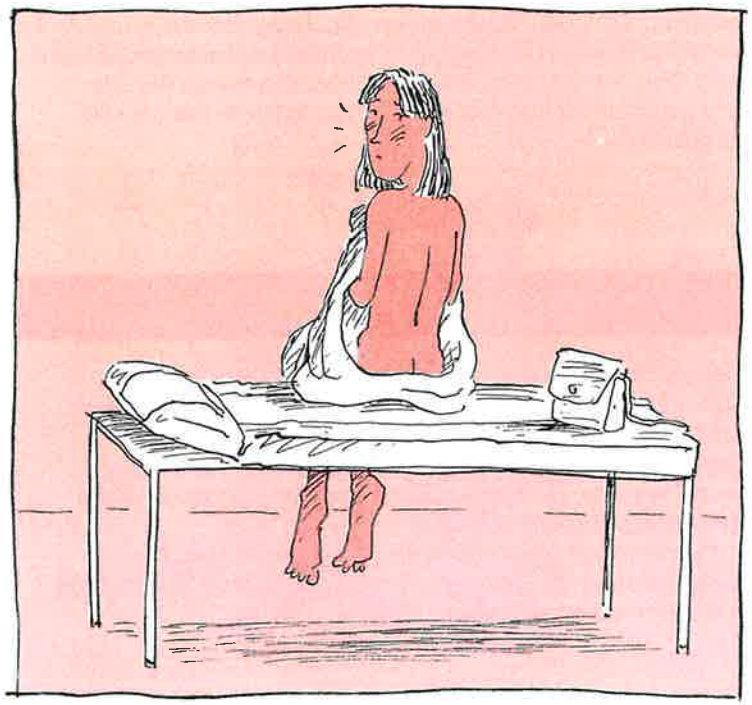
Depression is a common response to illness. Inability to cope with normal activities, e.g. after cardiac surgery or a stroke, may lead to depression. It can affect body functioning and personality. The person may suffer weight loss, poor sleep and loss of appetite. He/she may lose interest in usual activities and general appearance may suffer.

People suffering from depression need expert help. For the caregiver, the most important thing is to recognize the symptoms and seek professional help.

CHANGES IN BODY IMAGE

Body image is the way people perceive themselves as a physical whole. Society judges us by how we look, and if that image is distorted, people look at us differently. Anxiety, revulsion, disgust and pity are some reactions we show to people with an 'abnormal' body appearance, often without realizing it.

Some people feel threatened when their bodies are exposed to others. Physical examinations may lead to feelings of loss of privacy and embarrassment. The experience of unpleasant diagnostic procedures, such as a barium enema, can be upsetting.



Some changes in body appearance result from the side-effects of medication. A person receiving steroids may gain weight and develop a moonface, while chemotherapy treatment may lead to loss of hair.

Amputation of any part of the body can make the person feel incomplete. For example, a woman who has had a breast removed may not feel a 'whole' woman. The person who has had a colostomy may feel dirty and undesirable.

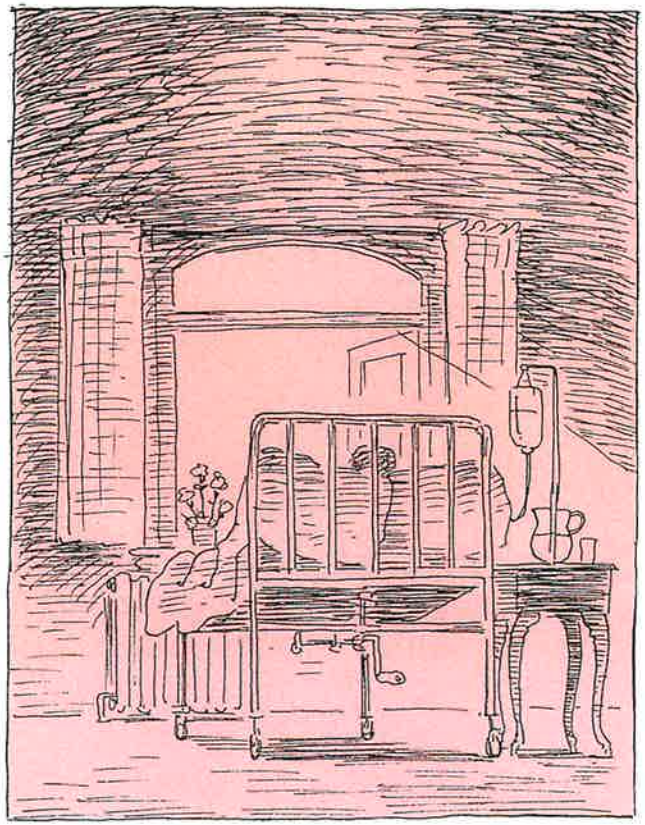
Adjustment to a new body image may take a long time. Talking about one's health and body functioning with the caregiver and close friends can help the person overcome many of the problems which must be faced when the body image changes.

Staying at home and refusing to socialize will only reinforce insecurities. Encourage the person to resume old activities, taking into consideration new limitations.

COPING WITH HOSPITALIZATION

When a person is admitted to hospital, there is natural anxiety. The routines in any form of hospitalization tend to deprive people of personal identity. The ill person may exhibit a variety of reactions.

He/she may become withdrawn and find it difficult to talk to family and friends. There may be a reluctance to speak to other people or the hospital staff, and long intervals may be spent sleeping. Family support and reassurance can restore the sense of personal identity so that in time, this phase will pass.



Hospital rules and routines tend to remove individual decision-making, so that the sense of personal control over a situation is removed. The structured existence of being told when to get up, what to eat and what to do, may alienate the person from the new environment.

He/she may be aggressive, refuse medication and develop an uncooperative attitude, which can jeopardize treatment and recovery. Reinforcement by relatives of the need to respect the medical and nursing staff's wishes and aims may be necessary.

Hospitalization may generate an attitude of command and demand. For example, an ill person may constantly summon a nurse, even for the most trivial matter. When he/she feels more secure in the new environment, this attitude will disappear.

If a person is hospitalized for a long period of time, he/she may become used to being part of the institution and resist diischarge from hospital. On return home, the person may complain of lack of service and understanding from family. With care and understanding, these feelings will pass.

HELPING CHILDREN COPE WITH ILLNESS

When children are very ill, they are not interested in much — the best care you can provide them is your time and affection, in order to help them feel secure. However, when they begin to recover, children who are confined to bed quickly become bored, particularly if they are unable to play with other children.

To help children cope with illness:

- give the child a small new toy to play with each day rather than an expensive toy which you expect to provide entertainment for the duration of the illness. This will help relieve the monotony of illness
- remember that an ill child often has a very short concentration span. Difficult puzzles and games may be frustrating. Similarly, even independent readers may prefer to be read to, or to leaf through picture books, when ill
- radio, television and videos can be relaxing – a remote control is helpful if the child is confined to bed
- drawing and painting can be enjoyed in bed. A tray with a padded underside can provide a firm surface on which to work and bedclothes can be covered with a plastic sheet. A new colouring book is enjoyed by most young children
- reading your child a story is often a good way to help him/her sleep at night.

Remember that ill children need more love and attention than usual. Try to have some special time with your child in the evening when he/she feels tired and restless. If possible, encourage brothers, sisters and friends to spend some time with the ill child so that he/she doesn't become lonely and isolated.

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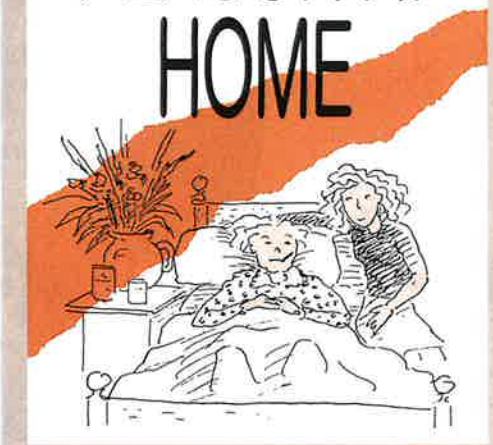
4

CARING FOR AN ILL PERSON AT HOME



CREATING A SUPPORTIVE ENVIRONMENT

Family relationships, interaction with friends and community services all contribute to the development of a supportive and friendly environment. Diversion and entertainment are also

important. An ill or incapacitated person can easily become depressed. Encourage interests within the range of the person's capabilities. New interests may need to be developed. Where possible, involvement in decisions affecting the family, or assistance with some household tasks, can help maintain self-esteem, and reduce the feeling of dependence.

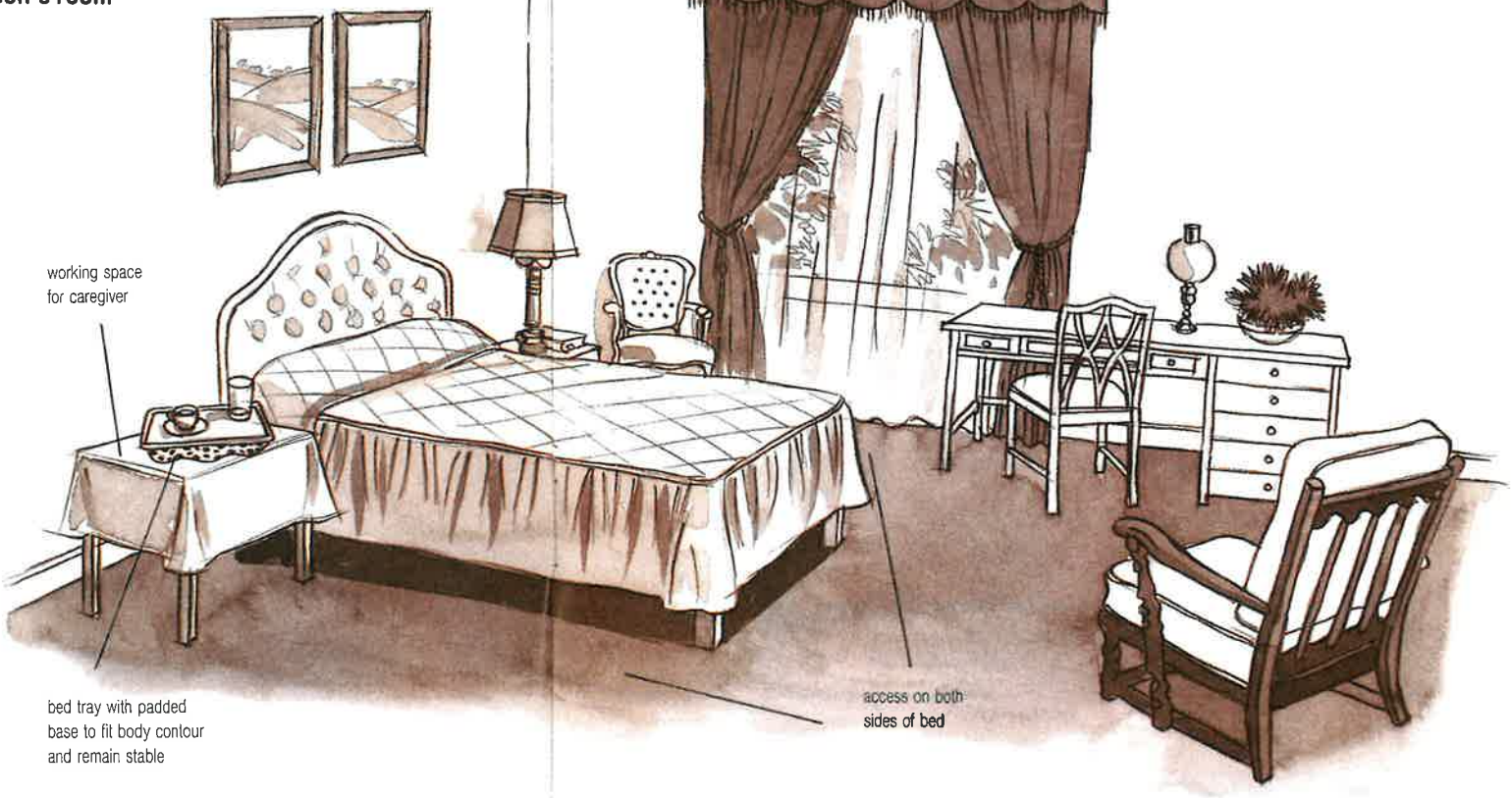
SETTING UP AN ILL PERSON'S ROOM

If possible, a ground floor room, near the bathroom and toilet, is usually the most convenient. It should be comfortable for the ill person and easy for the caregiver to work in.

Keep the room clean and fresh. If the person is to remain in bed for some time, or has a communicable disease, remove any unnecessary items from the room, if possible, to reduce cleaning. If the weather is not cold, fresh air is ideal. Heating may be necessary in winter.

If the ill person is confined to bed, it is preferable to use a single bed. This allows for easy access, preferably from both sides of the bed, and will help the caregiver avoid back injury. If possible, the bed should be located so that the person can see out of the window. The mattress should be firm and there should be sufficient pillows to allow comfort and support.

4.1 Setting up an ill person's room



PLANNING YOUR DAY

Daily activities will vary according to the ill person's special needs and the everyday happenings that occur in family life. It is important that family activities are not disrupted, and that the person feels included. Interruptions may occur during the day and plans may need to be changed. Every effort should be made to ensure that the ill person does not feel a nuisance.

- ❑ In the morning, you may need to assist with toilet needs, washing or showering. If dressings are to be changed, wait at least 30 minutes after bedmaking and cleaning so that dust has settled.
- ❑ If required, temperature, pulse and respiration should be measured at regular intervals. Medications should be given at the prescribed time.
- ❑ If the person is too sick or unable to feed him/herself, the caregiver may need to assist with feeding. If confined to bed, the person's position should be changed every 2 hours. Pressure care should be undertaken at this time.
- ❑ In the afternoon, when family members return from school and work, encourage interaction with the ill person. This will help establish a feeling of involvement in each other's lives.
- ❑ Try to spend a quiet evening so that the ill person is relaxed and comfortable for a good night's sleep.

ENSURING COMFORT IN BED

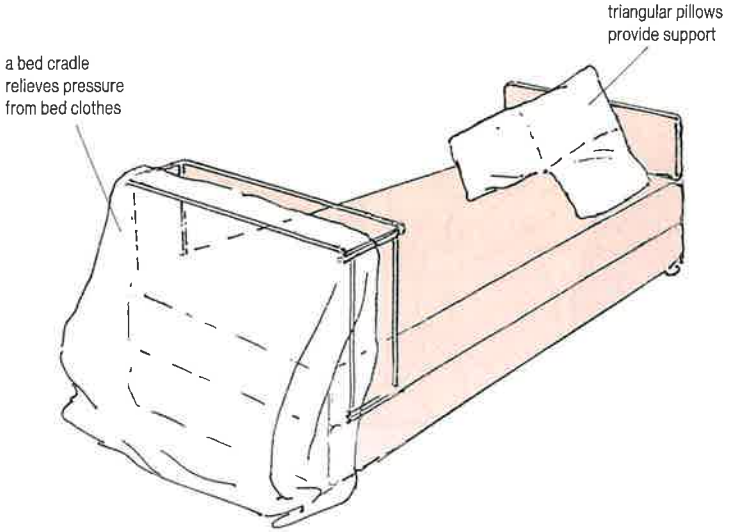
If a person is confined to bed, the bed should be neatly made and free of crumbs and wrinkles. If possible, the person should be out of bed while it is being made. However, it may sometimes be necessary to make the bed with a person in it. In this case, it is easier if two people work together. The room should be warm, and the person should be told what is happening. Soiled linen may need soaking in cold water and disinfectant before being machine washed.

4.2 Making a bed with someone in it

There are a number of appliances which may make an ill person more comfortable in bed, e.g. backrests, air cushions and sheepskins. Sheepskins should be in direct contact with the skin. Clothes and sheets should not be placed over them.

By supporting the person with three or four pillows or a backrest, he/she will be able to eat and drink without difficulty. Pillows may also be arranged to support the arms. A footrest, e.g. a pillow or a bolster, may help prevent the person slipping down the bed.

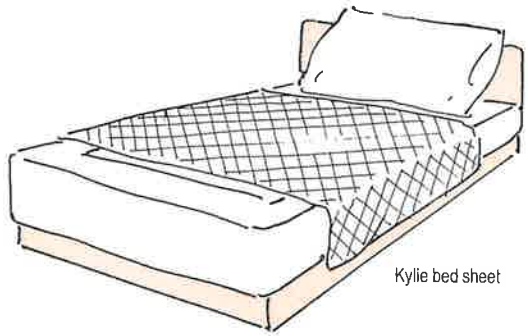
4.3 Ensuring comfort in bed

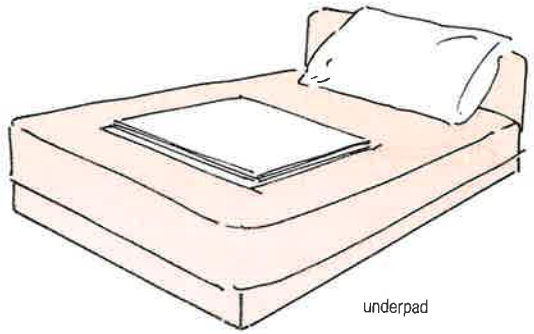


HELPING AN ILL PERSON TO SLEEP WELL

- Drink a warm beverage, unless the person is incontinent.
- Assist with toilet needs and pressure care if necessary.
- Encourage the person to listen to radio or relaxation tapes, watch TV or read.
- Freshen up with a sponge or bath.
- Use adapted night wear and bedding if the person is incontinent.

4.4 Aids for the incontinent





HELPING WITH CLOTHING

The way we dress is a very personal activity. However, sometimes caregivers may have to assist with dressing or the selection of clothing as a result of a particular illness or disability.

For many people who require assistance with dressing, independence and dignity can be maintained with the use of dressing aids. Information on these aids is available from Independent Living Centres or occupational therapists. For example, a long handled shoe horn can help someone who is unable to bend down to put shoes on.

By carefully selecting clothing, many problems with dressing can be avoided for the incontinent and the physically handicapped. Slip-on shoes may be easier to manage than lace-up shoes. For those with arthritic hands, clothing with fastenings at the front may be appropriate. Using velcro rather than conventional fastenings can also be of assistance. Trousers with braces may be easier to pull up, particularly with one hand. The community health nurse may be able to provide further advice.

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5 MOVING ABOUT

When an ill person is confined to bed for long periods of time, change position frequently, usually two hourly, to prevent pressure sores and other complications such as respiratory problems, and to improve circulation. The person will also need to sit up for meals. Help may be needed to do this.

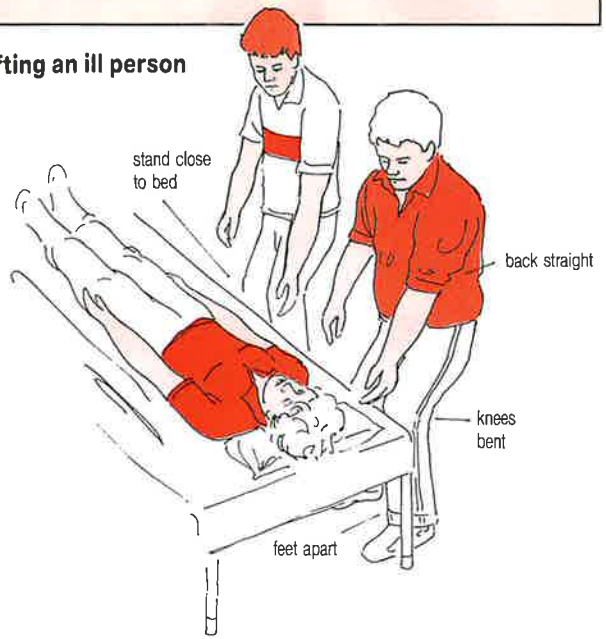
Some people may need help walking, e.g. those recovering from a stroke.

HOW SHOULD AN ILL PERSON BE LIFTED?

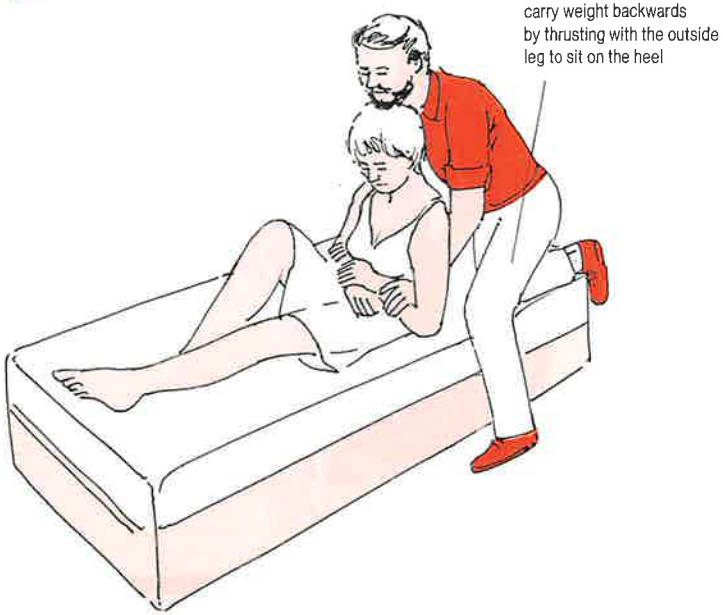
Correct lifting techniques will prevent discomfort to the ill person and back injury to the caregiver:

- tell the person and your assistant what you are going to do
- face the direction of the move
- place the feet far enough apart to maintain good balance
- stand close to the bed
- avoid lifting from the floor level
- keep the line of the back straight, with head erect and chin tucked in
- bend the knees to bring your body to work level. Do not bend your back.
- keep your elbows close to the body while lifting
- give a signal when ready to start and both move at exactly the same time — most of the weight should be directed to the leg muscles
- utilize the person's capacity for self help.

