

# PATIENT CARE IN THE HOME



A TEXT BOOK OF HOME NURSING

PATIENT CARE  
IN THE HOME

# PATIENT CARE IN THE HOME

A TEXTBOOK OF HOME NURSING

By

**M. CHRISTINE LIVINGSTON, B.S., REG. N.,**

**M. PEARL STIVER, B.S., REG. N.**



PUBLISHED, AUTHORISED, AND APPROVED BY  
**THE ST. JOHN AMBULANCE ASSOCIATION OF THE ORDER OF  
ST. JOHN OF THE PRIORY IN AUSTRALIA**

1969

FIRST AUSTRALIAN EDITION 15000 COPIES



Copyright and published in Australia by the  
St. John Ambulance Association of the Order of St. John.

Registered in Australia for transmission  
by post as a book.

Printed in Australia by The Ruskin Press Pty. Ltd.  
39 Leveson Street, North Melbourne, 3051.

## PREFACE AND ACKNOWLEDGEMENTS

Today, with hospital facilities increasing and health services expanding, one may wonder why there is so much emphasis on the care of patients in the home. Perhaps this is one reason why home nursing is so important. Although there is an ever increasing number of hospitals, there still are not enough to meet the needs of the population. Therefore, it is important to conserve hospital beds for those persons who need them most, the acutely ill.

There are other reasons for instruction in home nursing. Many patients, particularly children and older persons, seem to respond more readily to care in their own homes. This knowledge is of particular importance for the mother and homemaker.

Every year, somewhere in our country, a community may have to face the emergency of fire, flood or storm. Added to these there is in this atomic age, the possibility of enemy attack. In any such event, the care of the sick, injured and infirm, becomes a responsibility too great for the organized health services to cope with. The importance of every individual having a knowledge of first aid and home nursing takes on a new dimension in terms of community organization.

Although prepared as a basis for the Home Nursing course of St. John Ambulance, it is hoped that this text may be a useful guide for families during illness in the home. It is assumed, and this is emphasized, that any treatment or care, other than immediate first aid, has been ordered by a physician.

This text, and the courses for which it is prepared, does not in any way pretend to provide training or preparation for nursing as a career. It may, however, help create an interest in nursing and, through the courses, young people may discover that they have an aptitude for nursing and decide they wish to pursue it. Home nursing courses help provide preparation for voluntary service in the community.

For purposes of clarity and easy reference the authors have divided "Patient Care in the Home" into two parts.

—Part One presents general information regarding home nursing.

—Part Two gives an outline of simple nursing procedures and some methods of improvisation to fit into the family setting.

"Care Under Emergency Conditions" has been included as Part Three.


It is the hope of the authors that this text will prove helpful to families, to students who enrol in the Home Nursing Courses sponsored by St. John Ambulance, as well as to organizers and instructors of the course.

## FOREWORD

This manual is an abridged edition of the Canadian publication "Patient Care in the Home", and the Priory in Australia is indebted to the Priory of the Order of St. John in Canada for granting permission to publish material from that book.

This publication will satisfy a need in every home, and will also be used as the official manual for instruction and examination in Home Nursing within the Priory in Australia.

8/10/1969

  
E. A. DALEY,  
Director,  
St. John Ambulance Association,  
Priory in Australia.

# TABLE OF CONTENTS

## PART ONE

### **General Information**

|                   |                                   |                |
|-------------------|-----------------------------------|----------------|
| <b>CHAPTER I</b>  | <b>ILLNESS IN THE HOME</b>        | <b>Page 3</b>  |
|                   | Comfort of Patient                |                |
|                   | The One Who Gives Care            |                |
|                   | Rehabilitation of Patient         |                |
|                   | Posture of Patient and Attendant  |                |
|                   | Patient's Record                  |                |
|                   | Summary                           |                |
| <b>CHAPTER II</b> | <b>OBSERVATION OF THE PATIENT</b> | <b>Page 11</b> |
|                   | Things to Watch For               |                |
|                   | General Appearance                |                |
|                   | Condition of Skin                 |                |
|                   | Facial Expression                 |                |
|                   | Tongue, Mouth and Throat          |                |
|                   | Pain                              |                |
|                   | Temperature, Pulse, Respiration   |                |
|                   | Cough                             |                |
|                   | Vomiting                          |                |
|                   | Stools                            |                |
|                   | Urine                             |                |
|                   | Summary                           |                |