5.1 Lifting an ill person



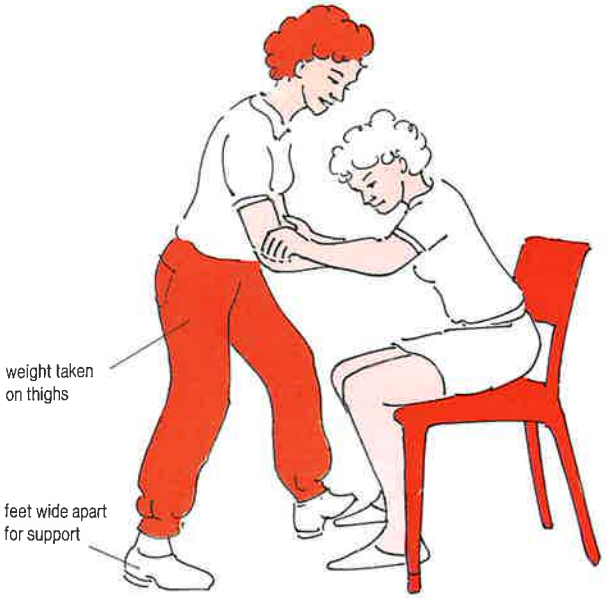
5.2 Helping someone sit up in bed



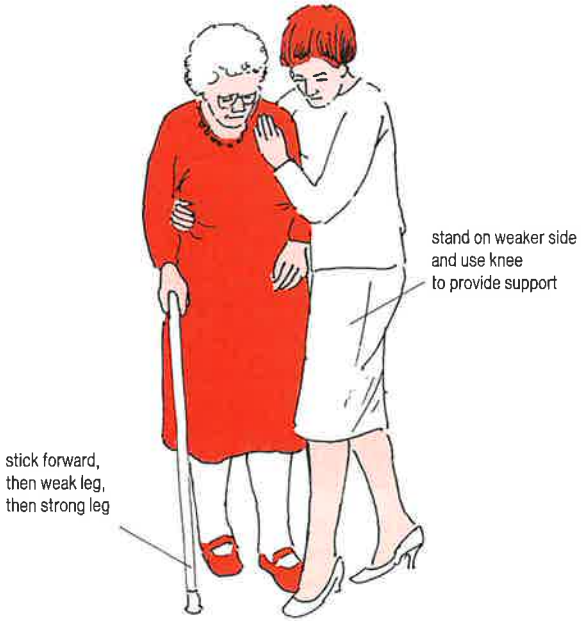
5.3 Helping someone sit up in bed (two helpers)

5.4 Helping someone from a bed to a chair

5.5 Helping someone who is sitting down to stand up

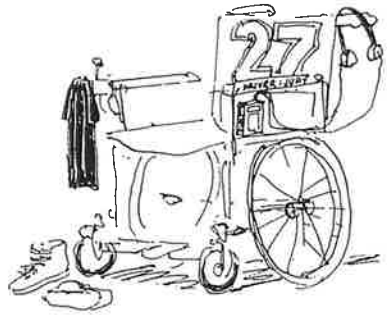


5.6 Helping someone to walk



WHAT HELP DOES SOMEONE IN A WHEELCHAIR REQUIRE?

The disabled person confined permanently to a wheelchair will be very familiar with the way to use it and will probably instruct you about the specific help needed, if any. The person most likely to need help using a wheelchair is the temporarily incapacitated or a frail elderly person.



Remember:

- note the position of the wheels and brakes, and establish whether the armrests and footrests are fixed or movable
- before moving someone into a wheelchair, check that the brakes are on, and the footrests are up or to the side. If the footrests are stepped on, the chair may tip forward
- electric wheelchairs are usually operated from a lever on the armrest and run on batteries that can be recharged overnight
- check how to use the wheelchair on slopes and steps
- carry out regular maintenance, including cleaning and checking for flat tyres.

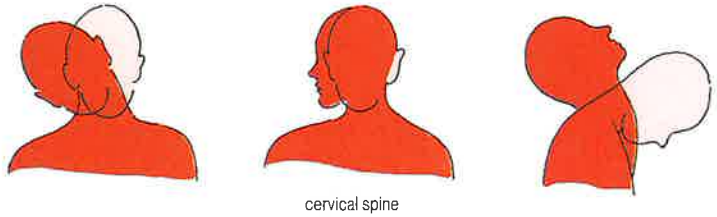
WHAT EXERCISES CAN AN ILL PERSON DO?

Passive and active exercises are necessary to prevent deformities and complications of illness or injury, e.g. pressure sores and pneumonia, and to maintain muscle strength and joint function.

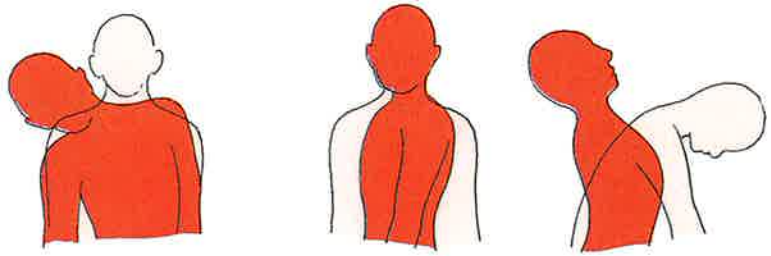
Passive exercises, performed by the caregiver, should be done by placing the person in a relaxed and comfortable position, arms by the side, knees straight and legs extended. The joints should be moved slowly and rhythmically within the pain limits, to the point of resistance. These should be carried out each time the person's position is changed.

Active exercise, performed alone by the ill person, includes frequent deep breathing to expand the lungs and to prevent chest complications. Tightening and relaxing of thigh and calf muscles, to prevent wastage of muscle and blood clots, must be performed regularly.

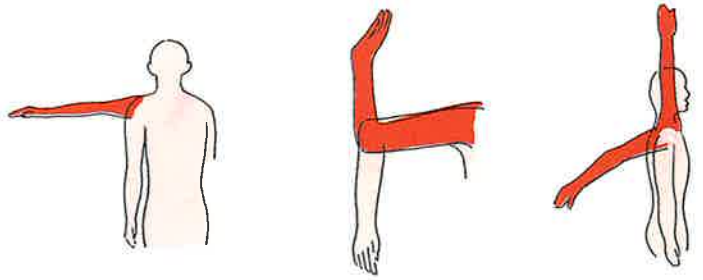
5.7 Passive exercises



cervical spine

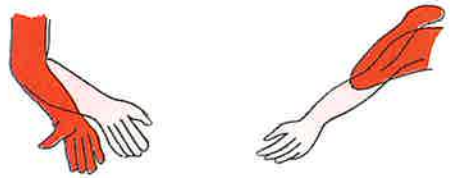


trunk



shoulder

leg



arm and hand

knee

wrist

ankle

fingers

toes

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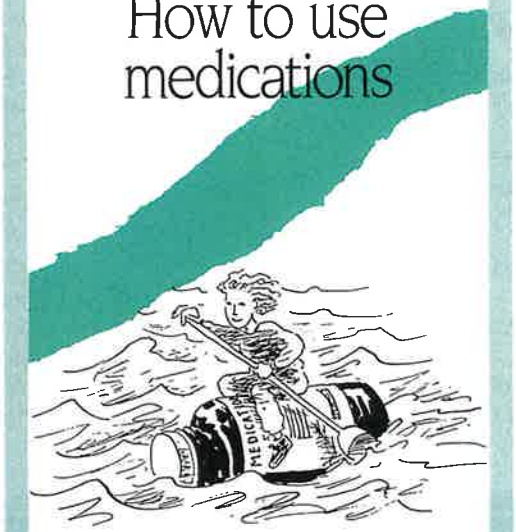
6 GIVE AS DIRECTED

How to use medications



WHAT IS A MEDICATION?

A medication is a substance used to:

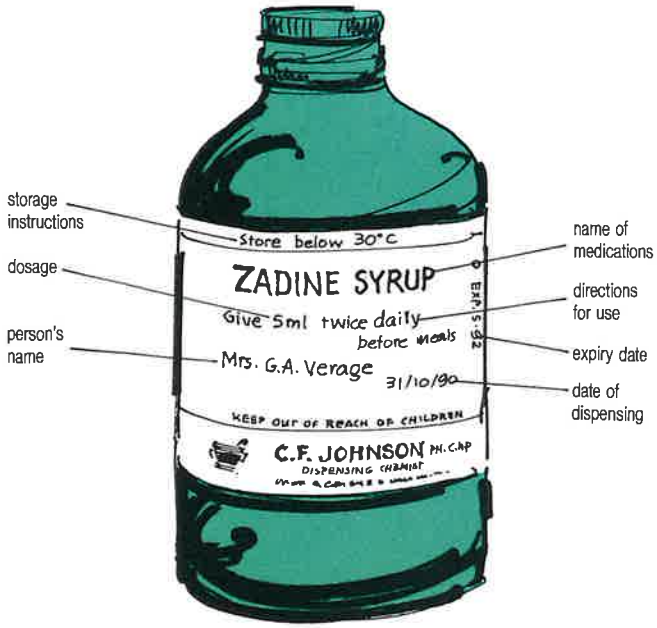
- promote healing, e.g. antibiotics to fight infection
- relieve symptoms, e.g. analgesics for pain
- prevent further illness, e.g. a medicine to control heart rate.

All medications are potentially dangerous if misused in any way.

WHAT ARE PRESCRIBED MEDICATIONS?

Medications may be prescribed by a doctor and should be given according to his/her directions.

6.1 Prescribed medications



CAN ANYONE ELSE PROVIDE ASSISTANCE WITH MEDICATIONS?

The *community nurse* may order non-prescription medications, e.g. an inhalation for clearing the airway or a proprietary substance for minor pain. The nurse works closely with the doctor and will give the caregiver instructions and assistance with the administration of medication.

The *pharmacist* is also able to assist with the selection of *proprietary medications* which may be of use. It is wise to check these with the community nurse or doctor so that duplication or conflict in treatment can be avoided.

WHAT SAFETY PRECAUTIONS SHOULD BE TAKEN WITH MEDICINES?

Store all medications out of reach of children. Check the label for storage instructions. Some medications require refrigeration or storage away from light or heat.

Check the expiry date. Some medications have a very short shelf life when opened, e.g. eye drops.

Do not give any medication from an unlabelled container or from a container with a damaged label which cannot be read. If instructions for use are unclear, check with the pharmacist or community nurse.

Never return a medicine which has been poured out back into its container. Discard it.

Always dispose of out of date or unused medications safely, by incineration, flushing down a non-septic tank toilet or by returning to your local pharmacy or hospital.

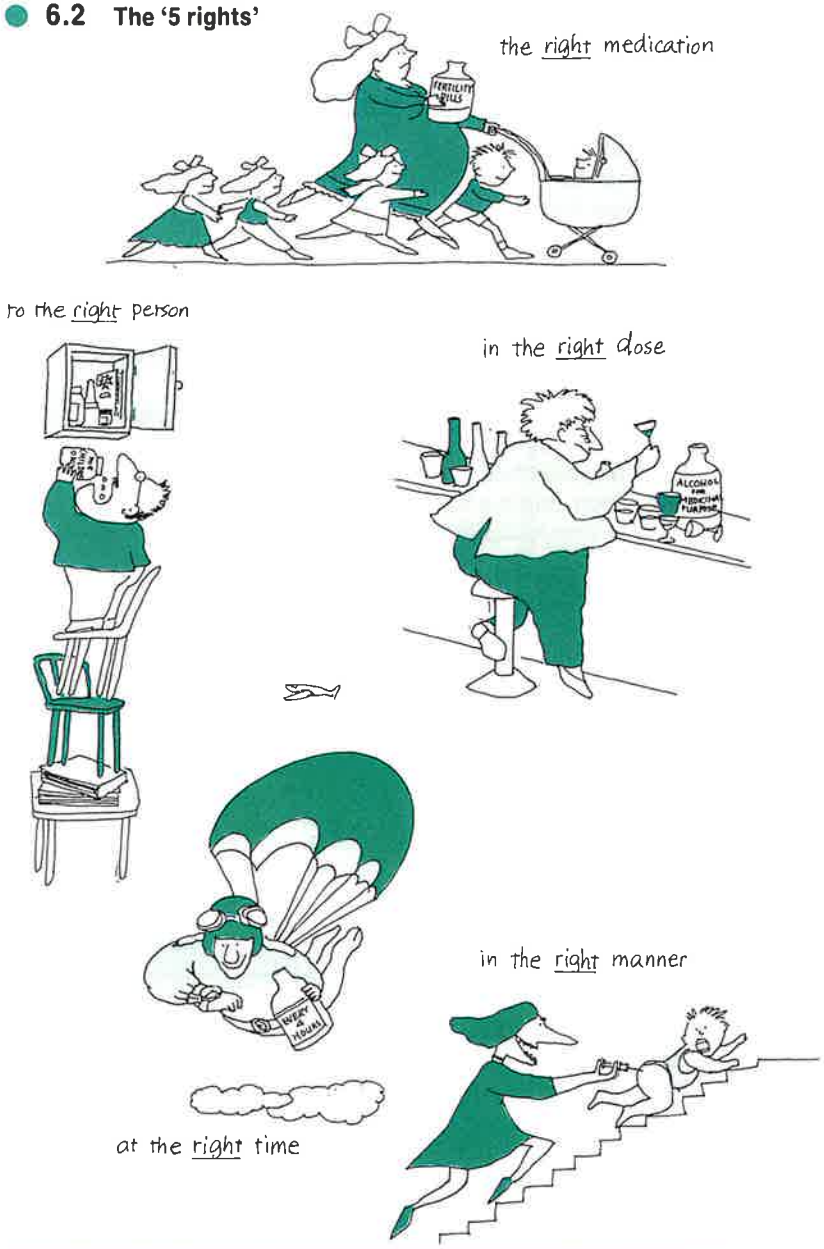
When giving any medication, you should:

- check the directions on the label before opening the container and again before dispensing the dose
- use a 'non-touch' technique when dispensing, using a medicine glass, spoon or small dish
- check the label again before returning the container to the cupboard
- explain the procedure to the person
- give the medication
- record the dose, the time given, the method and the date on the medication record if required.

Always watch for any reactions to a medication and report these to the doctor. Reactions could include:

- skin rashes
- breathing difficulties
- soft tissue swelling
- nausea, vomiting and diarrhoea
- undue drowsiness or excitability
- changes in pulse rate
- vision changes.

6.2 The '5 rights'



WHEN SHOULD MEDICATIONS BE GIVEN?

Daily:	Usually given at the same time each morning, except for sedatives which are given at night.
Twice daily:	8 am and 8 pm unless otherwise directed.
Three times daily:	6 am, 2 pm, and 10 pm, or as ordered (e.g. after meals).
Four hourly:	2 am, 6 am, 10 am, 2 pm, 6 pm, and 10 pm. If the doctor does not want the person to be woken at night, other instructions will be given.
Before food:	1 hour before meals.
After food:	1 hour after meals.
With food:	During meals.
At night:	When person is settling for bed.

HOW CAN CHILDREN BE ENCOURAGED TO TAKE A MEDICATION?

It is important to gain a child's confidence before attempting to give a medication by explaining exactly what is required. Offer the child a drink following the medication and give praise for taking the medication so well.

HOW SHOULD ORAL MEDICATIONS BE GIVEN?

These may be in liquid, tablet, pill, capsule or powder form. Use a 'non-touch' technique when giving oral medications. If it is necessary to crush tablets to aid swallowing, place the tablet on a spoon and crush with a second spoon. Mixing the medication with honey or jam may make it more palatable, especially for a child.

How is an inhalation given?

Nebulizers are used to administer medications for asthma. There are many types and the administration procedure for each may differ. The medication is delivered in a fine spray which is inhaled. Usually the person is able to self-administer the dose. However, help may be needed by children, the elderly or the frail.

Steam inhalations are often used to administer medications to clear and soothe blocked air passages. Examples are Friar's Balsam, eucalyptus and menthol. These are mixed in hot water that has been boiled and allowed to stand for 5 minutes.

6.3 Giving an inhalation

Giving a steam inhalation is potentially dangerous and should always be closely supervised, especially with children. There is a danger of scalding if the container of hot fluid is tipped over.

What is a rectal suppository?

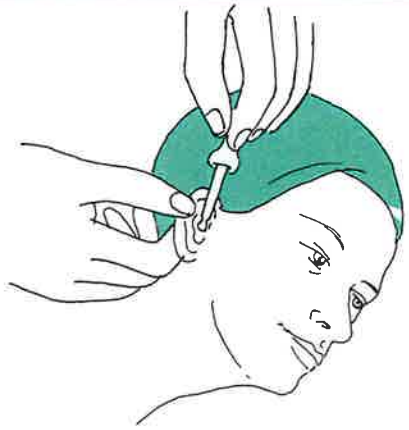
Rectal suppositories may be ordered for a variety of reasons, including the control of nausea and vomiting, the relief of chronic pain and haemorrhoids, or for constipation.

What is a topical medication?

Topical medications may be in the form of an ointment, lotion, cream or gel and may be ordered for skin rashes or ulcerations. They must not be taken internally. The person should be observed for any allergic reaction. When applying a topical medication, it is recommended that gloves be worn.

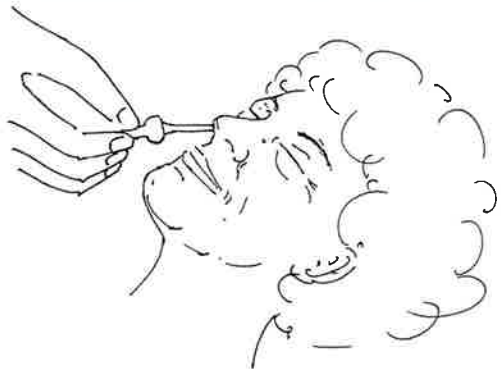
How should ear, nose and eye drops be given?

6.4 Giving ear drops — the person should keep the head still for a few minutes after drops are inserted



6.5 Giving eye drops — ease the lower eyelid downward and insert drop, being careful not to touch the patient's eye with the dropper

6.6 Giving nose drops — this may be done with the person lying down or sitting down with the head tilted back



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7

CARING FOR AN ILL PERSON

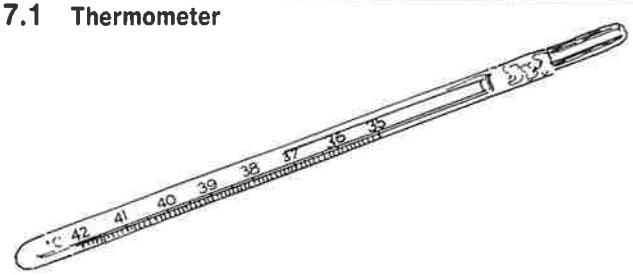
What to observe

Careful observation of the ill is important, particularly when caring for those who cannot always make their needs known, such as infants, the elderly and the terminally ill. Any alteration in the person's condition should be noted, and appropriate action taken.

TEMPERATURE

Normal body temperature is between 36.1°C and 37.1°C. It is common for the elderly to have a temperature below 36°C. The body's temperature may vary throughout the day. If the temperature rises and remains above normal, the person should be referred to medical aid.

7.1 Thermometer



The temperature is usually measured in the mouth for adults, unless they are:

- breathless
- very ill
- suffering injuries to the mouth and nose
- recovering from a mouth operation
- delirious, confused or mentally ill
- unconscious.

In these cases, and for children, the temperature is taken under the arm.

To take the temperature, pick up the thermometer (not the bulb end) and shake the mercury down to 35°C. When taking the temperature in the mouth, the bulb end of the thermometer is placed under the tongue for at least 2 minutes. To measure the temperature under the arm, ensure the underarm and thermometer are dry. The bulb is placed between the folds of skin and the arm is folded across the chest so that the thermometer will stay in place. Leave it in place for at least 10 minutes. Always stay with the person while taking the temperature.

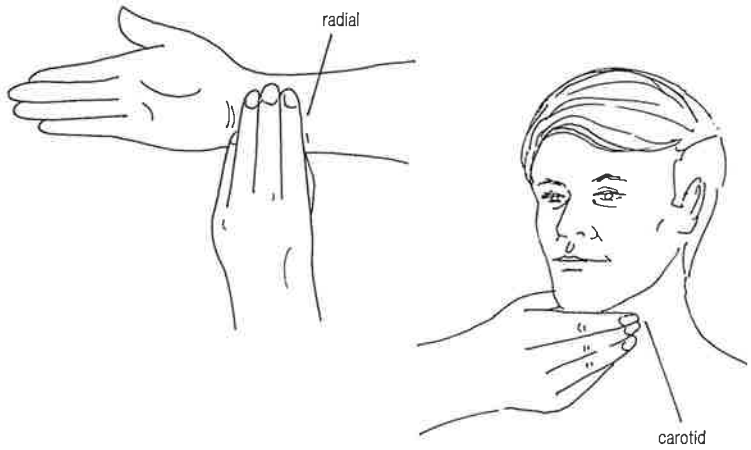
THE PULSE

The pulse may be felt in any artery which passes over a bone near the surface of the body, but is commonly taken on the front surface of the wrist on the thumb side (radial pulse) or on the side of the neck near the windpipe (carotid pulse). Taking the pulse gives information about the action of the heart and the person's general condition.

The observations made about the pulse are its rate, rhythm and strength.

The *rate* is the number of beats each minute. Exercise, some drugs and emotion can influence the pulse rate. The person should be at rest for at least 10 minutes before the pulse is taken.

7.2 Taking the pulse



	Average pulse rate
Infancy	120–140 beats per minute
Childhood	100–120 beats per minute
Adulthood	60–90 beats per minute
Old Age	< 60 beats per minute

The *rhythm* is the regularity of the beat. The normal pulse has a regular rhythm with evenly spaced beats.

The *strength* of the beat is influenced by a variety of factors. The pulse may be very strong or bounding after exercise or if the person has a fever or high blood pressure. It may be weak, soft or easily compressed, if the person is haemorrhaging or has heart disease.

Respiration

The main function of breathing is to provide oxygen to the body's cells and to remove excess carbon dioxide. Breathing is a reflex action although at times it can be adjusted at will. The complete rise and fall of the chest is one respiration.

The *rate* is the number of breaths in one minute. This may increase if the person has a fever or respiratory infection. It may decrease as a result of some drugs, or if the person has brain damage.

Average respiratory rate	
Infancy	30–50 breaths per minute
Childhood	20–36 breaths per minute
Adulthood	16–18 breaths per minute

It is important to note the *regularity* of respirations. Breathing may become irregular if the person is anxious or worried.

The *character* of respirations should also be noted. Breathing may be noisy, shallow or associated with effort, such as in asthma or bronchitis.

To count the respirations accurately, the person must be unaware of the procedure. Once the person is aware that the respirations are being observed, the rate will alter involuntarily. The best time to make the observation is when he/she is asleep, or alternatively when the pulse is being taken. After the pulse has been counted, leave the fingers in position and count the rise and fall of the chest.