**CHAPTER III      NUTRITION      Page 17**

Food Guide  
The Patient's Diet  
Function of Foods and Calorie Control  
Overweight  
Special Diets  
The Patient's Tray  
Preparation of Patient for Meals  
Happiness at Meal Time  
Summary

**CHAPTER IV      PREVENTION OF ILLNESS AND CONTROL OF INFECTION      Page 25**

Cause of Infection  
Ways by Which Disease Germs May Enter the Body  
How Infection Is Spread  
    Direct Contact  
    Indirect Contact  
Measures to Prevent the Spread of Infection  
Natural Defences of the Body  
Immunity  
Immunization  
Air Travel  
Individual Measures for Protection Against Infection  
Nursing Care of Patient with a Communicable Disease  
Charts of Some Common Communicable Diseases  
Summary

**CHAPTER V      CARE OF THE SICK CHILD      Page 39**

General Care of Sick Child  
Preparing Child for Hospitalization  
Care of Child in Convalescence  
Summary

**CHAPTER VI      SPECIAL NEEDS OF AGED AND PATIENTS WITH LONG-TERM ILLNESS      Page 43**

**Special Needs of the Aged**

Emotional Needs

Physical Needs

    Fresh Air and Exercise  
    Relaxation, Rest and Sleep  
    Clothing

Personal Hygiene

    Bathing  
    Care of Skin  
    Care of Feet, Hands, Hair and Mouth  
    Elimination  
    Diet

Prevention of Accidents

**Special Needs of Patients with Long-Term Illness**

    Emotional Needs  
    Bed and Bedding  
    Rehabilitation  
    Posture  
    Exercise  
    Incontinence  
    Prevention of Pressure Sores

Summary

**CHAPTER VII      PREVENTION OF HOME ACCIDENTS      Page 55**

Special Hazards to Little Children

General Accident Hazards

Special Hazards to the Elderly

Summary

## PART TWO

### **Simple Nursing Procedures**

|                     |  |                |
|---------------------|--|----------------|
| <b>CHAPTER VIII</b> | <b>GENERAL CARE OF PATIENT</b>             | <b>Page 63</b> |
|                     | Hand Washing of Attendant                  |                |
|                     | Daily Routine                              |                |
|                     | Morning Care                               |                |
|                     | Afternoon Care                             |                |
|                     | Evening Care                               |                |
|                     | Summary                                    |                |
| <b>CHAPTER IX</b>   | <b>CARE OF PATIENT NOT CONFINED TO BED</b> | <b>Page 69</b> |
|                     | Preparing Patient to Get Out of Bed        |                |
|                     | Getting Patient into a Chair               |                |
|                     | Helping Patient to Walk                    |                |
|                     | Patient's Tub Bath                         |                |
|                     | Patient's Shower Bath                      |                |
|                     | Making an Unoccupied Bed                   |                |
|                     | Making Mitred Corner                       |                |
|                     | Summary                                    |                |
| <b>CHAPTER X</b>    | <b>CARE OF PATIENT IN BED</b>              | <b>Page 79</b> |
|                     | Patient's Bed Bath                         |                |
|                     | Making Bed With Patient In It              |                |
|                     | Feeding a Helpless Patient                 |                |
|                     | Care of Patient's Mouth and Teeth          |                |
|                     | Care of Dentures                           |                |
|                     | Shampooing Patient's Hair in Bed           |                |
|                     | Taking Temperature, Pulse and Respiration  |                |
|                     | Points to Remember When Taking Temperature |                |
|                     | Taking Temperature by Mouth                |                |
|                     | Taking Temperature by Axilla (Armpit)      |                |
|                     | Taking Temperature by Rectum               |                |
|                     | Counting Pulse and Respirations            |                |
|                     | Bed Pans and Urinals                       |                |
|                     | Giving Patient Bedpan                      |                |
|                     | Putting Helpless Patient on Bed Pan        |                |
|                     | Urinals                                    |                |
|                     | Summary                                    |                |