Skin

When observing the skin, note:

- colour
- whether dry or moist, hot or cold
- if rough or smooth
- any bruises
- any rashes.

Flushed skin may be due to a high temperature or high blood pressure, while pale skin may be the result of anaemia or shock. Cyanosis, a bluish tinge in the skin due to lack of oxygen in the body tissues, is observed in some heart and lung conditions, and when there is an obstruction to the airway. Jaundice, a yellow colour of the skin, whites of the eyes and mucous membranes, is common in people who have diseases of the liver or gallbladder.

Oedema

Oedema is swelling due to excess fluid in the subcutaneous tissues and may be seen in the ankles, abdomen, under the eyes or other soft tissues. It may occur in advanced kidney or heart disease and pregnancy. It may also be found at the base of the spine if the person has been sitting for a long period.

Pain

Pain is an unpleasant sensation causing suffering or distress. Pains arising in different organs vary in their site, character and duration. The reaction to pain varies from one person to another.

Some pain has definite characteristics, e.g.

- angina — a constricting pain felt behind the breastbone. It usually occurs during exercise or strenuous activity, and is alleviated by rest and medication. Angina may be mistakenly associated with pain from indigestion
- colic — intermittent pain which worsens in short, regular bursts, and as a result of spasm of the organ involved. It is usually a sign of inflammation or obstruction, e.g. of the bowel, bile duct or kidney
- referred pain — is felt at some distance from its true origin, e.g. pain arising in the hip may be felt in the knee.

The following observations about pain should be noted:

- whether the onset of pain is sudden or gradual
- location
- duration and whether it is continuous or spasmodic
- character, e.g. shooting as in toothache, aching as in muscle pain, throbbing as in inflammation
- effect — this may be seen in the person's facial expression and posture
- occurrence — whether the person has pain on awakening or in the evening, whether it is aggravated by eating or exercise.

Urine

Urine is a waste material filtered by the kidneys and composed mainly of water. Its normal colour ranges from clear yellow or straw colour to deep amber. A change in colour may be the result of a variety of factors. If it is dark it may be concentrated due to infection or the result of a reduced fluid intake. A bright or smoky red colour may be due to the presence of blood. People with liver disease may produce urine that is greenish brown. Some food substances and drugs may also change the colour of urine. Urine is normally clear to slightly cloudy in consistency. This may change if infection is present.

Normal urine has only a faint smell, but if there is any infection in the bladder, the urine may have an offensive smell. An acetone smell to the urine may be noticed in those who have diabetes or if the person is dehydrated due to excessive vomiting.

The amount passed every 24 hours is approximately 1–2 litres but will vary according to the individual's fluid intake and the weather. The amount may increase in diabetes and certain kidney conditions, or decrease in the presence of fever or excessive vomiting.

Vomit

Food may be vomited if the person has a gastrointestinal disorder. Observe the character of vomit — bile or blood (bright red if fresh or resembling coffee grounds if stale) may be present.

Bowel

Constipation occurs for a variety of reasons including poor diet, inadequate fluid intake and failure to respond when the demand to move the bowel is felt.

Diarrhoea may be due to dietary causes, infection from contaminated food and nervousness. Black tarry stools occur if there is bleeding in the upper part of the digestive tract or an ulcer.

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

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8

CLEAN AND COMFORTABLE

To promote feelings of independence and recovery, ill people should be encouraged to move to the bath or shower. A stable stool or chair may be used for support. Information on bathing and showering aids is available from Independent Living Centres. If a person is confined to bed, he/she should be washed and sponged every day.

8.1 Showering aids promote independence

Those who perspire freely or have oily skin need to wash more frequently than others. If the skin becomes irritated or excessively dry, it may be necessary to change to another brand of soap. Creams or oils may be used sparingly to correct dryness. After washing, the skin should be thoroughly dried.

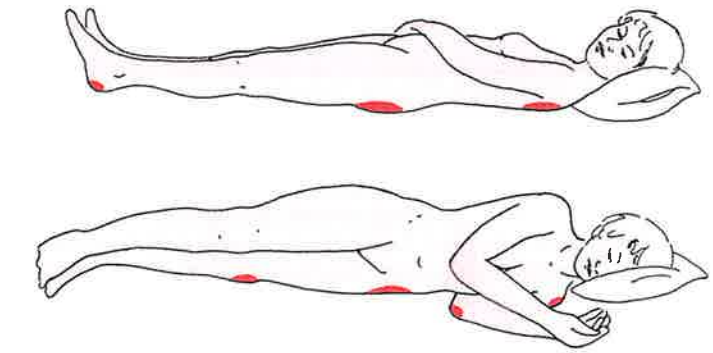
WHAT ARE PRESSURE SORES?

A pressure sore is an area of dead tissue caused by:

- prolonged pressure on any one area of the body, resulting in diminished blood supply to the area
- repeated friction over a certain area, e.g. by wrinkled or darned sheets, a loose bandage, crumbs in the bed
- exposure to moisture. The ammonia in urine and faeces also irritates the skin.

Pressure sores can occur when a person is confined to bed or sits in a chair for long periods.

8.2 Areas where pressure sores may occur



Some people are more at risk and require extra attention. These include:

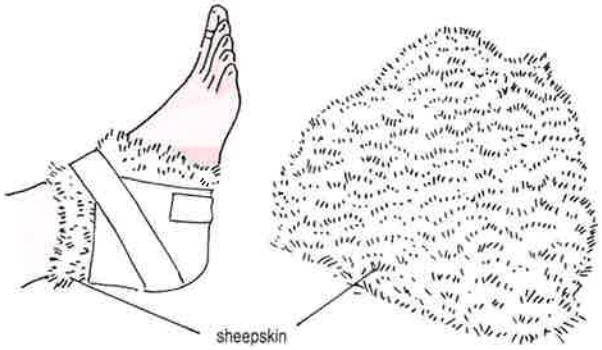
- very thin people
- obese people
- those who are paralysed or unable to move freely
- those who are incontinent
- people with disorders which affect circulation of the blood.

HOW CAN PRESSURE SORES BE PREVENTED?

Pressure sores can be prevented by:

- application of creams, e.g. barrier, zinc, vitamin E
- 2 hourly changes of the person's position and passive exercises. When sitting, the person can move onto alternate buttocks every 2 hours
- a well made bed. If possible, linen should not be patched or darned. Wrinkles and crumbs should be removed
- careful handling of equipment and good nursing procedures to prevent damage to the skin.

8.3 Aids to prevent pressure sores



HOW DO YOU SPONGE SOMEONE IN BED?

Make sure that the room is warm enough, and that towels, toiletries and clothing are within easy reach. Offer the person a bedpan before beginning. Wash and dry all areas of the body thoroughly, noting any signs of pressure sores or injury to the skin. If possible, bathe each foot in a bowl, and dry thoroughly especially between the toes. After sponging, carry out any special care of the skin and massage the back with a soothing cream. Help the person clean the teeth, brush hair and shave if necessary.

HOW CAN HAIR BE WASHED IN BED?

People who are confined to bed for a long time will need to have their hair washed. A dry shampoo in an aerosol spray may be useful in between shampoos. An alternative method is to rub through the hair with a soapy face washer, and rinse in the same way. This is useful for very ill or frail people, or people who have marked hair loss following chemotherapy.

When washing a person's hair in bed, it is easier if you have an assistant. If the bed has no back, the person can be lifted further up the bed, with the head slightly over the edge. One attendant supports the head, while the other washes the hair. If the bed has a bedhead, pull the mattress down over the edge of the bed and place a plastic sheet and bowl on the bed base. If this is not practical, the person can be moved to the side of the bed, with the back of the head towards the edge.

How can the caregiver help with bedpans and urinals?

If a person is confined to bed, unable to go to the toilet or use a commode, a bedpan or urinal will be necessary. These may be purchased from chemists or hired from Community Health Centres. In an emergency, a wide-mouthed jar may be used as a substitute urinal.

When giving a bedpan, ensure that clothing is free of the pan. Slide the pan underneath with the wide end towards the person's waist. If possible, help the person to sit up, then leave alone. Provide a bowl, soap and towel for hand washing. After emptying the pan and checking for any abnormalities such as blood in the urine, wash your hands thoroughly.

When giving a urinal, warm it if not made of plastic. If the person is very ill, you may need to place it in position. If possible, allow the person to stand or to sit up with the legs over the side of the bed. Measure and record the volume of urine passed if required.

How can the caregiver help someone with urinary incontinence?

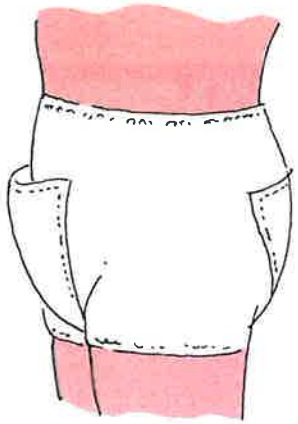
Urinary incontinence occurs when the person is unable to control the overflow of the contents of the bladder. This is more common than faecal incontinence. It may be the result of a disorder of the nervous system, or may be due to a weakness in the neck of the bladder, particularly in women who have had several children.

Sometimes the person may have stress incontinence, i.e. urine is passed involuntarily if the person laughs, sneezes or coughs.

Many people with incontinence can be educated to control the bladder outflow by voluntarily passing urine at regularly spaced intervals, e.g. 2-hourly, and also by limiting their fluid intake, especially in the evening.

The use of sanitary pads and incontinence pants helps in the management of people with incontinence.

8.4 Fitted incontinence pants



WHAT IS RETENTION OF URINE?

Retention is the inability to pass urine. It occurs more frequently in males than females and may be due to the following reasons:

- obstruction to flow, e.g. enlarged prostate gland in men over 70
- interference with the nerve supply, e.g. following surgery for uterine prolapse or hysterectomy
- unnatural position for passing urine, e.g. male confined to bed or needing to lie flat at all times
- constipation, particularly in the elderly.

Retention usually causes the person severe discomfort. Sometimes a warm bath will encourage the flow of urine. Privacy should be ensured. A pain relieving drug, e.g. paracetamol, may also be given.

Failure to pass urine may not necessarily be due to retention. It may be due to failure or shut down of the kidneys. In this case, there is usually no pain. Medical aid must be sought promptly.

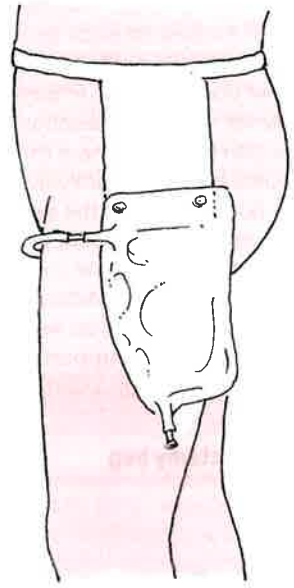
WHAT CARE DOES A PERSON WITH A CATHETER NEED?

A catheter may be inserted into the bladder to relieve urinary incontinence as a short- or long-term measure. Many people are taught to self-catheterize as part of their self management of conditions such as paraplegia, spina bifida, etc.

The urine drains from the catheter into a tube and then into a bag strapped to the leg and support by a waist belt. A drainage bag which can be emptied by a valve at the end is most commonly used. Before emptying, the tip of the valve should be washed with an antiseptic swab to avoid contamination. The bag should be emptied at 8-hourly intervals or whenever it fills. The volume should be measured and recorded.

The bag should not be raised above the level of the bladder as this will cause the reflux of urine in the bladder from the bag. It is important that the area around the urethral opening be cleansed with soap and water. If the catheter comes out for any reason, the doctor should be notified. It is usual to have a urine examination from time to time to check for signs of contamination or infection.

8.5 Catheter and bag



WHAT CARE DOES A PERSON WITH A COLOSTOMY NEED?

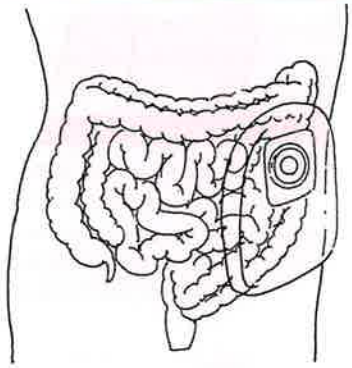
A colostomy is formed when a portion of the large bowel is brought through the abdominal wall, making a temporary or permanent opening. The aim is to provide an outlet for intestinal waste products.

Many people with colostomies live their lives without any apparent difference from those without the disability. The method of coping with a permanent colostomy varies from person to person. The person needs to know that a colostomy will not disturb his or her way of life, and that with patience, the technique of living with a colostomy can be mastered.

Some are troubled by a feeling of being unclean, finding it difficult to adjust to the bowel motion emptying into a bag on the abdominal wall. However, positive reassurance and active support by the family can help overcome this problem.

Disposable colostomy bags are readily available and the person will be taught how to care for the bag and the colostomy opening (stoma). Care must be taken that the skin does not become moist and inflamed around the colostomy. Dietary modifications will also be necessary. Advice can be obtained from the doctor or community nurse, as well as from stoma therapists who will visit the home. Support groups such as the Colostomy Association can provide assistance and solutions during initial difficulties.

8.6 Stoma and colostomy bag



WHAT IS FAECAL INCONTINENCE?

Bowel control may be lost for a variety of reasons. One of the most common causes of diarrhoea and faecal incontinence in the elderly may be severe constipation. The person should use the toilet at regular intervals so that a pattern may be developed. If this is not possible, he/she should be kept clean because of the danger of pressure sores. Special incontinence pants with a pad can be worn, providing greater security for the person when incontinence does occur. Use disposable pads and dressing sheets on the bed and chairs. Faecal incontinence can be very embarrassing, and the caregiver should provide support and reassurance.

WHAT IS CONSTIPATION?

Constipation may be caused by poor dietary habits, certain medications, muscle weakness, fever and dehydration. The condition can be relieved by medication. A high fibre diet, with plenty of food, fluid and exercise will contribute to prevention. The key to the management of constipation is the correction of dietary habits and the re-education of the bowel by retraining the person in his/her toilet habits.

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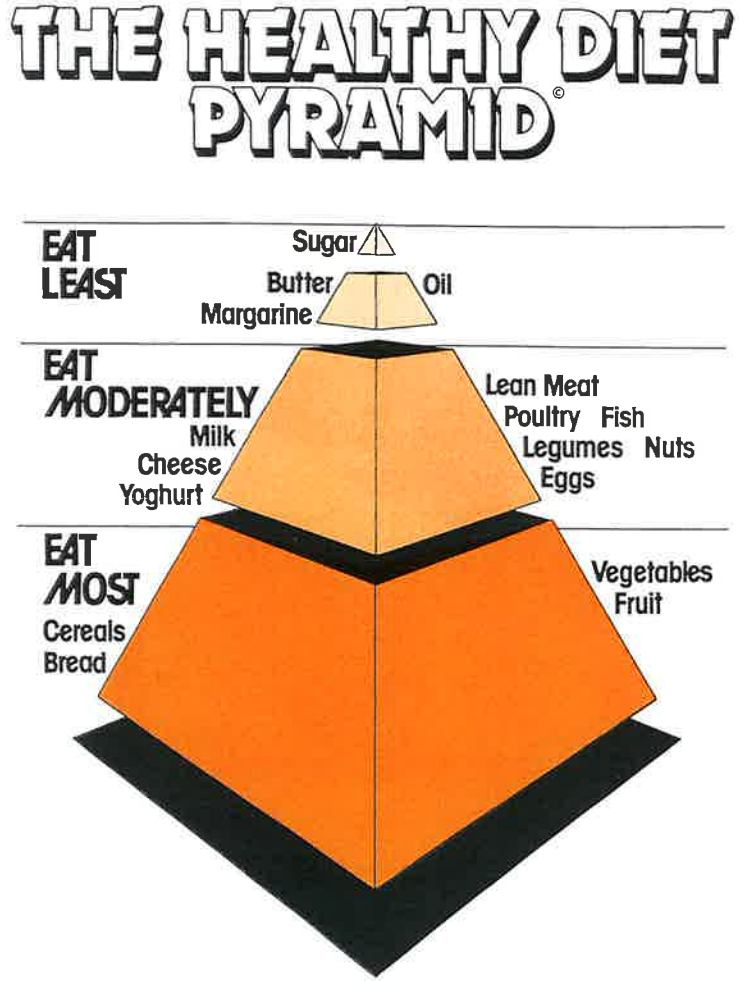
9 EATING WELL

Eating well means living well. A healthy diet does not have to be a boring or restrictive diet, and it can help prevent diet-related lifestyle diseases such as heart disease, cancer and diabetes.

The Australian Nutrition Foundation's Healthy Diet Pyramid is a good plan for healthy eating.

9.1 The Healthy Diet Pyramid



(reproduced courtesy of the Australian Nutrition Foundation)

WHY SHOULD WE EAT LESS FAT?

Fat is a concentrated source of energy which provides more than twice as many kilojoules as the same weight of protein or carbohydrates. As physical activity lessens in Australia, consumption of fat has been increasing, leading to many overweight and obese people in our community. There is also evidence suggesting that a high fat diet contributes to the occurrence of diseases such as heart disease, stroke, diabetes and some forms of cancer.

HOW CAN FAT INTAKE BE REDUCED?

Fats are found in butter, margarine and oils. They are used in the preparation of fried foods, pastries, and snack foods such as chips and biscuits. These snack foods can be replaced by bread, vegetables and fruits.

Meat also contains fat. Consumption of fat can be reduced by choosing lean meats, trimming off excess fat, and using cooking methods that require a minimum of fat.

Dairy products contribute significant quantities of fat in our diet — this can be reduced by using low fat and reduced fat products.

9.2 Aim to reduce fat intake

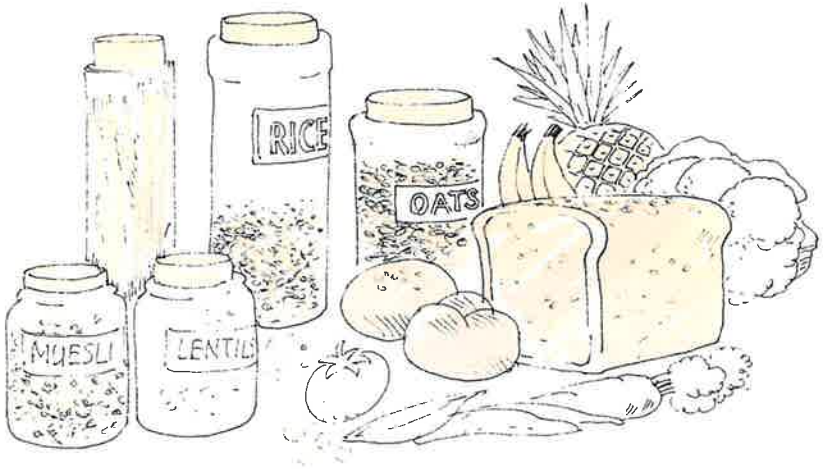
WHY SHOULD WE EAT MORE FIBRE?

A high fibre intake promotes normal bowel action and prevents constipation. This helps reduce the risk of diverticulitis, and may also reduce the risk of bowel cancer. Some fibres also help lower blood cholesterol. High fibre foods help satisfy the appetite, thus reducing the risk of obesity.

HOW CAN FIBRE INTAKE BE INCREASED?

Use wholemeal bread, rice and pasta instead of refined brands. At least four slices of wholemeal bread and one serve of wholegrain cereal should be eaten each day. Fruit and vegetable intake should also be increased. Legumes such as beans and lentils can be added to soups, stews and casseroles.

9.3 Aim to increase fibre intake



WHAT OTHER HEALTHY EATING HABITS SHOULD BE ENCOURAGED?

- ❑ Eat less sugar — use less sugar in tea and coffee, and limit honey, jam, sweets and cordials.
- ❑ Eat less salt and lessen the risk of high blood pressure: cook without salt (try using alternative ingredients such as herbs, garlic, pepper, spices and lemon juice) and choose processed foods with reduced salt. Eat less salted foods, e.g. bacon and snack foods.
- ❑ Drink less alcohol or skip it altogether.
- ❑ Take time to relax and enjoy your meals.

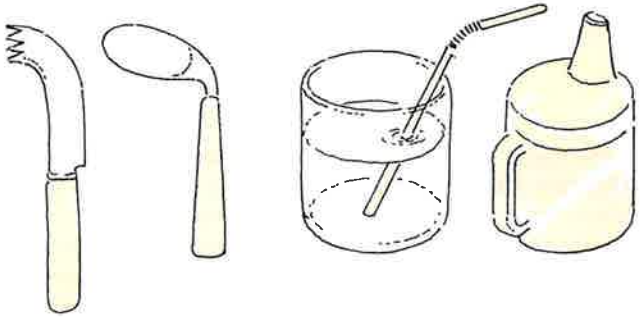
WHERE CAN I FIND MORE INFORMATION?

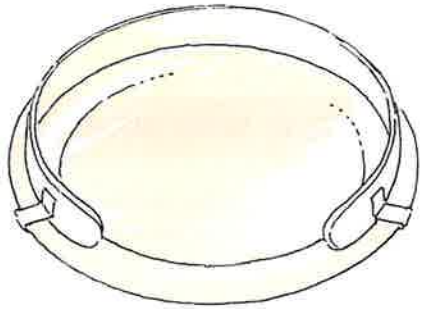
Organizations such as the Australian Nutrition Foundation and the National Heart Foundation can provide you with more information on eating healthily.

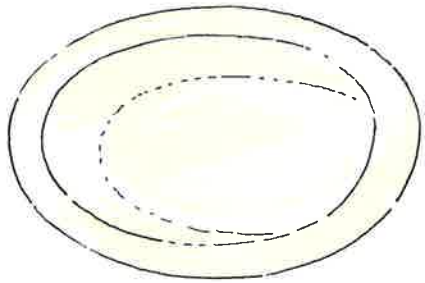
WHAT HELP DO ILL PEOPLE WITH SPECIAL NEEDS REQUIRE?

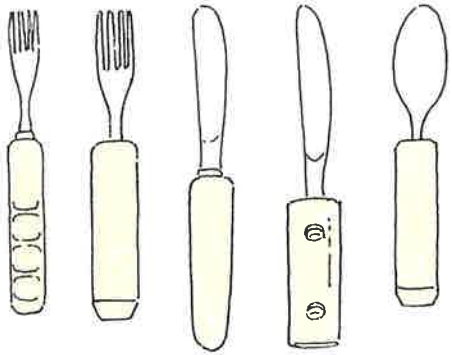
Some people may require assistance if they are unable to feed themselves. Various utensils are specially designed to help people with physical disabilities cut and eat food independently. Advice regarding the availability of these aids can be obtained through the occupational therapy department of the local hospital, Independent Living Centres and pharmacies.

9.4 Specially designed eating utensils to assist disabled people to eat independently









Most blind people are able to feed themselves. They will be greatly assisted if their food is served on plates with raised edges to prevent spilling. Clip-on rims are available for flat plates. Serve spaghetti, rice and similar foods in bowls. Food should be cut into small, bite-sized pieces and any bones should be removed. It is important to let the blind person know where meat and vegetables are on the plate and what types have been served, particularly if the taste sensation has been altered due to illness.

For elderly people living alone, Meals on Wheels can provide one full meal a day for a small price. This is an excellent support for those who are worried about how elderly relatives are managing for meals.

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St John Ambulance Australia

10 COMMUNICABLE DISEASES

Hints for caregivers

WHAT ARE COMMUNICABLE DISEASES?

Communicable diseases are those diseases that can be spread from one person to another. They are caused by germs such as bacteria and viruses.

They include:

- colds
- influenza
- measles and mumps
- glandular fever
- hepatitis A and B
- AIDS (Acquired Immune Deficiency Syndrome)
- herpes
- tuberculosis
- some forms of meningitis
- some skin infections, e.g. impetigo.

CARING FOR SOMEONE WITH A COMMUNICABLE DISEASE

The following precautions should be taken:

- ❑ reduce dust in the person's room by vacuuming carpets, damp cleaning furniture with a moistened cloth and handling bed linen carefully

10.1 Wash hands thoroughly

- ❑ clean bathrooms and toilets with household disinfectant made up as described on the bottle
- ❑ always wash your hands thoroughly before and after providing care. Wash with soap and water from the finger tips to the elbows
- ❑ during the infectious period of a disease (your doctor will advise you about this), keep the person in a separate room, and if possible only one person should care for him/her. Keep separate eating utensils for the person's use until the infectious stage has passed. These should be washed separately
- ❑ all tissues should be placed in a bag and burnt. The caregiver should turn away if the person sneezes or coughs
- ❑ if bedpans are used, the contents should be disposed of immediately and the bedpan soaked in disinfectant.

HOW CAN ITEMS BE STERILIZED IN THE HOME?

Boiling water is an ideal way to disinfect objects at home. Articles should be placed into a clean container and completely covered with water. Boiling should be for 10 minutes and at no time should anything further be added as it will interfere with the procedure.

When disinfection is complete, carefully drain the water and replace the lid on the container. The articles can remain in the container until ready for use.

When ready to use, items can be removed from the container with a pair of household tongs which have been disinfected by the same method. The instruments should not be touched as they will be contaminated again.

A *steam* pressure cooker may also be used. Articles should be placed into the cooker, and, once pressure is established, should be 'cooked' for 15 minutes. The same care in handling the contents applies as for boiling.

Articles such as dressings, bandages and cotton swabs, which cannot be sterilized by boiling, can be sterilized in the *oven*. The articles should be placed in a casserole dish with the lid on, or in a clear oven bag. They are then 'cooked' for 1 hour at 160°C or 325°F. After sterilization, the articles can remain in the sterile container until ready for use.

When sanitizing articles in a *disinfectant*, they must be thoroughly cleaned of all blood, pus or other contaminants. The articles should be totally immersed in the strongest recommended solution of a name-brand household bleach for 30 minutes. Usually this solution will be one part bleach to nine parts water, but follow the instructions on the container. **Always** make sure that a freshly prepared solution of bleach is used. Wash clothing following disinfection. If bleaching is not appropriate, machine-wash clothing in the normal way, using the hottest possible water temperature. Only use household bleach in well-ventilated areas. Clothes and bed linen should be dried in sunshine, if possible.

To clean contaminated working surfaces, soak paper towels in the strongest recommended solution of a name-brand household bleach (see above). Leave the towels sitting on the surface for 30 minutes. Wash the wet areas with water and household detergent, and dry them thoroughly.

HOW SHOULD WOUNDS BE DRESSED?

Avoid talking, coughing or sneezing, and use a non-touch technique when dressing a wound. Do not touch anything that comes into contact with the ill person and handle everything with forceps, not your hands. Wash your hands before and after dressing the wound.

● 10.2 Use a non-touch technique to dress wounds

If using a disposable dressing pack, use one pair of forceps to remove the soiled dressing; the second pair to swab the wound from the inside to the outside; and the third pair to apply the new dressing. All items should be disposed of by burning.

WHAT CAN THE CAREGIVER DO IF AN ILL PERSON IS FEVERISH?

Ensure that the room is cool and comfortable. An air conditioner or fan can be used, if available. Draw the blinds or curtains as direct sunlight may aggravate a headache. Remove any blankets and cover the person with a sheet. Sponging the face with a cool, wet washer will reduce perspiration. If the person's temperature does not lower with these measures, a full tepid sponge may be necessary.

Fever may cause dehydration. Give the person iced drinks, and, once the temperature begins to subside, a light meal such as soup or toast. Frequent mouth washes will also provide moisture and comfort.

MORE INFORMATION

More information is provided below on some infectious diseases which are listed in alphabetical order for easy reference.

AIDS

Information on caring at home for a person with AIDS is available from state and federal health authorities. Further information is also available in the St John Ambulance Australia pamphlet, Communicable Diseases and the First Aider.

Chickenpox

The infectious period for chickenpox is from the day before the rash first appears until it clears up. Crusts are not infectious. In addition to a rash, the person will also experience fever and discomfort. Try to prevent scratching by using calamine lotion and giving frequent cool baths. Seek medical advice. The person should not return to school or work until the scabs have lifted.

Conjunctivitis

The eye will be painful, itchy and red with a crusty discharge. Seek medical advice. Those with conjunctivitis should not return to school or work until the discharge from eyes has ceased, as conjunctivitis is very infectious. Ensure that the person uses his/her own towel, face washer and soap, and do not put eye pads over the eyes.

German measles

See rubella.

Glandular fever

Glandular fever is an acute infectious disease of the lymphatic system, caused by a virus. It is most common in those aged between 14 and 30 years.

A typical attack begins with chills and a fever accompanied by a sore throat and a general feeling of being unwell. For several months before the attack, the person may complain of headaches. On the second or third day, the glands begin to swell, particularly around the neck, causing tenderness and pain. A temporary rash may develop which may be confused with rubella. There may be some swelling of the liver and spleen.

Medical advice should be sought. The person should be encouraged to remain in bed until the fever passes and to rest as much as possible. While the person usually recovers from the acute attack in 2–3 weeks, general recovery may be slow and he/she may tire easily for some months.

Hepatitis

Hepatitis is an acute inflammation of the liver. The incubation period for Hepatitis A is 2 to 6 weeks. As the incubation period for Hepatitis B is up to 100 days, there may be a long period between being infected and showing symptoms.

Hepatitis A is caused mainly by consuming food or drink infected by the virus. It can be prevented by good personal hygiene, and immunization if you are going to be exposed to the virus.

Common symptoms include:

- an absolute loss of appetite with indigestion and nausea
- a mild chest infection, sometimes accompanied by fever
- a yellow skin colour (jaundice) which may be itchy, and reaches its peak about 10 days after its appearance
- enlargement of the liver and spleen causing some discomfort
- dark coloured urine
- pale coloured bowel actions.

Management includes bed rest and a fat-free diet. Alcohol should be avoided. Seek medical advice.

Hepatitis B may be transmitted by contaminated blood and blood products, use of contaminated needles and as a sexually transmitted disease. State and federal authorities can provide information on the prevention of Hepatitis B.

The symptoms and signs are similar to Hepatitis A. The person may also have abdominal pain with generalized muscle ache and weakness. Management includes bed rest, adequate nutrition and total avoidance of alcohol. Convalescence may take 3–4 months. Seek medical advice.

Impetigo

Also known as school sores, the infectious period for impetigo is 2 days before sores appear until after scabs heal.

Symptoms and signs include:

- small red spots which change to blisters which break open, leaving pus-filled, crusty sores
- tenderness and swelling of lymph glands and glands in groin, armpit and neck.

Hygiene is particularly important as impetigo spreads rapidly. Wash clothes and linen separately, and use separate eating utensils. Try to prevent scratching and cleanse the skin around the sores well.

Influenza

Influenza is highly infectious. Immunization can help but is not totally effective as there are many different types of flu virus.

Symptoms and signs include:

- fatigue
- headache
- aches in the body and limbs
- a high temperature (38–40°C)
- chills
- blocked nose
- cough.

Management includes bed rest, plenty of fluids and a light diet. Temperature can be reduced by drugs such as paracetamol. If the temperature remains high, sponge frequently. Consult your doctor.

Lice

Also known as pediculosis, the main area affected is the head. Seek advice on appropriate treatment from your doctor, pharmacist or Community Health Centre. Close contacts should be inspected regularly for signs of infestation or infection. If your child has lice, his/her school should be informed.

Measles

The infectious period for measles is from 4 to 5 days before the rash first appears until a week later.

Symptoms and signs include:

- white-centred red spots in the mouth
- fever
- runny nose and watery eyes
- dry cough
- pink-red rash.

Measles can be prevented by immunization. Management includes rest, a light diet and fluids. Seek medical advice.

Meningitis

Symptoms and signs include:

- bad headache
- stiff neck
- fever
- vomiting
- loss of appetite.

Seek urgent medical advice.

Mumps

The infectious period is a week before swelling, until swelling subsides.

Symptoms and signs include:
- fever
- headache
- nausea and/or vomiting
- pain in jaw and glands below ears
- swelling and tenderness of glands below ears.

Mumps can be prevented by immunization. Management includes using separate eating utensils, bed rest and a light diet. Seek medical advice.

Poliomyelitis

Polio can be prevented by immunization.

Symptoms and signs include:
- fever
- headache
- numbness
- paralysis.

Seek urgent medical advice.

Ringworm

A small round scaly patch may appear on the skin or in the hair. Severe inflammation and crusting may develop. Good hygiene is necessary — linen and clothing should be washed separately. Seek medical advice.

Rubella

Also known as German measles. The infectious period is from before the rash appears to 5 days after its appearance.

Symptoms and signs include:
- fever
- headache
- enlarged neck glands
- pink rash
- runny nose
- inflamed eyes
- painful joints.

Immunization is available and should be obtained by women of child-bearing age prior to pregnancy. Managment includes bed rest and a light diet. Seek medical advice. There should be no contact with pregnant women as rubella during early pregnancy may be harmful to the unborn baby.

Scarlet fever

Symptoms and signs include:
- painful throat
- fever
- nausea
- vomiting
- fine rash.

Management includes plenty of rest and fluids. Seek medical advice.

School scores

See impetigo.

Whooping cough

Symptoms and signs include:
- spasms of coughing
- difficulty in breathing
- vomiting
- runny nose.

Prevention is by immunization with triple antigen. Seek urgent medical advice.

WHEN SHOULD IMMUNIZATION TAKE PLACE?

State and federal health authorities can provide more information on immunization against infectious diseases. The following table is a guide only.

Age	*Immunization*
2 months	Triple antigen (diphtheria, tetanus, whooping cough)
4 months	Triple antigen, polio
6 months	Triple antigen, polio
12–15 months	Measles/mumps
18 months	Diphtheria/tetanus
5 years (or prior to school entry)	Diptheria/tetanus Polio
10–14 years (girls only)	Rubella

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11 HEART DISEASE

WHAT IS A HEART ATTACK, A CORONARY, HEART FAILURE AND ANGINA?

These are just a few of the names that are given to various disorders of the cardiovascular system — that is, the system by which the heart and blood vessels (arteries, veins and capillaries) circulate blood to and from all parts of the body.

Before we go any further, let's be clear about what the heart is, and what the more important terms mean.

The heart

The heart is a muscle which pumps blood, at the rate of about 60 to 90 beats a minute in a resting adult, and 100 to 120 in a child. It is about the size of your fist and located in the chest behind the breastbone. It beats faster during exercise, stress or excitement. Its beat may be felt as the *pulse* in your wrist or the side of your neck.

Arteries

These are the tubes carrying oxygen-rich blood from the heart to all parts of the body. Coronary arteries supply blood to the heart itself.

Atherosclerosis

This is a narrowing and hardening of the arteries by fibrous, fatty deposits on their internal walls.

Cardiopulmonary resuscitation (CPR)

CPR is a resuscitation technique, taught in St John first aid courses, for use when both breathing and heartbeat have stopped.

Cholesterol

This is a fatty substance in the blood, found in large quantities in atherosclerotic deposits.

Electrocardiograph (ECG)

An ECG is a record of the heart's electrical impulses, taken through electrical leads attached to the body.

Veins

These are the tubes which return blood to the heart.

Ventricles

These are the two chambers of the heart that do the pumping. (Above each ventricle is an *atrium*, which acts as a receiving chamber for the blood which is to be passed to the ventricle.)

The following are some common disorders of the cardiovascular system.

Angina, or angina pectoris

This is chest pain which warns the sufferer that the heart is not getting enough blood, and therefore not enough oxygen, through the coronary artieries. Angina in itself does not damage the heart, and the pain usually eases when the person rests. It is due to atherosclerosis of the coronary arteries.

Cardiac arrest

This occurs when the heart stops beating. It most commonly occurs as a result of a 'heart attack' (see below), but may occur without the physical damage usually caused to the heart by an 'attack'. Needless to say, cardiac arrest causes death unless the heartbeat is restored.

Heart attack

A heart attack occurs when a blockage in one of the heart's arteries cuts off the flow of blood to a section of the heart muscle, which may then die. The heart attack may be mild, severe or fatal according to the size and location of the affected section of the heart. The person may experience pain in the chest, arms and/or jaw, or may feel only minor discomfort or breathlessness. Don't be baffled by the terms *coronary thrombosis*, *coronary occlusion* or *myocardial infarction*; these are just other names for a heart attack.

Heart failure

This is not the same as 'cardiac arrest', but is a failure by the heart, over a period of time, to function fully. This may be due to congenital or acquired heart disease or following a heart attack. It may cause breathlessness, swelling of the ankles and legs, and a range of other symptoms.

Heart murmurs

These are abnormal sounds in the heart, as heard through a stethoscope. They may or may not indicate a serious disorder.

Hypertension

Hypertension or high blood pressure, is one of the more important factors increasing the risk of cardiovascular disease and heart attack.

Myocardial infarction

This is death of the heart muscle following a heart attack.

Ventricular fibrillation

This is a rapid uncoordinated twitching of the heart muscle which sometimes replaces the normal coordinated contraction of the ventricles and thereby prevents the effective pumping of blood by the heart. It is the most common cause of cardiac arrest, and is a very serious condition requiring quick action to restore a heartbeat.

HOW CAN CARDIAC DISORDERS BE PREVENTED?

Prevention is better than cure, and in the case of heart disorders, there are a number of simple steps which not only reduce the risk of the disorder occurring in the first place but also reduce the risk of it recurring or worsening. They are:

- Don't smoke. Though perhaps associated in the public mind more with lung disorders, smoking has been conclusively shown to be a major risk factor for heart disease.
- Reduction in those blood fats (cholesterol and triglycerides) which are associated with heart disease. This is a matter of diet, and should be tackled on the basis of blood tests and medical advice. Aim to reduce the intake of foods such as fatty meat, cheese and fried food.
- Regular checking of blood pressure levels by your doctor. High blood pressure is a major risk factor for heart disease and stroke.
- Control of weight. Being overweight not only places an extra strain on the heart but also tends to be associated with high blood pressure, and with high blood fats which may contribute to a narrowing of the arteries.
- Maintenance of a reasonable level of fitness. This does *not* mean an obsessive program of intensive exercise. Regular walking, cycling or swimming in moderation, should be sufficient. The important thing is to avoid an entirely sedentary and inactive life.

Valuable advice on these and other matters related to the prevention and care of heart disorders can be found in the publications of the National Heart Foundation of Australia.

How are cardiac disorders managed?

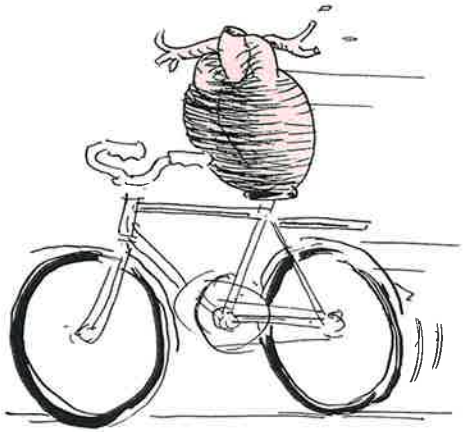
Because of the relative seriousness of most cardiac disorders, the ground rules for management will come from the person's GP, specialist or hospital rehabilitation staff. Anyone who is caring for a person who has suffered a heart attack or who is known to have a cardiovascular disorder of some kind must recognize the possibility that at some time a cardiac arrest may occur, in which case quick action will be necessary. CPR (cardiopulmonary resuscitation) is a technique that needs to be learnt from a qualified instructor. This and other first aid skills are taught in St John first aid courses. Such a course is clearly a 'must' for anyone looking after a cardiac patient in the home.

Learn to recognize a heart attack so that if it occurs, you will know that it is necessary to get the person to the nearest major hospital quickly. This is usually best achieved by calling an ambulance. The person's chance of surviving is much greater if he/she reaches hospital as quickly as possible.

The most common symptoms of a heart attack are:

- pain in the centre of the chest, behind the breastbone, lasting for more than a few minutes
- the pain may radiate to the arm or the neck and jaw
- the person may feel weak, breathless, nauseated and sweaty.

In caring for the cardiac patient at home, remember that methods of diagnosing and treating heart disease are constantly improving, and that the outlook for many people is in fact good. Subject of course to any specific instructions from the doctor, in most cases there is no need to treat the person as an invalid. People whose heart attacks are not particularly severe are encouraged to return to a normal working life after an initial healing period which may be as short as a few weeks.



The recipe is:

- firstly, reassurance and encouragement, to allay the person's initial fears of death and anxieties about their own and the family's future. Knowledge of the facts helps the person, whereas ignorance causes fear and stress. Now is the time to educate the person about the condition, prospects and how risk factors should be minimized
- secondly, the mobilization of the person and the gentle introduction of a moderate program of light exercise, under medical advice, together with any necessary changes in diet and lifestyle
- thirdly, the ongoing avoidance of undue physical strain and emotional stress.

Many a heart attack victim, after going through this painless rehabilitation program, has within a matter of months been happily boasting to friends that he/she never felt better! The new lifestyle and the new precautions must of course be maintained, and not relaxed, to ensure a continuation of this happy state of affairs.

WHAT MEDICATIONS ARE PRESCRIBED FOR CARDIAC DISORDERS?

It goes without saying that the prescription of pharmaceutical treatment for cardiovascular disorders is very much a matter for professional medical expertise. However, once the appropriate drugs have been prescribed, there is much that the caregiver can do to ensure that those drugs are used properly. Here are some basic guidelines.

- Drugs should be taken at the times and in the quantities prescribed. The person should not be allowed to succumb to the temptation to decrease the dose when feeling well, or to increase it when feeling ill. If there is any uncertainty about the prescribed dosage (the person may have forgotten exactly what the doctor said, and/or the pharmacist's label may seem ambiguous), don't hestitate to check again with the doctor or the pharmacist.
- Make sure that the prescribing doctor knows what other drugs are already being taken, and don't let the person take other drugs at a later stage without checking first with the doctor. Some cardiovascular drugs can have unpleasant or even serious side-effects if taken with any of a range of other drugs, including some fairly common medicines taken to relieve the symptoms of the common cold.
- Report any unusual symptoms to the doctor, in case they are side-effects of the drugs. He/she may be able to prescribe an alternative drug which does the job without causing the side-effects.
- *Don't* experiment with the person's health by trying out drugs being used by someone else who may appear to have a similar condition. What is right for someone else may be horribly wrong for this person.

Some of the drugs commonly used in the treatment of cardiovascular conditions are:

- aspirin, to reduce the blood's tendency to clot
- digitalis, to strengthen the heart's contractions and thereby improve the circulation
- diuretics, to eliminate excess water and salt from the body through the urine, and thereby assist in controlling high blood pressure or heart failure
- antihypertensives, to lower blood pressure by acting directly on the blood vessels, relaxing them and permitting a smoother flow of blood
- antiarrhythmics, to regulate the rhythm of the heartbeat
- vasodilators, e.g. Anginine, to open the blood vessels and relieve the pain of angina.

WHAT CAN THE CAREGIVER DO TO HELP SOMEONE WITH A CARDIAC DISORDER?

The care of the heart disease patient involves much more than medical care. More than most other conditions, heart disease causes psychological stresses which may need as much attention as the physical condition itself. Traditionally, heart attacks are seen as life-threatening in a very fundamental way, even though the chances of recovery are good. To the person, a heart attack comes as a reminder of mortality, and often causes considerable anxieties over and above those caused by the symptoms themselves — anxieties about work, the future security of the spouse and children, the mortgage, the breadwinning role and so on. To the person's friends and relatives, the heart attack causes shock and concern, and all too often instills a fixed belief that for the rest of the person's life he/she must be cosseted and generally treated as a permanent invalid.

The caregiver needs to be aware of these fears and concerns, and to be ready to give reassurance and encouragement at all times, both to the person and to those who come into contact with him/her. Knowledge is the best weapon against fear, and open discussion of the condition and its treatment is the best remedy for anxiety.

Although heart attack has in the past been more common in men than in women, an increasing incidence of heart attack among younger women is now being recorded, possibly because of changes in lifestyle, with women playing a more active, and stressful, role in business and industry and increasingly adopting traditionally male vices such as drinking and smoking; and possibly also because of improved diagnosis. Women who have heart attacks can be confronted with special problems when they come home from hospital, since in many cases they are returning to what is in effect their normal work environment. It may be harder for them than for men to relax in the home and adopt a genuinely recuperative role.

There is also some evidence that women are more depressed after a heart attack than men, and less likely to persevere with the rehabilitative programs that their doctors prescribe for them. This, together with the other factors just mentioned, means that the task of caring for the female heart patient in the home may well have an added dimension, of which the caregiver should be aware.