|                     |   |                 |
|---------------------|---|-----------------|
| <b>CHAPTER XI</b>   | <b>TREATMENTS WITH HEAT OR COLD</b>               | <b>Page 101</b> |
|                     | Dry Heat Treatments                               |                 |
|                     | Electric Pad                                      |                 |
|                     | Electric Blanket                                  |                 |
|                     | Heat Lamp   |                 |
|                     | Ultra Violet Radiation or Sun Lamp                |                 |
|                     | Hot Water Bag                                     |                 |
|                     | Moist Heat Treatments                             |                 |
|                     | Hot Moist Compresses                              |                 |
|                     | Steam Inhalation                                  |                 |
|                     | Cold Treatments                                   |                 |
|                     | Ice Bag   |                 |
|                     | Cold Moist Compresses                             |                 |
|                     | Tepid Sponge Bath                                 |                 |
|                     | Points to Remember about Heat and Cold Treatments |                 |
|                     | Summary   |                 |
| <b>CHAPTER XII</b>  | <b>ADMINISTRATION AND CARE OF MEDICINES</b>       | <b>Page 111</b> |
|                     | General Precautions and Instructions              |                 |
|                     | Administration of Medicines by Mouth              |                 |
|                     | Tablets, Pills and Capsules                       |                 |
|                     | Other Methods of Giving Medicines                 |                 |
|                     | Medication by Eye and Nose                        |                 |
|                     | Summary   |                 |
| <b>CHAPTER XIII</b> | <b>OTHER COMMON TREATMENTS</b>                    | <b>Page 119</b> |
|                     | Enemata   |                 |
|                     | Care of Enema Equipment                           |                 |
|                     | Simple Dressing                                   |                 |
|                     | Summary   |                 |

|                    |   |          |
|--------------------|---|----------|
| <b>CHAPTER XIV</b> | <b>ADAPTING HOME EQUIPMENT FOR<br/>PATIENT CARE</b> | Page 123 |
|                    | Bed Table   |          |
|                    | Bed Cradle  |          |
|                    | Back Rest   |          |
|                    | Foot Rest   |          |
|                    | Bed Blocks  |          |
|                    | Pressure Pads                                       |          |
|                    | Newspaper Bag for Waste                             |          |
|                    | Newspaper Pad for Bed                               |          |
|                    | Bed Protector of Newspaper                          |          |
|                    | Summary   |          |

## **PART THREE**

### ***Care Under Emergency Conditions***

|                    |   |          |
|--------------------|---|----------|
| <b>CHAPTER XV</b>  | <b>MANAGEMENT OF EMERGENCY<br/>DELIVERY</b> | Page 133 |
|                    | Stages of Labour                            |          |
|                    | Delivery of the Baby                        |          |
|                    | Care of the Baby                            |          |
|                    | Care after Delivery                         |          |
|                    | Summary                                     |          |
| <b>CHAPTER XVI</b> | <b>THE ROLLER BANDAGE</b>                   | Page 141 |

## **PATIENT CARE IN THE HOME**

# **PART ONE**

### ***General Information***

## CHAPTER I

### Illness in the home



Everyone wants to be healthy and happy. Unhappily illness or accidents may occur without any warning. Frequently the person who is ill can be cared for at home if there is someone capable of looking after him under the doctor's direction. Sometimes arrangements can be made for a Visiting Nurse to give the necessary treatment once a day, or oftener, as necessary. The responsible one in the home carries on with the rest of the care during the interval between the nurse's visits.

The rapid diagnosis and immediate treatment on the spot of an accident or sudden illness, while awaiting the arrival of the doctor, is called First Aid and is quite distinct from Home Nursing.