Some practical assistance with immediate needs which otherwise might add to the person's stress can also be very beneficial. There may be simple social or 'housekeeping' matters to be attended to — medical insurance procedures, the need to communicate with the person's workplace and with relatives, bills to be paid, social security payments to be arranged, and so on. The knowledge that someone else is dealing with these matters can take a load off the person's mind and reduce stress.

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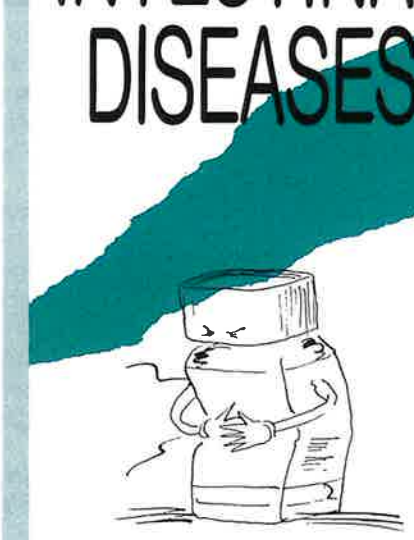
St John Ambulance Australia

12 GASTRO-INTESTINAL DISEASES



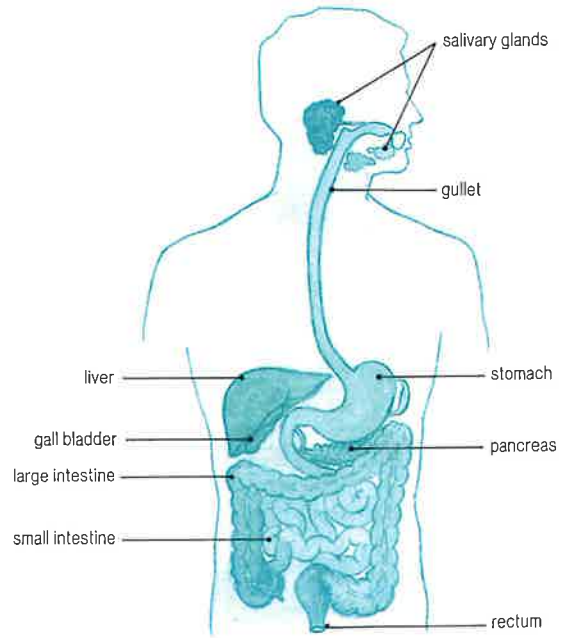
WHAT ARE GASTROINTESTINAL DISEASES?

The gastrointestinal system is also known as the digestive system. Its main function is to receive food from which it must digest, transport and absorb the nutrients required by the body for maintenance, repair and supply of energy.

The food must contain a mixture of nutrients to maintain health, such as protein, fats, carbohydrates, salts, vitamins and water. A disruption to the supply, digestion, transport or absorption of nutrients is likely to lead to gastrointestinal diseases.

The gastrointestinal tract consists of the mouth, oesophagus, stomach, small intestine, large intestine and rectum. Normal function of the liver and pancreas with their secretion of enzymes, which help in breaking down the nutrients, is essential for normal functioning of the gastrointestinal tract.

•12.1 Digestive System



Symptoms from the gastrointestinal tract do not necessarily mean that there is a disease in the system, as a variety of other disorders and treatment may cause symptoms from the gastrointestinal tract.

WHAT ARE SOME COMMON GASTROINTESTINAL DISORDERS?

Heartburn — oesophagitis — a burning sensation moving up and down the chest, sometimes associated with warm fluid coming up into the throat.

Dysphagia — difficulties in swallowing.

Peptic ulcer — ulceration found in either the lining of the stomach or the duodenum which is the first part of the small intestine.

Gastritis — an inflammation of the stomach lining which may present itself as an acute reaction to certain chemicals and drugs, such as alcohol and aspirin. Gastritis also exists in chronic form as a slow progressive disease, often associated with chronic alcoholism.

Inflammatory bowel disease — includes ulcerative colitis and regional enteritis (Crohn's Disease). These diseases predominantly occur in young people and are chronic recurrent diseases which are characterized by exacerbation and remission.

Diverticula disease — a protrusion of the intestinal lining out through the wall, forming a small pouch, which, when inadequately drained, may be a source of infection and bleeding.

Appendicitis — infection in the appendix, a small worm-like sac attached to the large intestine.

Tumours — benign and malignant tumours can occur anywhere along the gastrointestinal tract.

Cholecystitis — an inflammation of the gall bladder which frequently is associated with stones which interfere with the bile drainage.

WHAT ARE SOME COMMON INVESTIGATIONS USED TO DIAGNOSE GASTROINTESTINAL DISEASES?

If your doctor suspects a gastrointestinal disease, some of the following procedures may be requested.

Barium meal and barium enema — a contrast medium is used to fill the intestine so that abnormality of the wall can be detected on the radiographic film.

Gastrointestinal endoscopy — a flexible fibre optic tube allows the physician to directly view aspects of the gastrointestinal tract. Apart from its use in diagnosing, the endoscope can also be used for minor procedures such as obtaining biopsies and removing small stones from the entrance of the bile duct into the intestine.

Sigmoidoscopy — a lighted tube is used to visualize the lower end of the colon and the rectum.

HOW CAN GASTROINTESTINAL DISEASES BE PREVENTED?

Although the cause of many gastrointestinal diseases is unknown, they are often associated with bad eating habits. Most of the prevention therefore, must be directed towards improving the nutrition and eating habits of the individual. A balanced diet with food from all the major food groups, at regular intervals, is recommended.

Vegetable fibre is an important non-nutritious food element which is not absorbed through the wall of the intestinal tract, but adds bulk to the content of the intestine. Fibre helps to move food through the intestine and result in a more regular emptying of faeces and reduced gas pressure in the intestine. It reduces the time the wall of the intestine is exposed to small quantities of cancer-inducing agents present in some foods.

There is evidence to suggest that people who eat high fibre content food and refrain from eating convenience foods, are less likely to suffer from appendicitis, haemorrhoids and cancer of the large bowel. In addition, this type of food intake also reduces the risk of atherosclerosis, a disorder in the blood vessels which leads to serious heart disease.

Regular exercise and toilet habits, with adequate time to defecate, will promote normal bowel function.

Avoid regular intake of aspirin, and non-steroidal anti-inflammatory drugs as they can damage the stomach lining.

HOW ARE GASTROINTESTINAL DISEASES MANAGED?

Many of the gastrointestinal disorders have similar symptoms, and therefore they require similar types of treatment and care.

If the person is suffering from nausea and vomiting, the care-giver can assist by discarding the vomitus promptly, so that the smell and sight of it does not induce further vomiting.

Good mouth care is important, especially if fever is present, as the saliva secretion is suppressed to conserve water. If food particles are not cleaned out, they may contribute to infection.

Another problem experienced is diarrhoea. This can be extremely frustrating as the person is likely to be very embarrassed about the condition, especially if he/she becomes incontinent. The skin around the anal area can become very red and sore.

It is important that the caregiver is very tactful and carries out the cleaning of the person and the bed with a minimum of fuss. Vaseline or other protective creams should be used to prevent further skin damage. The person with diarrhoea should also be encouraged to rest until the diarrhoea is under control. Attempts should be made to reduce any unnecessary stress which will further aggravate the situation.

If the ill person is vomiting or has diarrhoea, he/she needs to be encouraged to drink plenty of fluid. The caregiver should note the amount of loss, the colour and any presence of blood in the vomit or diarrhoea. Prolonged periods of vomiting or diarrhoea will lead to salt imbalances. The doctor should be kept informed and asked for advice regarding appropriate fluid replacement.

Presence of fresh blood should be notified immediately to the doctor as this might be a sign of active bleeding in the gastrointestinal tract.

Once the acute problems have settled, the person with a gastrointestinal disorder is usually given a liquid diet first, and then a bland diet, depending on the nature of the disease. For example, ulcerative colitis moves from a liquid diet in the acute phase, to a low residual diet during the recovery, to a bland diet which is high in protein, calories and vitamins but low in fat.

For the person with a peptic ulcer, the regularity of meals is more important than the content. A milk, cream and bland diet has not been shown to have any effect on healing peptic ulcers. However, alcohol and liquids containing caffeine stimulate acid production. In addition, alcohol irritates the gastric lining. These should therefore be avoided.

WHAT MEDICATIONS ARE COMMONLY PRESCRIBED FOR GASTROINTESTINAL DISORDERS?

Antacid is an accepted treatment of duodenal ulcers. A variety of products is available over the counter. They vary in their ability to neutralize the acid and their potential to cause adverse effects. Medical advice should be sought when selecting an antacid to achieve the optimum treatment in individual cases.

H_2 receptor antagonist, e.g. Cimetidine — another group of drugs which blocks the secretion of gastric acid and is the most frequently used medication for duodenal ulcers.

Laxatives — a variety of laxatives exist. However, they should be used with caution as they are habit forming and once dependent on them, it is difficult to break the habit. Laxatives are administered to people who suffer from constipation.

Enemas — an enema is the administration of a solution into the rectum which stimulates the bowel and causes defecation. Most enemas act very quickly and the person receiving it should be able to have immediate access to the toilet.

WHAT CAN THE CAREGIVER DO TO HELP SOMEONE WITH A GASTROINTESTINAL DISORDER?

Eating is an essential part of socialization, with age, cultural background and social position being the main determinants for food preferences. Individual likes and dislikes are perhaps the strongest influences on the diet. A person suffering from gastrointestinal diseases often cannot participate in normal meals and is therefore at risk of feeling isolated.

The caregiver should obtain information about the person's preference in food and take this into account when preparing the allowable diet. Older people especially, have a tendency to cling to cultural food habits during illness when the appetite is also reduced.

The caregiver should be informed about the type of food and diet that is prescribed for the ill person. Meal times should be arranged across the 24-hour period so that no period of hunger occurs. It is important to make the environment as pleasant as possible for the person with a gastrointestinal disorder and to encourage him/her to take meals together with the family in the normal dining area.

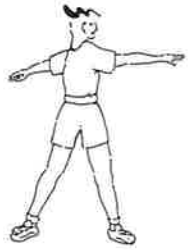
It may be possible to substitute part of the family's diet with foods tolerated well by the person with the gastrointestinal disorder. The caregiver should encourage family members to engage in positive comments about the restricted diet of the person with the gastrointestinal problem to help him/her adjust to the special diet.

The caregiver needs to have a good understanding of the importance of proper diet and adequate fluid intake, regular bowel routine, exercise, and what to do when bowel elimination problems occur.

It is important that the caregiver can support an established trust between the doctor and the person who is suffering from inflammatory bowel disease, as these people often get angry and depressed. The caregiver needs to be aware of these feelings and be prepared to have open discussions about the problems. The person can be assisted by obtaining as much information as possible and involving the doctor or other health professionals when difficult situations arise.

The person with an osteotomy faces very specific problems and has an individual need as well as a family need for adjustment to the disease and change in body image. Stomal therapists and special support groups can provide practical information about new types of equipment, clothing, how to manage at work, sexual relationships, swimming etc.

If special foods are required for a person with a gastrointestinal disorder, the caregiver should seek a health professional's advice, as consumers are often misled by inappropriate advertising and sale promotions. General information is also available from Health Promotion Units in most states. Specific diet requirements and advice regarding ongoing problems should be sought with the treating physician and other health professionals directly involved with the ill person.



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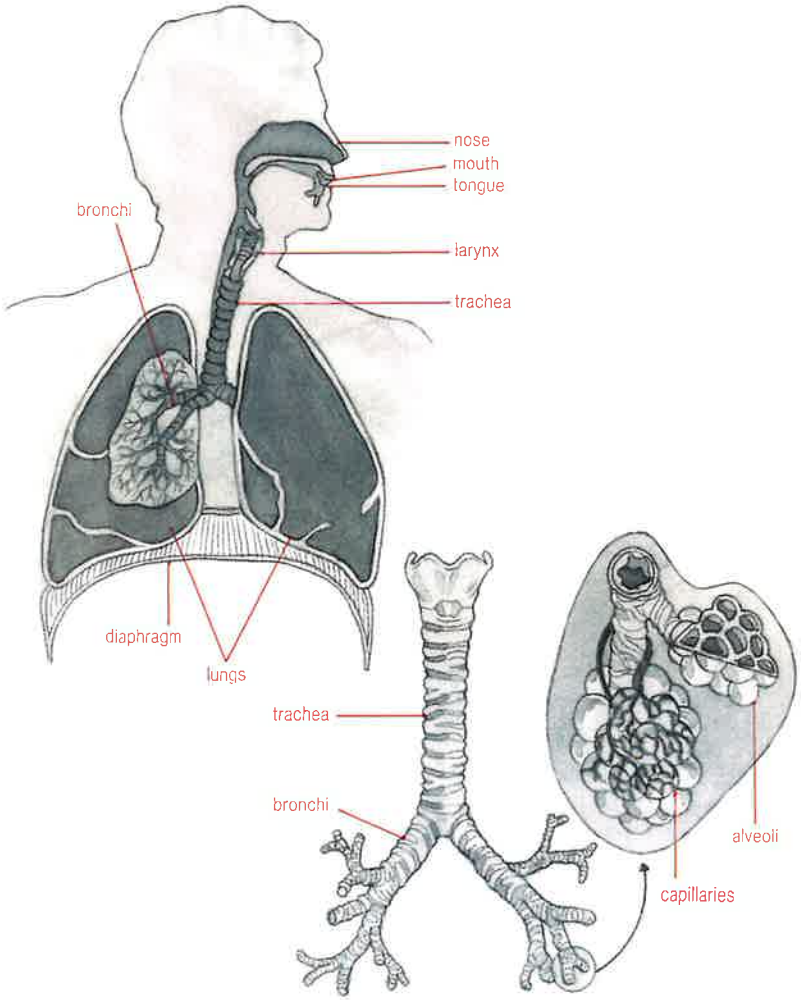
13 RESPIRATORY DISEASE

WHAT IS THE RESPIRATORY SYSTEM?

The main function of the respiratory system is to transfer air into the body, where it is brought into contact with blood, so an exchange of oxygen with carbon dioxide can take place.

The respiratory system consists of the upper airways (nose, mouth and throat), and the lower airways (windpipes and lungs with their three hundred million alveoli or air sacs). The vast surface area in these air sacs is surrounded by six billion capillaries that enable gas exchange to take place. About 500 ml of air is moved in and out of the lungs in each breath.

13.1 Respiratory System



WHAT DO SOME OF THE TERMS USED WHEN DISCUSSING RESPIRATORY DISEASES MEAN?

Ventilation is the process by which gases are moved in and out of the lungs. It is sometimes referred to as respiration.

Dyspnoea is shortness of breath or breathlessness.

Cyanosis is a bluish tinge, specially noticeable on lips and fingernails.

Wheezing is an abnormal whistling breathing sound.

chest x-ray is a radiographic picture of the chest. This is an important diagnostic test in respiratory diseases.

When a **bronchoscopy** is performed, a lighted tube (bronchoscope) is passed down the windpipe to examine the interior of the lungs.

pulmonary function test measures the volume of air that enters and leaves the lungs. This is usually done through an instrument called a **spirometer**

WHAT ARE SOME COMMON DISORDERS OF THE RESPIRATORY SYSTEM?

Colds and influenza are communicable diseases caused by viruses which affect the upper airways, in particular.

Pneumonia is an acute infection of the lungs' tissues.

In its chronic form, **bronchitis** is a condition which causes excessive cough and sputum production for at least three months of the year.

Emphysema is a distention of the lower air spaces, with some destruction of the walls of the air sacs.

Chronic obstructive airways disease is a condition where there is chronic obstruction to the airflow, due to chronic bronchitis and/or emphysema.

Asthma is an attack of widespread narrowing of the lower airways which may be relieved spontaneously or after treatment with medication, which dilates the bronchi.

Respiratory failure is failure of the respiratory system over a period of time, which results in dyspnoea, cyanosis and lack of oxygen being available to the tissues.

Respiratory arrest is the cessation of breathing. It may occur due to a physical obstruction to the upper airways, or as a result of respiratory failure. If not treated immediately, it will lead to cardiac arrest and death unless cardiopulmonary resuscitation is carried out to restore the breathing and heartbeat.

HOW CAN RESPIRATORY DISORDERS BE PREVENTED?

As is true for many other disorders, a healthy lifestyle is the best precaution against respiratory diseases. It is unlikely any person can go through life without suffering the occasional cold and influenza. However, good nutrition, exercise, and a fresh, clean environment are the best defences against many respiratory disorders.

Stop smoking — or if a non-smoker, avoid passive smoking situations. Smoking can cause lung cancer and reduces the normal protective mechanism present in the lungs. It is also a major risk factor in heart diseases.

Exercise regularly to maintain fitness. Deep breathing exercises will help maintain the elasticity of the lungs.

Maintain clean and ventilated living and working environments. Damp dust regularly to reduce dust particles. Seek information about the potential dangers of chemical substances which are encountered in the work and home environment. Use protective clothing and respiratory apparatus, if suggested by Occupational Health and Safety Guidelines. Store dangerous products out of reach of children and confused people.

Health Promotion Units, Asthma Support Groups and other respiratory disease support groups are available in most states. They offer valuable advice and some publications on the prevention and care of respiratory disorders.

HOW ARE RESPIRATORY DISORDERS MANAGED?

The management of respiratory disorders involves three areas:

- good aeration of the lungs to maintain an acceptable level of oxygen and ventilation
- prevention of sputum and secretion retention
- maintaining a patent airway.

In caring for someone with a respiratory disorder at home, it is important that the caregiver observes the person's ease of breathing and ability to clear the airway through an effective cough.

Breathing exercises provide two important benefits. First, by the increased volume of air in each breath, the rate of breathing will slow down. Secondly, the task of breathing often reassures an anxious person and helps him/her to relax. The caregiver should encourage the person to breathe deeply by inhaling through the nose, to enable the normal warming, cleaning and moistening of the air to take place. The air should then be slowly exhaled through the mouth, with an effort to empty the lungs as far as possible, as if blowing up a balloon.

Breathing exercises and frequent position changes assist in promoting good lung expansion, and help move secretions from the tiny airways into the large airways, so they can be expelled through coughing.

Adequate fluid intake is important for someone with a respiratory disorder to ensure the secretions are thin and watery, so they can easily be removed with minimal coughing. An intake of six to eight glasses of fluid per day is recommended, unless otherwise ordered by the doctor.

When a person is lying down, the expansion of the chest is limited and prolonged bed rest can cause accumulation of secretions in the lower portion of the lungs. Many people with respiratory disorders find the upright position makes breathing easier, and in some severe cases, it may be necessary to sleep in a chair or propped up with several pillows.

The caregiver can assist by trying out different positions that will make the person most comfortable. Frequent position changes help reduce the risk of more severe respiratory complications, such as pneumonia. It is important to change the position regularly, for example every two hours, and to encourage short walks.

Coughing is a protective reflex to clear the lungs and upper airways of irritants and secretion. The caregiver should notice if the cough results in sputum or not. Chronic bronchitis sufferers produce sputum all day, but specially when they are getting up from a lying position. The caregiver should notice the colour consistency, odour and presence of blood in sputum. When handling sputum, the caregiver should wash hands thoroughly after disposing of any items which have been contaminated. A container for tissues and/or sputum should be readily available to the person with a respiratory disorder.

It is a good idea to encourage frequent mouthwashes to remove traces of coughed up secretions. Good mouth care also helps keep the upper airway moist, and thereby humidifies the inhaled air. Additional moisture in the air may be needed, if secretions are thick and difficult for the person to cough up. This can be achieved in the bathroom by running a hot shower, or by boiling pans of water in the kitchen with windows and doors closed. If the person is unable, or unwilling, to cough and breathing sounds noisy and rattly, then the doctor should be contacted immediately for further advice.

Some people with artificial airways, such as a tube into the throat (a tracheostomy tube) are cared for at home. In this situation, the caregiver should have special training in suction of the airway, by medical or nursing staff.

WHAT CAN THE CAREGIVER DO TO HELP SOMEONE WITH A RESPIRATORY DISORDER?

Any person who has experienced a coughing fit would understand the anxiety and fear that people with respiratory disorders frequently suffer due to episodes of air hunger. The dependence on medication, which relaxes the muscle of the airway, may cause anxiety which in itself can bring on an asthma attack. Uncertainty about environmental or other triggers which cause the asthma attack will add to this anxiety.

In other respiratory disorders, a person may only be able to speak a few words or sentences before he or she begins to gasp for air, or to wheeze or cough. These situations create a sense of fear, as the person realizes the life-threatening aspect of the condition.

It is important that the caregiver is able to discuss these fears and concerns openly with the person and the family. The caregiver can also help ensure that appropriate information about the condition and its treatment is available. The caregiver can help by keeping a history of what happened immediately before the person started wheezing, as this may help the doctor identify the cause of the attack.

As most respiratory disorders lead to difficulties in breathing, and produce a state of fear and panic which may make the respiratory distress worse, it is important that the caregiver knows how to clear the airways and has confidence in his/her own ability to manage the situation. Caregivers should be able to perform cardiopulmonary resuscitation. This skill can be learnt in a St John Ambulance Australia first aid course.

Some people with respiratory disorders require postural drainage to remove secretions, and oxygen therapy in the home. In both these situations, specific instruction should be given to the caregiver by health professionals to ensure that the treatment is carried out safely and effectively.

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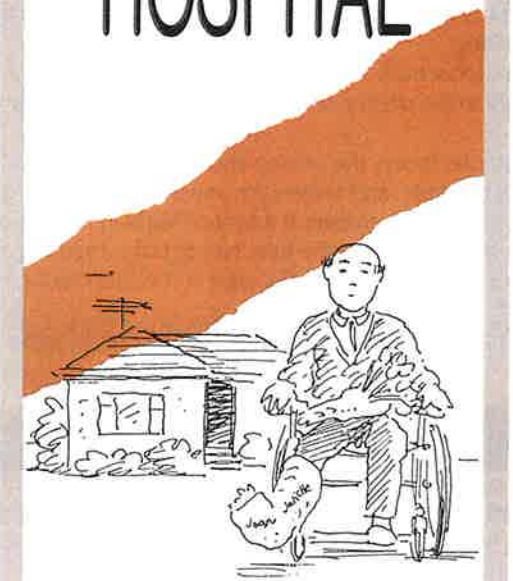
14

HOME FROM HOSPITAL



The experience of being in hospital is often traumatic, both emotionally and physically, for the sick person and the family.

Following discharge from hospital, the person will need time to recover at home. It is important that the caregiver understands the person's capabilities and limitations. The medical and nursing staff will advise the person and the family on what should be done until healing and recovery are complete.

WHAT CARE DOES A PERSON WITH A PLASTER NEED?

A person with a closed, uncomplicated fracture who has had a plaster applied in hospital is usually sent home with it still wet. Directions for care are usually given to the person before he or she goes home.

After application, a freshly applied cast should be exposed to air so that it will dry. This may take up to 48 hours. During the drying period, the plaster should be kept cool. Avoid covering it with clothing or bedding, and resting it on hard surfaces or sharp edges. Support the limb, slightly raised, on pillows to help reduce swelling.

Watch for looseness, or signs of tightness. If this occurs, report immediately to the doctor or casualty department at your local hospital.

When the cast is dry, the person should move about as normally as possible, and undertake any exercises prescribed by the doctor or physiotherapist. If a foot or leg is in plaster, avoid walking on wet floors or in the rain. Never poke anything down the cast as it may cause tissue damage. If the cast cracks, seek medical aid.

After the cast is removed, the limb may be painful and stiff for a few days.

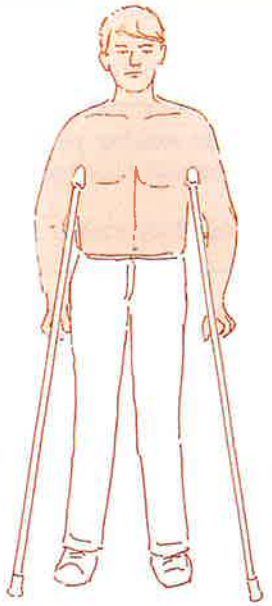
HOW ARE CRUTCHES USED?

A physiotherapist or specially trained nurse will normally show the person how to use crutches before discharge from hospital.

To stand up with crutches
Sit on the edge of the chair or bed, with the strong leg placed slightly under the edge. Hold both crutches in the hands on the side of the weaker leg. Stand up by pushing down on the hand pieces with both hands, and pushing up with the strong leg. Balancing on the strong leg, place the crutches on either side about 20–25 cm in front of the toes. The weight is supported on the hand pieces, not the armpit rests.

To walk with crutches
Balance on the strong leg and move the weak leg and both crutches forward about 30 cm. While leaning forward, take full

14.1 Using crutches



weight on the crutches and swing the body to a position even with them. Then place the strong leg on the ground to take full weight, and repeat the sequence.

To go down steps
Stand as far forward on the step as possible. Taking full weight on the strong leg, move the crutches to the lower step. Move the weaker leg first, then take the weight on the crutches and move the stronger leg.

To go up steps
Move the strong leg up first, taking the weight on the crutches. Transfer the weight onto the strong leg and move the crutches and the weak leg.

WHAT CARE IS NEEDED AFTER AN ABDOMINAL OPERATION?

Common operations include the removal of an appendix, a hernia repair and Caesarian section. Whatever the cause, general postoperative management at home remains the same.

The person may be discharged with stitches or clips still holding the wound together. These are usually left in place for 7–10 days and the wound may be covered with a dressing, a plastic spray or left exposed.

Observe the wound for any signs of:

- infection, e.g. redness, swelling, pain or pus
- bleeding, e.g. if the dressing becomes suddenly stained with blood
- the edges of the wound separating.

If these occur, cover the wound with a sterile dressing and seek medical advice immediately. Medical advice should also be sought if the person experiences:

- colicky abdominal pain
- vomiting
- constipation
- swelling of the abdomen.

The person will be advised to avoid heavy activities that may put strain on the abdomen for several weeks or even months. Heavy lifting should be avoided and the wound should be supported when coughing or on the toilet. Sudden and unexpected movements that put strain on the abdomen should be prevented.

Encourage the person to breathe deeply and to do moderate exercise, e.g. walking, if permitted by the doctor. Rest periods are advisable to avoid over-tiredness.

WHAT CARE IS NEEDED AFTER A GENITO-URINARY OPERATION?

After surgery for an enlarged prostate gland, difficulty in regaining urinary control may be experienced. Incontinence may occur at night. This will gradually diminish. Strenuous exercise and long car trips should be avoided. Alcohol should also be avoided as it may cause burning when urine is passed. The person should drink plenty of fluids. If any bleeding occurs, seek medical advice immediately.

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St John Ambulance Australia

15 SOME ANSWERS TO NEW PARENTS' QUESTIONS

There are many excellent publications available from your library or bookshop which contain helpful information for new parents. Your local hospital, Infant Health Clinic, and Nursing Mothers Association are also able to provide advice, often after-hours when things most often seem to go wrong.

How long should my baby sleep each day?

Every baby is different — some may sleep as much as 20 hours per day; others seem to hardly sleep at all. As your baby gets older, he or she will probably sleep less. If you notice a change in sleeping habits, if an older baby is continually sleepy, or if you are concerned about how long a newborn sleeps, seek advice from your doctor or infant health nurse.

My baby seems to cry a lot — what can I do?

Every new parent is surprised by how much a baby can cry! Your baby is probably crying less than you think, but if you are worried, try these steps:

- check for obvious signs of discomfort: does the baby's nappy need changing; is he/she hungry; will winding help?
- take the baby for a walk (being in a new environment may help you both)
- give the baby a bath or a massage
- if someone else can care for the baby for a while, have some time to yourself to relax
- talk with your doctor or infant health nurse for more advice.

How do I know my baby is feeding properly?

If your baby is contented and is growing well (your doctor or infant health nurse will be able to advise you about this), he or she is getting enough food.

Milk is a baby's major source of food until about 12 months of age. If not breastfeeding, use an infant formula, prepared exactly as described on the tin. Solid foods can be introduced gradually some time between 3 and 6 months of age. Discuss the introduction of solid foods and cow's milk with your doctor or infant health nurse.

Some babies dribble their food or regurgitate after feeding. This may be because they are overfed, have wind, are lying uncomfortably or have fed too quickly. Similarly, the baby may be troubled by colic after feeding. Feeding more slowly and winding adequately can help. If the problem does not ease, seek medical advice.

How long will it take the umbilical cord to separate, and what care does it need?

Many infants go home with a small portion of the umbilical cord still attached to the umbilicus (navel). The cord usually separates within 2 weeks although it may take longer. It must be kept clean and exposed, not covered with a bandage. After the cord separates, the navel should dry up in a few days. Methylated spirits applied with a cotton bud can assist this process. If a discharge is present or the surrounding tissue looks swollen or discoloured, advice should be sought from the family doctor or infant health clinic.

MY BABY GETS PRICKLY HEAT — WHAT CAN I DO?

Prickly heat is characterized by a fine spotty rash which appears mainly on the head, neck and shoulders. It usually occurs in hot weather but it may be seen in any season. Keeping the baby cool by bathing in tepid water several times a day and applying calamine lotion can provide relief.

WHAT CAN I DO ABOUT NAPPY RASH?

Nappy rash can be prevented by washing thoroughly at each nappy change and by changing nappies regularly. Water repellent creams are available to protect the skin and to soothe nappy rash.

WHAT IS THRUSH AND WHAT CAN I DO ABOUT IT?

Thrush is recognized by small fine milky spots which usually start in the mouth. It may also appear as a red rash around the anus and genitals. Strict attention to clean dummies and teats is essential, and medical advice should be sought.

MY BABY HAS 'SLEEP' IN HER EYES — WHAT SHOULD I DO?

Some babies have problems with 'sleep' in their eyes and deposits of this, if left, can cause inflammation. It is best to remove this very carefully with a moist cotton wool ball or cloth. Saline made from 200 ml boiled water and a quarter of a teaspoon of salt may be used. Medical advice should be obtained for any persistent discharge or continual watering.

HOW CAN I HELP EASE MY BABY'S PAINFUL GUMS?

Gums may be swollen and painful from teething. They may be gently rubbed with oil of cloves, or an infant teething gel. Giving the baby something to chew on, e.g. a teething rusk or ring, may help. Teething rings that have been placed in the freezer for a while may be soothing.

WHAT SHOULD I DO ABOUT DISCHARGE FROM MY BABY'S EARS?

Any discharge from the ear may be serious and, if neglected, may result in permanent deafness. In every case medical advice should be obtained.

WHAT SHOULD I DO ABOUT DIARRHOEA AND VOMITING?

Loss of fluid is dangerous to babies as they may become rapidly dehydrated. If faeces are green, offensive or fatty in appearance, if the baby has diarrhoea, or is vomiting, seek medical advice immediately.

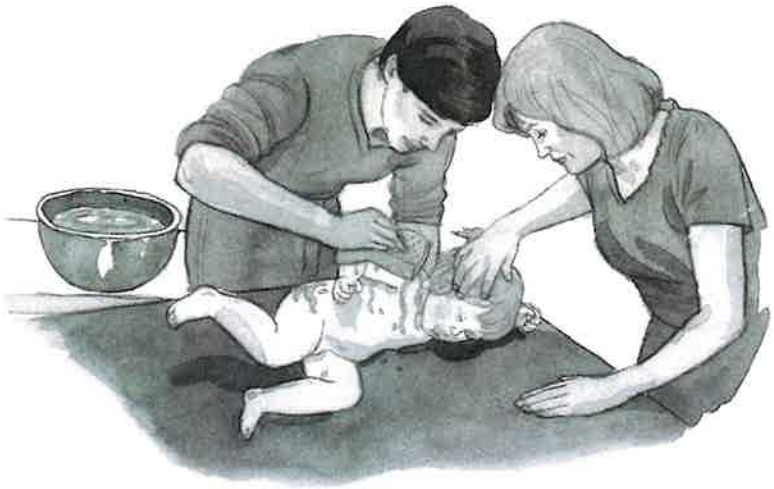
WHAT IS CROUP?

Croup usually occurs between the ages of 4 months and 2 years. It is preceded by a hard rasping cough with a striking barking sound. The baby may have difficulty breathing and attempts to do so result in a shrill crowing sound. The baby may suffer muscular spasms or convulsions. Call the doctor immediately. Relief can be obtained by moistening the air with steam from an electric kettle or shower.

WHAT SHOULD I DO IF MY BABY HAS A CONVULSION?

Convulsions may occur in children between the ages of 10 months and 4 years, often as a result of high body temperature from a cold or other illness. The child's body may be stiff and rigid with twitching limbs. Sometimes there is arching of the head and back. Other signs include rolling of the eyes, congested face and neck, blue face and lips, and unconsciousness.

15.1 Managing a convulsion



Your first priority is to ensure a clear and open airway: if necessary, turn the child head down. Remove all clothing and if the child feels hot, sponge down with water that is slightly below body temperature. Fan the wet child with a newspaper or magazine to speed up cooling, but do not overcool. When the child has ceased convulsing and the body temperature has been reduced, cover lightly and seek medical aid.

WHAT SHOULD I DO IF MY BABY IS CHOKING?

To prevent choking, avoid giving small children large pieces of food, nuts and lollies. Always supervise children when eating. If your baby is choking, place him/her over your knees with the head down and give three or four smacks between the shoulders.

15.2 Managing choking

WHERE CAN I LEARN MORE ABOUT CARING FOR MY BABY IN THE EVENT OF AN ACCIDENT?

Now is the time to do a first aid course! As your child begins to explore, you will need to make sure your home is safe, and learn more about caring for common injuries and illnesses. St John Ambulance Australia runs first aid courses throughout Australia which will give you many helpful tips on making your environment safer, and will enable you to care for those cuts and bruises (and any more serious accidents) that inevitably happen as your baby becomes a toddler.

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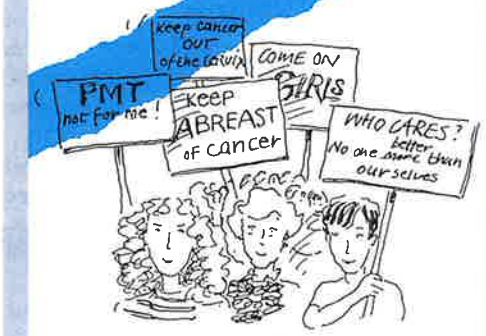
St John Ambulance Australia

16 CARING ABOUT YOURSELF

Women's health



There are many things women can do to take better care of themselves. Some of these actions are described below. For more information, or if you are worried about any aspect of your health, consult your doctor, local Women's or Community Health Centre, or the Family Planning Association.

BREAST SELF EXAMINATION

Why should I examine my breasts regularly?

Breast cancer is the most common form of cancer in Australian women, affecting 1 in 14 women. However, early discovery increases the likelihood of successful treatment. By examining your breasts regularly (each month a few days after your period has stopped), or on the first day of each month if you no longer have periods, you will know what is normal for you. If you do notice any lump or abnormal change, see your doctor — not every lump is cancerous but it's worth checking! You should also have your doctor examine your breasts annually when you have your Pap Smear.

How should I examine my breasts?

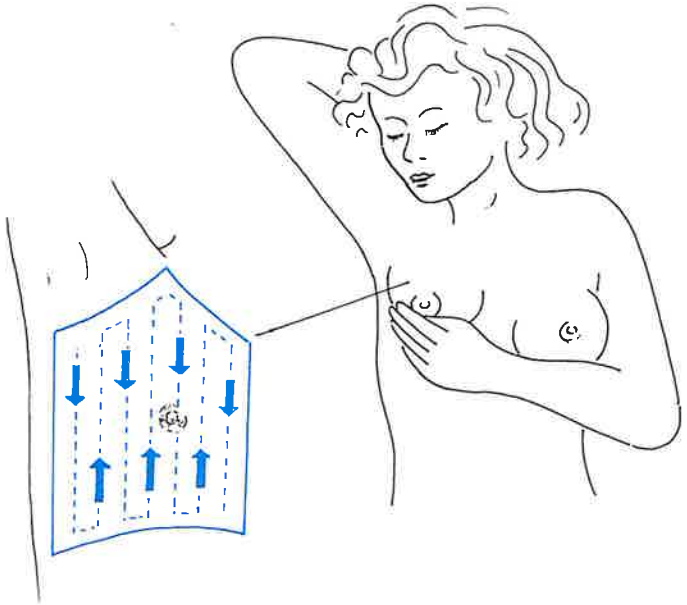
Examine your breasts lying down. First feel for any lumps. Lie on your left side, with bent knees. Roll back to have your shoulders flat on the bed, but don't shift your legs. Place your right arm under your head. Put your left hand under your armpit and make a light, then firm circle over the area. Move your hand towards the bra-line, continuing to make circles of light, then firm pressure. Then move about 2 cm to the left and work upwards to the collarbone. Continue working up and down the breast in strips until you reach the nipple. Then lie flat on your back and continue till you reach your breastbone. Bring your right arm down by your side and feel your armpit firmly.

Repeat this procedure for your left breast, lying on your right side with your left arm behind your head.

Then stand in front of a mirror with your arms by your side. Look at your breasts carefully. Raise your arms above your head and turn slowly from side to side. Look for:

- any changes in your breasts
- any irregularities in size or shape
- any skin changes, e.g. dimpling or puckering
- any discharge from the nipples.

16.1 Examine your breasts regularly



When should I seek medical advice?

See your doctor as soon as possible if you notice any lumps in the breast (especially painless lumps and lumps which do not become smaller after your period); any changes in existing lumps; any skin changes such as flaking or weeping around the nipple or dimpling (like orange peel) over part of the breast; withdrawal of the nipple; or pain.

PAP SMEAR

What is a Pap Smear and why should I have it done?

The Pap Smear is a test which allows precancerous changes in the cells of the cervix to be detected at an early stage. Cancer of the cervix is one of the most common cancers in women. Early detection by the Pap Smear will enable treatment to be carried out with a good possibility of a complete cure.

Your doctor will collect some cells from the cervix by gently scraping it with a spatula. This may cause some discomfort. The cells are then sent to a pathologist for examination.

What is an abnormal Pap Smear?

An abnormal Pap Smear is one where the cells have changed or appear abnormal. Often these abnormalities will be minor, but treatment is required to prevent the condition progressing to cancer. Only about 5% of women have abnormal smears.

Who should have a Pap Smear and when should it be done?

All women who have had sexual intercourse should have a Pap Smear every year. Consult your doctor, or the local Family Planning Association or Women's Health Centre. Make sure you check the result of the smear.

If you experience irregular bleeding between periods, bleeding after menopause, bleeding after intercourse, or more vaginal discharge than usual (sometimes brown or bloodstained), see your doctor as soon as possible.

PERIOD PAIN

Why do women sometimes experience pain with their periods?

Period pain happens in women who have high levels of prostaglandins (body chemicals). Prostaglandins can cause cramp-like pains, and sometimes vomiting and diarrhoea. This type of period pain usually begins in adolescence.

Painful periods can also be caused by disease or infection. This is more common in women over the age of 25.

Do I need to see a doctor?

If you are over 25 and experience period pain for the first time, or if you experience pain for a few days before and during or longer than the period, you should see a doctor. You should also consult your doctor if the methods described below for relief of period pain are unsuccessful.

What can I do to relieve period pain?

When lying down, put a pillow under your knees, or lie on your side with your knees drawn up to your chest. A hotwater bottle on your abdomen or lower back may also help. Relaxation techniques and massaging the lower back and buttocks can provide relief.

Develop some new lifestyle habits — exercise regularly (e.g. swimming, walking and cycling); do daily pelvic floor exercises; sleep well, especially when your periods are due; and avoid constipation by eating more fibre and drinking more water.

PREMENSTRUAL SYNDROME

What is premenstrual syndrome?

The symptoms of premenstrual syndrome, also known as premenstrual tension or PMT, may be experienced up to a fortnight before the beginning of a period. The cause is probably hormonal changes. Different women experience different symptoms, including swollen ankles, fingers, legs and abdomen as a result of water retention; swollen, tender breasts; headache; and aches in the back, knees or ankles; clumsiness; irritability and tension; sudden mood swings; aggression and depression. The symptoms are usually much worse in the week before the period and lessen a few days after it has started.

What can I do about it?

Generally caring better for yourself helps — eat well, sleep well, relax (try using a relaxation technique) and cut down stress levels by planning ahead and avoiding stressful situations. Regular, moderate exercise assists, particularly swimming. Wear a well-fitting cotton bra if you get sore breasts and do your pelvic floor exercises daily. Avoid eating chocolate, fatty and salty foods, and drinking too much alcohol or drinks containing caffeine. Try not to wear tight clothes that constrict.

If these measures don't relieve symptoms, see your doctor for more information.

PELVIC FLOOR EXERCISES

What are the pelvic floor muscles?

The pelvic floor muscles provide a muscular floor across the pelvis and act like a hammock. They hold up organs such as the bladder, uterus and intestines, and form the muscle walls for the urethra, vagina and rectum.

Who needs to do pelvic floor exercises?

It is important for women to keep these muscles strong throughout their lives. Starting as a child, you should do these exercises daily, particularly if you are pregnant, if you have had a child, if your job involves lifting heavy objects, and after menopause.

Strong pelvic floor muscles can help you avoid stress incontinence and other problems such as prolapse of the uterus.

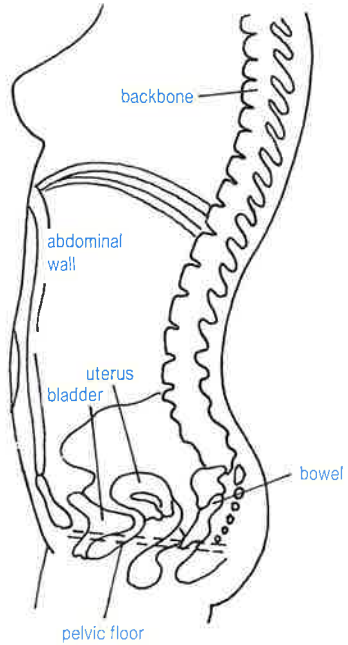
How can I exercise pelvic floor muscles?

Get in the habit of doing your pelvic floor exercises daily. They can be done anywhere without anyone knowing — at the office, while watching TV or talking on the phone.

First tighten the muscles around the entrance of your vagina. Then imagine you are tightening the muscles around the front passage (urethra) to stop yourself urinating. Then tighten the muscles around the entrance of the back passage (anus). Try doing this all at once, holding tight for 5 seconds. Relax for 15 seconds and try again. Repeat this 100 times a day for the rest of your life.

If you have problems with these exercises, discuss how they should be done with a physiotherapist.

16.2 Do your pelvic floor exercises regularly



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St John Ambulance Australia

17 HEALTHY AGEING

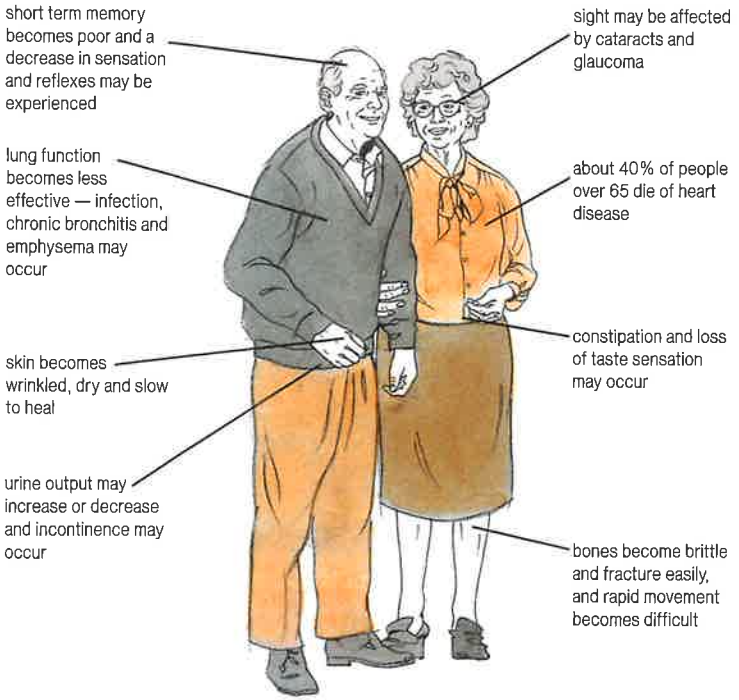
THE PROCESS OF AGEING

Ageing is part of the normal process of human development, but it is not a specific condition that is identical for everyone.

Some characteristic changes to physical appearance include:

- decrease in height due to a stooping posture. This may be the result of habit
- decrease in body size
- thinning hair which becomes grey or white
- loss of hair leading to baldness, particularly in men.

17.1 The ageing process



TAKING GOOD CARE OF YOUR BODY

As you get older, you are more vulnerable to stress, injuries and disease, and the healing process takes longer. Some physical illnesses associated with old age, and loss of function and independence are:

- heart disease
- stroke
- osteoarthritis
- respiratory disease
- cancer
- diabetes.

Taking good care of your body will help you prevent the onset of some diseases. You should:

- have an annual physical examination
- eat well and maintain a healthy weight
- exercise daily — your doctor or physiotherapist will be able to advise you on how much and the type of exercise you should do. Walking is a good moderate exercise and costs nothing
- wear comfortable clothing and shoes
- get adequate rest and sleep
- avoid smoking and keep alcohol intake to a minimum
- maintain good hygiene.

If you feel unwell, consult your doctor. Ask questions about anything you don't understand (writing your questions down before the visit may help). Always make sure you understand how to take any prescribed medications.

HEALTHY EATING

Nutritional requirements vary according to age, weight, amount of activity and climate. In general, a healthy diet based on eating more fibre, less fat and plenty of fruit and vegetables is suggested. More information on a balanced diet can be obtained from the Australian Nutrition Foundation, your doctor or community health nurse. St John Ambulance Australia has produced a pamphlet, *Eating Well*, which contains some ideas on developing a healthy diet.

Various kitchen aids are available to assist in meal preparation. Information on these is available from self-help groups, pharmacies and Independent Living Centres. The Meals on Wheels service can supply one full meal a day for a small fee.

KEEPING ACTIVE

Keeping active is one of the secret ingredients for healthy ageing. That means being active physically and mentally throughout life. Even if you have not been physically active in the past, it is never too late to start. However, remember to seek medical advice before undertaking any new exercise program, and to begin your program gently.

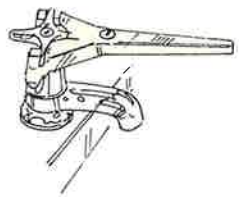
Physical exercises can help you by:

- making blood circulation and breathing more efficient
- improving mobility and muscle function
- improving digestion and decreasing constipation
- controlling your weight
- increasing your energy, confidence and well-being
- giving you the opportunity to meet others
- promoting your independence.

Your local Community Health Centre or Senior Citizens club may have information on exercise groups for elderly people, e.g. tai chi or yoga. Many older people enjoy bowls, golf, tennis and swimming. Walking is very good exercise for people of all ages and has the added advantage of being free.

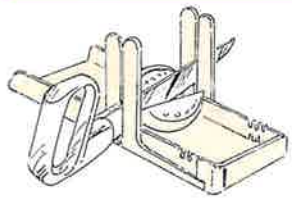
17.2 Aids for independent living

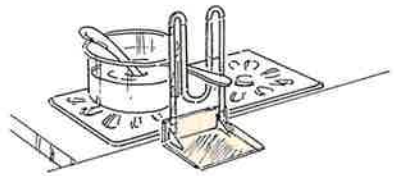
a trolley makes moving things easier

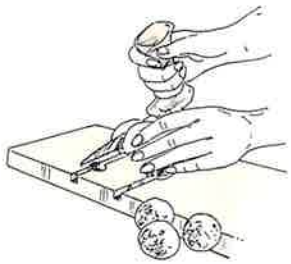


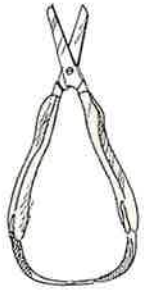
a tap with a lever is easier to turn on and off

extended handles minimize bending









special attachments make it easier to get a grip on things

Taking an active interest in life helps maintain mental activity levels. Playing games such as bridge and joining organizations like Probus or community discussion and craft groups will help you meet other people and get more out of life. Many voluntary organizations (and the community in general) benefit from the experience and time that retired people can contribute as volunteers.

LIVING SAFELY

With increased age, there is a need to compensate for slower reflexes, poor eyesight and other physical disabilities, by taking extra care to prevent falls and other accidents.

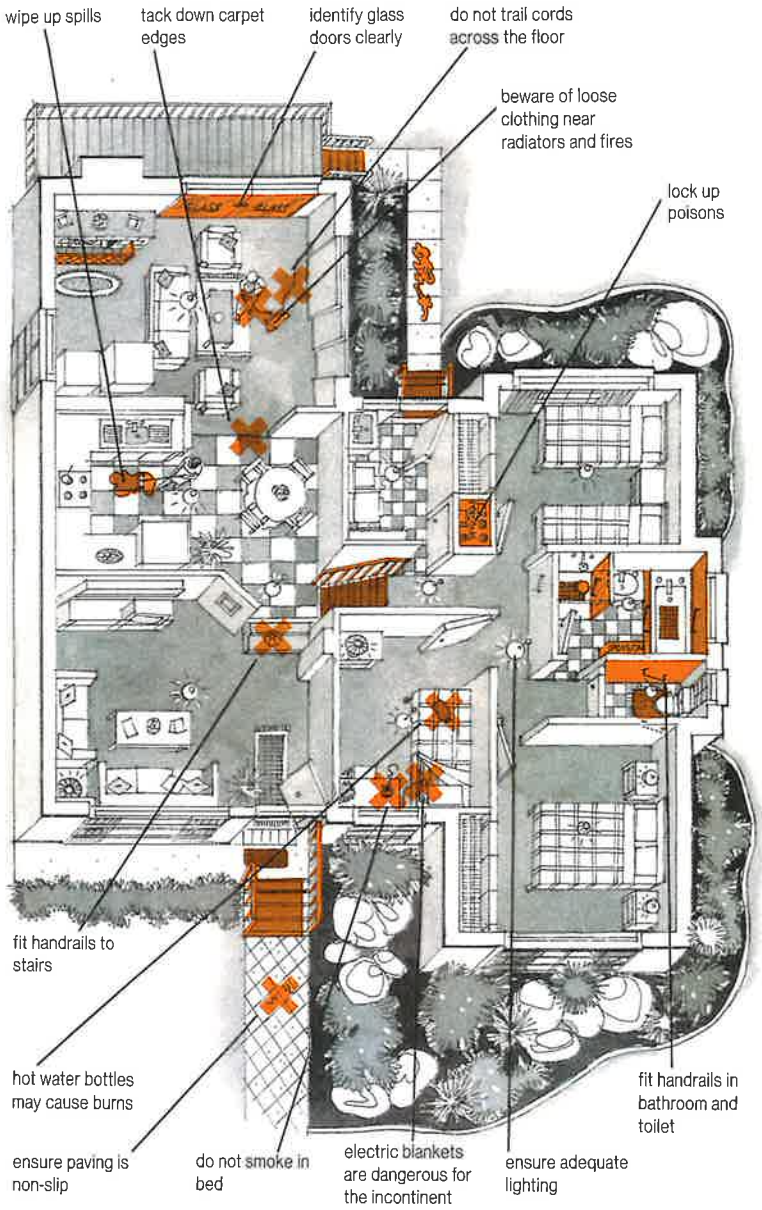
To prevent falls:

- hold firmly to something that will not give way when stooping or reaching upwards
- avoid sudden turns
- change position in stages — from lying to sitting, sitting to standing. Pause after each stage
- if unsteady, sit on a chair to dress and shower
- use a night light to help minimize falls and disorientation when getting out of bed
- ensure that shoes fit properly.

Use this checklist to determine whether your home is safe, or if it needs modification.

- Are carpet edges tacked down and floormats non-slip?
- Do you ensure floors are not over-polished?
- Do you wipe up spills immediately?
- Do you avoid smoking in bed?
- Are glass doors clearly identified?
- Have handrails been attached to stairs, and in the bath, shower and toilet?
- Are fire guards fitted to fireplaces?
- Are the kitchen, bathroom, halls and stairways adequately lit?
- Do you use a rubber suction mat or stool in the shower?
- Are medicines labelled and stored safely?

17.3 Living safely at home



IF YOU BECOME ILL

If you become ill and need to see a doctor, use the following checklist to make sure that you get the most out of your visit. It may help if you write down any questions you have before seeing the doctor.

- Explain the symptoms that you are experiencing.
- Tell the doctor about any medications you may be taking including over-the-counter items.
- Ask the doctor to explain what is wrong with you. When will you recover? How did you become ill and can the illness be prevented from recurring?
- Ask the doctor to explain the results of any tests you have had.
- If medication is prescribed, check if there are any special instructions or any side effects you may experience.
- If you need to see a specialist, find out why.
- Check whether you need to return for another visit.
- Find out what you should do at home about diet, physical activity, treatment and precautions.

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St John Ambulance Australia

18

CARING FOR AN ELDERLY PERSON

To find out more about the ageing process, read the St John Ambulance Australia pamphlet, *Healthy Ageing*.

MAKE SURE YOUR HOME IS SAFE

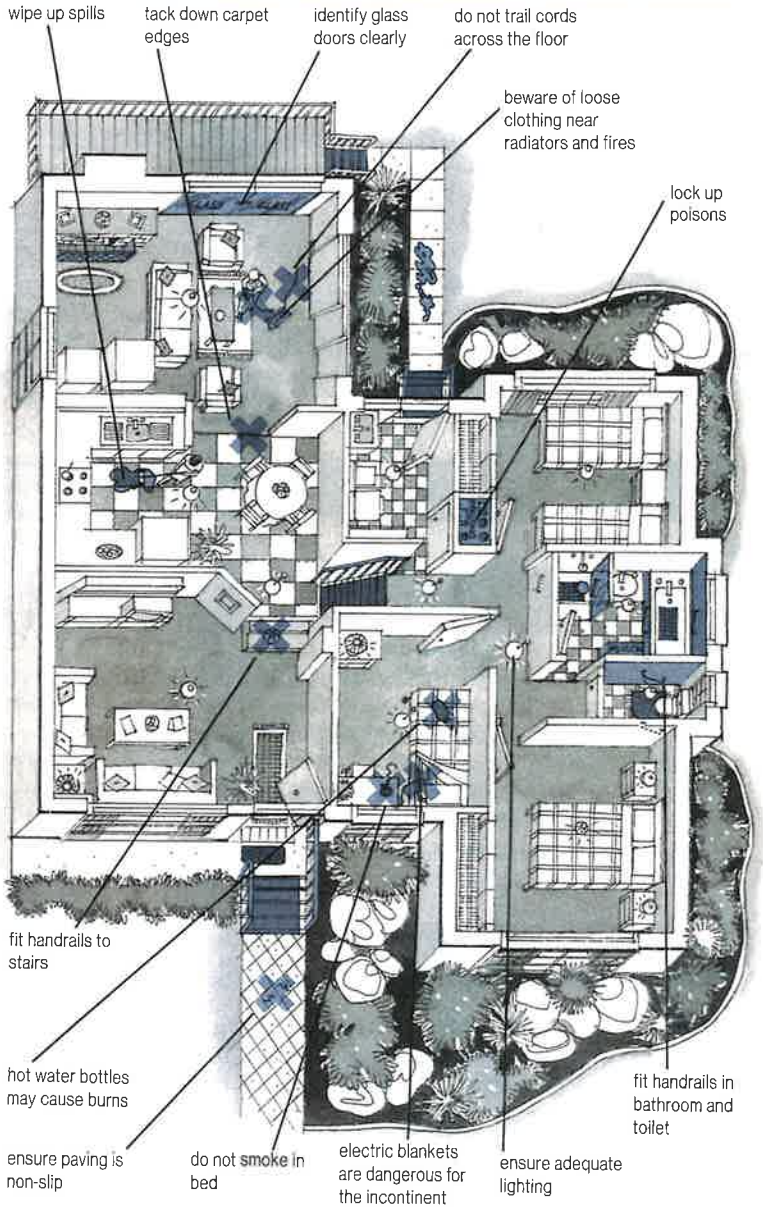
To make a safer home:

1 Floors and fittings
- tack down carpet edges
- use floor mats with non-slip backing
- avoid highly polished floors
- wipe up spills
- avoid beds on castors
- avoid smoking in bed
- tuck in bedspreads
- remove loose objects from floors and stairs
- ensure that glass doors are clearly identified
- fit handrails to stairs.

2 Electrical appliances and heating
- do not have cords trailing across the floor
- beware of loose clothing, long sleeves and trailing sashes near open fires and radiators
- fix sturdy fire guards to fireplaces
- electric blankets are dangerous if the elderly person is incontinent
- hot water bottles may cause burns
- lighting should be bright in the kitchen, bathroom, halls and stairways
- fit two-way switches at the top and bottom of stairs.

3 Bathroom
- use a rubber suction mat in the bath and shower
- fix towel rails within easy reach
- fit hand rails beside the bath, shower and toilet
- have a chair or stool to sit on in the shower
- ensure that water temperature is not too hot.

18.1 Living safely at home



4 Outside
- repair uneven garden paths
- be careful on wet paths or steps
- outline the edges of steps with white paint.

5 Poisoning
- ensure all potentially harmful substances are labelled and stored safely. If the elderly person is confused, medications and other substances should be locked up or kept out of reach.

ENSURE A HEALTHY DIET

Poverty or disabilities that prevent an elderly person from obtaining food may lead to malnutrition. Distance from shopping facilities, lack of access to transport and nervousness about managing in large shopping complexes may compound the problem. Poor eyesight or arthritis may make it difficult to prepare meals. Many elderly people who try to retain independence are reluctant to seek help and may conceal difficulties.

Nutritional requirements vary according to age, weight, amount of activity and climate. For more information on diet, talk to your doctor, community health nurse or hospital dieticians.

PROVIDE EMOTIONAL SUPPORT

The elderly person has to adjust to physical, mental and emotional changes. A supporting family and friendship system is of great benefit.

The death of a spouse will result in grief and loneliness. Many elderly people experience a loss of purpose in life. They may fear being unable to manage alone, and may be confused about unfamiliar activities,e.g. managing finances and preparing meals.

Loneliness is possibly the most significant emotional factor affecting elderly people living alone. However, even those who live with others may experience isolation and loneliness, particularly if unwell or disabled.

Living with other family members may not be easy, for both the elderly person and the family. The elderly person should be involved in household tasks and family events, and retain some independence, in order to foster a sense of belonging and self worth.

Voluntary groups, that cater for the needs of elderly people, exist in the community. They provide assistance with shopping, library services, visiting and social outings. Senior citizens clubs provide a range of activities including arts and crafts, music and other entertainment, bingo, indoor bowls, meals, outings and holiday trips.

Community based day centres offer a variety of activities and are staffed to provide for the needs of frail or incapacitated people. Professional services such as physiotherapy and occupational therapy are available at some centres. Some day centres provide respite for family carers.

ASSIST WITH HYGIENE

Assistance may be required in maintaining personal hygiene, depending on the elderly person's capabilities.

Clothing can become soiled if there is difficulty managing food and drink. If necessary, protect clothing at mealtimes with a serviette or small towel. A feeding cup with a lid is useful if hands are unsteady Assistance may be needed with washing clothes.

Ensure that bathing facilities are safe. If the elderly person does not bath regularly, handle the situation tactfully to avoid offence.

Poor eyesight, weak or painful hands and other disabilities may prevent adequate footcare. If neglected, toe nails become long, hard and uncomfortable, and the skin between toes may become split and infected. Regular attention by a podiatrist may be advisable.

Care of pressure areas and prompt cleaning and drying of the skin if the elderly person is incontinent are essential. Continence problems may be worsened by decreased mobility, arthritic hands and speech impairments. Incontinence is distressing and needs to be dealt with kindly to minimize embarrassment. Anger

and denial are common reactions: it is advisable to check that soiled clothing has not been concealed in drawers or wardrobes. A variety of pads and incontinence pants are available, and clothing should be easy to manage and launder. At night, it may be preferable to place a urinal or commode within easy reach.

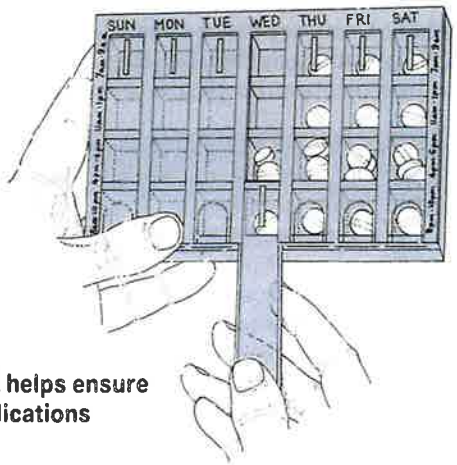
Practical advice on dealing with continence problems may be found in the St John Ambulance Australia pamphlet, *Clean and Comfortable*.

Elderly people living in their own home may require assistance with house cleaning. This situation may also require tactful handling to avoid offence.

ENSURE MEDICATIONS ARE USED SAFELY

Some childproof containers are extremely difficult to open, particularly if the elderly person has poor eyesight or arthritic hands. This situation should be reported to the pharmacist so that alternative packaging can be arranged.

An elderly person with memory lapses or confusion may be unable to remember whether or not medications have been taken. This can lead to under- or overdosage. If this is experienced, a family member may be able to administer the medication at the appropriate time. Alternatively, Dosetts are available, allowing medications to be placed into timed compartments for a week. These can be filled by the pharmacist, community health nurse or a family member.



18.2 A Dosett helps ensure safe use of medications

CARING FOR THE CONFUSED ELDERLY PERSON

Temporary confusion may occur if a person has an illness such as pneumonia or a kidney infection. With some mental illnesses, periods of confusion may be experienced. However the majority of confused elderly people have a condition of a more permanent nature.

In some cases, e.g. in persons suffering from an infection or injury, or overdose of medication, mental confusion may occur rapidly. It is important to observe the elderly person carefully. This confusion is usually reversible if medical aid is sought promptly.

Dementia means a loss or impairment of mental powers and may be caused by several different diseases, e.g. Alzheimer's' disease. The intellectual capacity deteriorates gradually from forgetfulness to total disability. The cause is unknown and there is no known cure or means of preventing the disease progressing. Dementia may be accompanied by other illnesses. The confused person is also less likely to take responsibility for his/her own safety.

When the diagnosis is made, the affected person and the family have to come to terms with living and coping with a chronic disabling condition. The rate of progression of the disease varies amongst individuals, and the person's abilities may change from day to day.

It is important to realize that many of the person's actions are beyond his/her control and that the concentration span is poor. The elderly person may become distressed and frustrated at his/her own confusion and mistakes.

Some people experience dramatic personality changes, becoming demanding or passive, dependent, easily upset and irritable. Frequently they become suspicious of other people, including family members.

As the dementia progresses, the memory becomes worse. Taps may be left running and electrical appliances left on. Memory aids, e.g. labelling drawers and reminders such as 'TURN OFF THE STOVE', may be helpful. Clocks and calendars in view may assist with time orientation. Talking about family members and having photographs on display may help in recognition of others.

Eventually, the person will become uncoordinated, unable to read, write, speak coherently, walk or perform simple tasks such as dressing.

Some general suggestions for caregivers are:

- be informed, so that you will be more effective in managing behaviour and other problems
- try to devise appropriate memory aids together with the confused person
- try to solve problems one at a time
- if possible, organize respite care to allow the caregiver and family time to regain physical and emotional strength
- be prepared to adapt to constantly changing situations
- share your experiences with others and try to maintain a sense of humour
- try to establish an environment that allows as much freedom as possible, whilst also providing structure and security for the confused person
- talk to the confused person and explain what you are doing. Repeated explanations may be required
- an identity necklace or bracelet is advisable as a confused person may wander and become lost
- encourage the person to undertake moderate exercise, e.g. walking
- look for things the person is still able to do, and try to involve him/her in family life for as long as possible.

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19 CARING FOR THE MENTALLY ILL

Caring for someone who is mentally ill requires patience, affection and above all, knowledge about the person's illness.

A mental disturbance may be a disorder of thinking, memory, mood, perception or personality. It may be precipitated by too many life events which are negative and unpleasant. It is often associated with physical illness and may be acute or chronic.

Specific clinical syndromes may be classisfied as:
- disorders of infancy, childhood and adolescence
- organic mental disorders, including delirium and dementia
- substance use disorders, e.g. alcohol abuse
- affective disorders, including depression, mania or both
- anxiety disorders
- psychosexual disorders
- personality disorders.

The mentally ill person may be a grandparent, parent, spouse, sibling or child. Of greatest significance in old people are the dementias, e.g. Alzheimer's disease.

WHAT IS DEMENTIA?

Dementia is defined as a loss of intellectual abilities of significant severity to interfere with social or occupational functioning. Features include loss of memory, memory impaired judgement, impairment of abstract thinking and personality change.

WHAT ARE SCHIZOPHRENIAS?

There are several types of schizophrenias. These may include:
- bizarre delusions (false beliefs which can not be logically assessed)
- auditory hallucinations (voices which persecute the ill person).

WHAT IS AN AFFECTIVE DISORDER?

Major affective illnesses are dominated by a mood disorder which can swing from mania to depression. Signs of mania include:
- euphoric mood
- talking loudly and fast
- overactive behaviour, including not sleeping.

Signs of depression include:
- sadness
- weight loss or gain

- sleeplessness
- being underactive with loss of energy
- recurrent negative thoughts including thoughts of suicide.

DOES PSYCHOSIS OCCUR IN CHILDHOOD?

Psychosis in childhood is rare. Behavioural disturbances in childhood generally reflect family disturbance. Mental retardation is often confused with mental illness.

WHAT ROLE DOES HOSPITALIZATION PLAY?

Hospitalization is usually brief and flexible. The emphasis is on maintaining contact with the family and community, and helping the ill person adapt to them more effectively.

WHAT ARE THE PROSPECTS FOR RECOVERY?

Much depends on the quantity and quality of continuous treatment, and stresses to which the person continues to be exposed, and the severity of the illness. Social recovery, e.g. returning to family and job, is often excellent.

How can the caregiver help a mentally ill person?

Some changes may be required to family life. Tolerance and understanding of the problem will be needed. The following are guidelines that may be adapted to suit an individual's needs and to help the person cope with daily social skills:

- encourage contact with current affairs
- assist time orientation by having a clock and calendar in view
- reinforce communication skills. Encourage the person to discuss issues and talk with friends and other family members.
- assist with personal hygiene, if necessary
- ensure adequate nutrition
- encourage the person to avoid sleeping through the day
- encourage the person to take up a hobby — old or new
- arrange outings
- compliment the person when an effort has been made to enhance physical appearance
- ensure medication is taken correctly
- ensure that doctor's appointments are kept
- find out what support services are available in your local community
- report any changes in behaviour to the doctor
- avoid stressful situations.

If problems arise:

- don't bully — be firm
- don't mother or smother — treat the ill person as an adult
- don't break promises
- explain what you are doing clearly
- understand the person's responses.

Where can I find more information?

More information is available from state and federal health authorities and support groups such as GROW and the Schizophrenia Fellowship.

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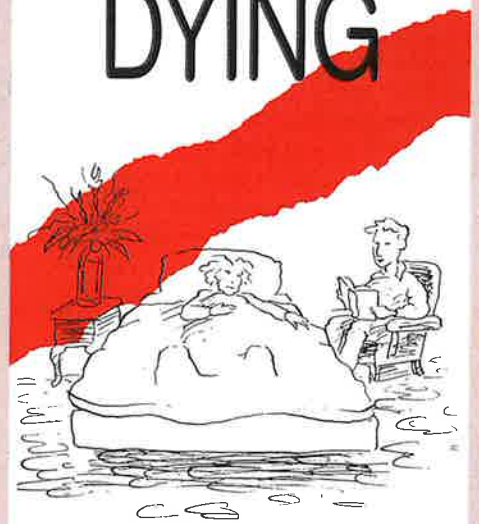
CARING FOR THE DYING



Death may be sudden, preceded by a short illness or a long and painful illness. It is approached with varying degrees of calm, fear or trepidation. Many terminally ill people prefer being at home amid familiar surroundings, rather than in hospital.

Because of the problems associated with terminal illnesses, special demands may be made on the caregiver and family.

The key factors in care of the dying are:

- care for the person's physical comfort
- patience, compassion and an understanding of the psychological reactions of the person facing death.

THE PERSON I AM CARING FOR DOESN'T WANT TO EAT. WHAT CAN I DO?

Loss of appetite (anorexia) commonly occurs. The person may be uninterested in eating or drinking. It is important to maintain adequate fluid intake. Small quantities of high protein fluids are ideal.

Nausea and vomiting may occur as a result of the illness, as a side-effect of prescribed drugs, or as a result of psychological or emotional factors. Seek medical advice.

Difficulty in swallowing (dysphagia) is a common problem and may become so severe that anything taken by mouth can cause retching or coughing. Try to discover what the person finds easiest to swallow. Iced drinks, junket and yoghurt are often acceptable.

WHAT SHOULD I DO ABOUT NAUSEA AND VOMITING?

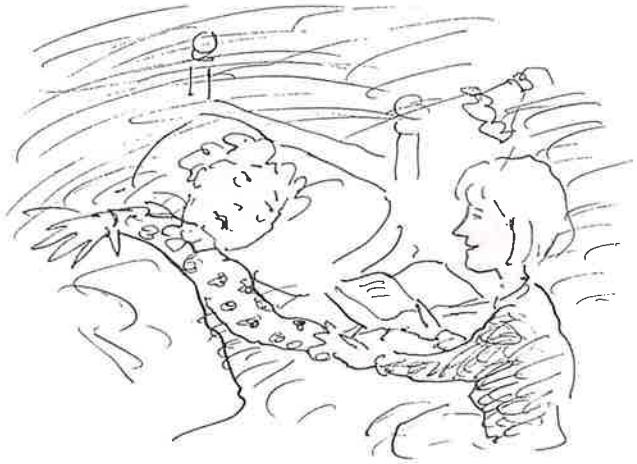
Nausea and vomiting may occur as a result of the illness, as a side-effect of prescribed drugs, or as a result of psychological or emotional factors. Discuss this with your doctor.

THE PERSON I AM CARING FOR HAS DIFFICULTY BREATHING. HOW CAN I HELP?

Difficulty in breathing (dyspnoea) is worrying for both the person and the caregiver. An upright position, with pillows for support, may assist. Try to remain calm and reassure the person. Seek medical advice.

HOW CAN I HELP THE PERSON I AM CARING FOR TO SLEEP?

Insomnia (difficulty in sleeping) may be lessened by a warm drink, toileting and a change of sleeping position. Sometimes sleeping tablets may be ordered by the doctor and, if pain is a problem, analgesic drugs will be ordered to be given regularly or when pain is suffered. The person may be too frightened to sleep. A night light may provide comfort at such time, or a loved one or special friend may sit alongside until the ill person falls asleep.



WHAT OTHER SPECIAL NEEDS DOES THE DYING PERSON HAVE?

Special needs include care of pressure areas, and helping the person to adopt a position of comfort in bed. If too weak to move, the person should be turned gently and frequently.

In the last stages of dying, the person may wander mentally while consciousness comes and goes. Even when there is no sign of recognition, he/she may still be aware of those nearby and find great comfort in such a presence.

HOW DO PEOPLE RESPOND TO THE KNOWLEDGE THAT THEY ARE DYING?

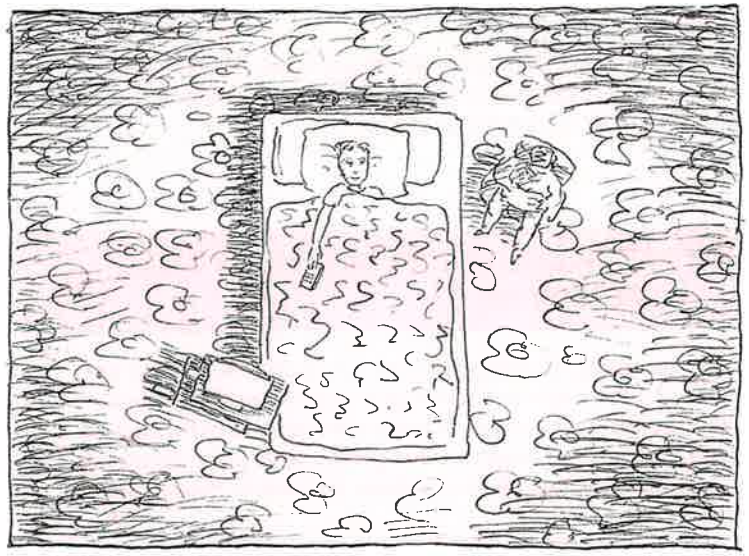
The reactions and responses of those facing death differ from one individual to another. However, studies have shown that the emotional reactions of the dying usually progress through five stages:

- denial and isolation
- anger
- bargaining
- depression
- acceptance.

The stages may not necessarily occur in this order and may overlap.

Denial and isolation

Knowledge that death is imminent can be difficult to accept. The automatic protection measure that develops is one of denial. Sometimes family members may deny the reality of the situation as a means of coping. This stage passes when the person realizes he or she is being cheated of time and may begin to think of things that will not be able to be attended to.



Anger

Sudden realization of the truth may lead to anger. The person may exhibit difficult behaviour and nothing seems to please. There is no harm in encouraging the venting of anger. Patience and understanding will help the person.

Bargaining

This stage is an attempt by the person to cope. He/she may try to negotiate a bargain. The bargaining may be with the doctor, someone close, a relative, or God. The person is often pleading for extra time. If the reason or the event for which extra time is required can be granted, death is often faced with greater acceptance.

Depression

Depression occurs when the inevitability of death is realized. Few defences remain. Sadness and anguish follow. This stage usually leads to acceptance.

Acceptance

This can be a time of peace and tranquillity, of reflection on the past as well as preparation for death. During this stage some may find comfort through spiritual means.

WHAT SPIRITUAL SUPPORT DOES A DYING PERSON NEED?

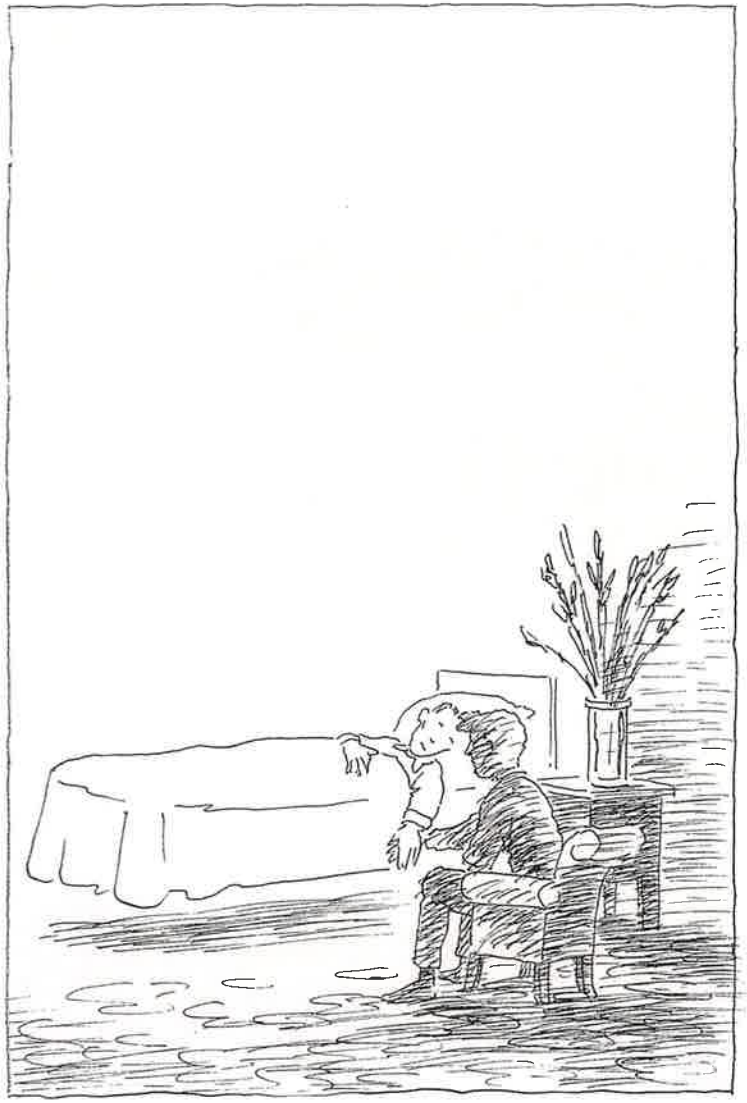
If you are caring for a dying person, it is important that you are aware of his/her spiritual beliefs and customs relating to death. There are great differences in the commitment of individuals to spiritual values and religion. If the person wishes, the assistance of an understanding priest or minister can help in preparing for death.

Many people who are dying do not like to be left alone. Comfort for both the person and the family can be greatest when members of the family and close friends take turns at sitting with him/her. This is the time when both the person and family can talk about their personal feelings, bringing great spiritual comfort to all.

At the time of death, the person's religious beliefs and customs, e.g. the giving of last rites, not touching the body with bare hands, should be respected.

WHERE CAN I GET MORE HELP?

Your doctor or community health nurse will be able to arrange for professional counselling or assistance with the dying person's physical needs. They will also be able to put you in touch with voluntary support groups.



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21 CARING FOR A DISABLED PERSON

LEADING A NORMAL LIFE

Whether the disability is short-term, e.g. a fracture, or long-term, e.g. spina bifida or multiple sclerosis, a disorder of mentation, e.g. Alzheimer's disease or a physical constraint due

to sensory impairment, e.g. blindness, the aim is to encourage maximum independence for the disabled person with minimum disruption to the family.

With the help of community support services, disabled people should be helped and encouraged to lead as normal a life as possible. This pamphlet provides some hints to help you achieve this aim.

MAKING YOUR HOME MORE ACCESSIBLE

If the disabled person is in a wheelchair, significant modifications to your home may be required. The areas that present greatest problems to people in wheelchairs are the toilet, bathroom and kitchen. Undercover access from the car to the house is desirable.

Mats, carpets, wet and polished floors may be hazardous to people using crutches or a stick. Mats can have a non-slip backing attached and frayed carpets should be repaired. Always wipe up spills promptly and avoid over-polishing floors.

If the person has a short-term disability, minor modifications such as small wooden ramps, hard rails and extension tubing for the shower can enable the person to manage independently.

In the case of long-term disability, major house alterations such as a lift and an ensuite bathroom may be required. It may even be necessary to move to a more accessible home at ground level.

Advice on making your home more accessible can be obtained from Independent Living Centres, therapists at your hospital's rehabilitation unit, or volunteer support groups.

GETTING AROUND

Disabled people need to be able to move around independently, using crutches or a wheelchair if necessary. It is important that they are able to travel outside the home. If public transport is not appropriate, wheelchair taxis (Medicabs) are now available. Vouchers enable disabled people to travel for half fare.

Your doctor, rehabilitation unit therapists and volunteer support groups can provide information on the various options available to increase mobility.

WHAT CAN YOU DO FOR A DISABLED PERSON?

Treat the person with respect. He or she needs your understanding and patience, and possibly assistance with some aspects of daily living. Ask what help is required and be prepared to assist if necessary. You may also need to work in conjunction with other people as part of a team. Find out what support services are available in your community.

FINDING HELP IN YOUR COMMUNITY

Volunteer support services are listed in the white pages of the telephone directory. Your doctor, Community Health Centre or rehabilitation unit may also be able to provide you with information.

Disabled people need to be made aware of available community resources, and should be encouraged to use them. Continuing involvement within the community, and maintaining social relationships with family and friends help people remain independent.

Caregivers also need help sometimes. Encourage other relatives or friends to help, especially at weekends. Respite care may also be available in your area — check with your doctor or Community Health Centre.

SPECIFIC NEEDS OF VARIOUS DISABLED GROUPS

Tetraplegia

Tetraplegics may experience loss of hand movement, feeling in the trunk and lower limbs, balance, temperature control, voluntary control over bowel and bladder and normal sexual function. With training and simple aids, many of these problems can be overcome. However they remain vulnerable and can lose their independence as a result of apparently minor accidents.

Paralysed limbs often fracture easily. Burns can occur over desensitized areas in the shower. Urinary or faecal incontinence can result if diets are not adhered to. Minor scrapes over pressure areas such as the buttocks can often lead to pressure sores. Any of these minor problems can cause the tetraplegic to become totally dependent, and hence, most are not able to live alone.

Bladder management in tetraplegics is usually in the form of a penile sheath attached to a leg bag for males, and a permanent in-dwelling catheter for females.

Most independent tetraplegics can drive with hand controls and many return to the workforce.

Paraplegia

Given the ideal environment, paraplegics can manage alone, but are still vulnerable to pressure sores, urinary tract infections and bowel problems that can render them in need of help. These problems may lead to employment difficulties, although most paraplegics return to the workforce.

People with good hand function can usually manage their bladder by self-catheterizing every 4 hours. Bowel action can be initiated with the insertion of suppositories.

Although sexual function is limited, most spinally injured people derive some sexual gratification from alternative sexual practices and all have normal libido (sex drive). Most females are able to bear children, but only 20% of males are fertile.

Nearly all paraplegics can drive with hand controls.

Spina bifida

These people have the same problems as paraplegics, but suffer usually from additional problems related to hydrocephalus (pressure on the brain in early life). This is usually controlled by the early insertion of a 'shunt' which drains excess fluid from around the brain into the abdominal cavity. They are often left with some residual brain damage that may be subtle, but may cause poor academic achievements; the usual weakness being in mathematics. They often have difficulty organizing themselves when attempting to live in an independent situation. Many remain unduly dependent on their parents.

Multiple sclerosis

This is a progressive disease that can continue for many years. It eventually can lead to all the problems that are associated with tetraplegia but can also affect the brain and cranial nerves.

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ALCOHOL AND DRUG DEPENDENCY

EFFECTS ON THE FAMILY

Dependency on alcohol and other drugs frequently results in a chaotic domestic lifestyle which seriously affects family, marital and household relationships. The caregiver in the family

may well be in the uncomfortable position of providing care, but receiving little thanks for it. He/she may receive verbal and/or physical abuse because of the effects of the drugs. For this reason the caregiver should have a support system — other family members or close friends — to give much needed help. The nature of drug dependency, however, frequently results in other people avoiding the family because of the distress they feel at observing or even receiving abuse themselves.

SUPPORT SERVICES

Drug and alcohol counsellors are located in most regions. The caregiver should adhere to any advice offered by them. Emotional and practical support can be obtained from them and from self help groups in the community, e.g. Al-Anon, Al-Ateen and Nar-Anon. The local Community Health Centre will give you details of their locations. You will find the phone numbers of Lifeline, local hospitals and other agencies where you may find help in your telephone directory.

DEPENDENCY

Dependency can occur with the following groups of drugs:

- alcohol
- barbiturates, e.g. Amytal, Phenobarb
- benzodiazepines, e.g. Valium, Serepax, Mogadon
- narcotics, e.g. morphine, heroin.

These drugs act on the central nervous system (C.N.S.) and depress various functions. They are known as C.N.S. depressants. Other drugs upon which people may become dependent are stimulants, such as amphetamines and hallucinogens such as L.S.D.

A person can easily become dependent upon these drugs because they are psychotropic, or mind/mood altering substances which can relieve the stresses, anxieties or pain of an unpleasant life situation. Repeated taking of the drug provides a mental state which may be preferable to facing the realities of life.

Many drugs have chemical properties which change the function of the central nervous system cells. If a person ceases taking the drug, an extremely unpleasant or even fatal withdrawal syndrome may be experienced, as the body tries to adapt to the changed chemical environment. The person therefore continues taking the drug to prevent this feeling from occurring. This is when drug-seeking behaviour begins to dominate the person's life. A number of doctors may be used to obtain prescriptions for legal medications, or the supplies may be procured illegally. In the case of alcohol, there is easy legal access to plentiful supplies.

People who are drug dependent frequently resort to subterfuge, lying, dishonesty and other antisocial behaviours to meet their need for a constant supply of drugs. They need professional help to change their behaviour, often with medical intervention to support them physically through the period of withdrawal.

THE CAREGIVER'S ROLE

The caregiver must administer any prescribed medications exactly as ordered, and ensure that the person does not have access to other drugs.

A common problem is that of the person who is dependent upon two or more different drugs, as the effects of many drugs are additive.

This can have very serious, and potentially fatal effects, e.g. a person may become unconscious if too much medication is taken with alcohol.

The person should be warned of the dangers of drinking alcohol with other drugs. It would be wise to monitor his/her behaviour closely if alcohol is kept in the house, or to lock up the alcohol.

When a person is confined to the home with a physical illness, it may be very tempting for the caregiver to use the opportunity to withhold the dependent person's drugs. **This must never be attempted** as such action could cause serious effects. Such an intervention should only be started with professional advice and support.

WITHDRAWAL

When a drug dependent person is in a state of withdrawal, the caregiver must be aware that sudden changes in physical and medical condition can occur. Depending on the nature of the change, medical help may be required urgently. The person may not have admitted the extent of the dependency, in which case the withdrawal syndrome could be far worse than anticipated.

Unless the withdrawal syndrome is very mild, the person withdrawing from alcohol, barbiturates or benzodiazepines may experience:

- anxiety
- fear/agitation
- disorientation in time, place or situation
- dehydration
- visual, auditory and tactile hallucinations, i.e. the person sees, hears and feels things that are not present in the environment, yet believes they are real
- seizures (fits)
- occasionally, death from cardiovascular collapse.

A person withdrawing from narcotics may experience:

- anxiety
- raised blood pressure
- tremor
- agitation
- sleeplessness
- cramps
- diarrhoea and/or vomiting
- sweating
- dehydration
- flushing or pallor
- sneezing
- visual or auditory illusions (false perceptions of real objects).

The person will not have a seizure (fit). The withdrawal from narcotics may be similar to a bad dose of the flu, but the person experiences it as a distressing event because he/she is used to blocking out physical and mental pain with a drug.

MANAGEMENT OF WITHDRAWAL AT HOME

Seek advice from your doctor about when and how the withdrawal program should be taken. The management of withdrawal at home must be with close medical supervision.

The environment

A quiet atmosphere is important. Keep visitors to an absolute minimum, and encourage family members to be as quiet as possible, as the person can be overstimulated by noise and movement in the house. Be alert to the fact that friends could bring more drugs (particularly narcotics) to the person.

The room should be well lit because the person may become fearful, anxious and hallucinate in a dark or ambiguous environment where the unreal cannot be differentiated from the real.

Psychological management

Remain with the person as much as necessary and listen and talk, reorienting him/her in time and place, and providing factual information on his/her condition. For example, you could say, 'Dad, you're in your own bed at home. It's 9 o'clock on Saturday morning. You're feeling very restless because you are getting over the effects of alcohol'.

If the person is anxious:

- try some relaxation exercises
- explain the nature of the withdrawal process and assure the person that it will pass
- use gentle touch
- use the person's name
- do not become bossy, authoritarian or angry
- appear calm, relaxed and attentive
- do not talk too much, and keep the conversation at a simple level.

Physical management

- nausea — ensure adequate fluid intake, e.g. orange juice, and give vitamin B1
- tremor — this may last up to 3 days. Assure the person that it will pass
- diarrhoea — give fluid and foods in small amounts. Give multi B vitamins as prescribed
- vomiting — have bowl or bucket available and ensure adequate fluid intake. Give any medication ordered by the doctor
- cramps — encourage eating small amounts of food often. Keep limbs warm (with hot water bottles, warm baths and blankets) and massage them gently. Give any medication ordered by the doctor
- insomnia — it may take months for a normal sleep pattern to be restored. Avoid giving sedative drugs. Encourage sleep with a warm bath, warm milk, a walk, relaxation techniques, or quiet music.

WITHDRAWAL SEIZURES

A withdrawal seizure (fit) is a medical emergency. It may occur between 24–28 hours after cessation of alcohol, barbiturates or benzodiazepines if these drugs have been taken in even moderate amounts over a period of time.

The person will lose consciousness and a violent, involuntary contraction or series of contractions of the voluntary muscles occurs. Urine may be passed involuntarily. The seizure will normally last a few minutes.

Management:

- seek medical aid
- maintain the person's airway, and keep the tongue forward by pressure on the angle of the jaw
- move any dangerous objects and protect the person
- avoid restraining the person
- keep your fingers out of the person's mouth
- roll the person on to the side and loosen tight collar and clothing
- eliminate loud noise
- assist the person to bed following the seizure and observe for changes in the level of consciousness
- monitor the person for onset of *Delirium Tremens*.

DELIRIUM TREMENS (DT'S)

Delirium Tremens may be preceded by seizures. The person is disorientated, excited and has hallucinations.

Symptoms and signs:

- rising blood pressure and pulse
- perspiration
- tremor
- anxiety
- agitation
- high temperature
- hallucinations
- disorientation.

Management:

- seek medical aid urgently.

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