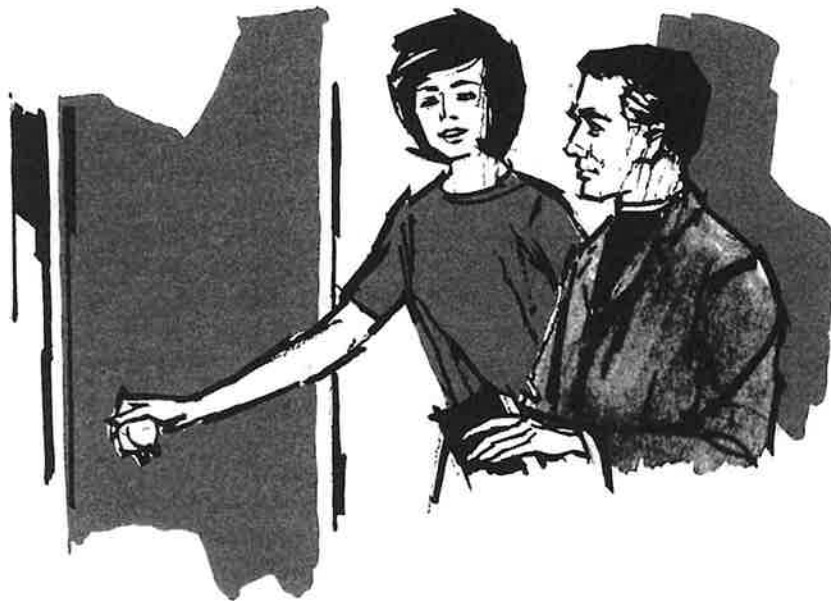
When illness does come the whole family is affected. Many adjustments have to be made but the family routine need not be disrupted completely. Often it can be re-arranged with home duties simplified to conserve time and energy, thus reducing strain on the family.

The over-all responsibility for giving nursing care is usually assumed by one person, frequently the mother. However, in order that she may have some much needed rest, or in case she herself is ill, other members of the family should learn how to help when sickness occurs. Even children may play a part by reading to the patient, helping him with his tray or keeping him company when he is lonely. The care of the patient should be a happy experience shared by all and not a burden on any one person.

### **Comfort of Patient**

The comfort of the patient is nearly always directly related to good nursing care. Every effort should be made to see that he is as comfortable as possible at all times. This will help him to rest and sleep better, to be more relaxed and will assist in his recovery. His comfort should always be considered, whether he is confined to bed, in bed part-time or able to be up and about.

Too often, although physical comfort is assured, the mental, emotional and spiritual needs of the patient are overlooked. These too are important.



This is particularly true if the illness is of long duration or terminal in nature. The member of the family caring for the patient, because of her familiarity with his attitudes, beliefs, convictions or fears, is in a favourable position to recognize symptoms of unrest and uneasiness.

It is often helpful to provide an opportunity for the patient to talk about problems which are on his mind. Sometimes he may wish to discuss things with his priest, rabbi or minister. As in physical care, it is important that the doctor be kept informed of the patient's mental and emotional condition.

### **The one who gives care**

The person responsible for giving care must be quiet in her speech and actions. She should have patience, sympathy and understanding to help the patient adjust to pain, frustration and the limitations of his illness. She should be tactful on all occasions, show tolerance of her patient's likes and dislikes and resourceful so that she may act immediately in any emergency to protect the patient from harm.

Anyone caring for a sick person must be meticulous about her personal hygiene both for her own comfort and particularly for the sake of the patient. Body cleanliness must be assured at all times, avoiding strong scents that may be unpleasant to one who is ill. Underarm deodorants should be used regularly. The hands must be well cared for. They should be washed before and after attending the patient and before handling any food. Hand lotion should be used to keep the hands from becoming chapped and rough. Any cut or abrasion should be covered with an adhesive dressing. The finger nails should be kept short and clean.

The person giving care should present a well groomed, fresh appearance. A clean coverall apron should be used while caring for the patient. The hair should be clean and tidy. Comfortable shoes that give adequate support to the feet are important. It helps to reduce fatigue if shoes are changed during the day.

A well balanced diet is essential to maintain energy and time should always be taken to enjoy meals. Adequate rest, exercise and fresh air are



important. Seven or eight hours of sleep are desirable. Work should be arranged so that it is possible to have some exercise each day in the out of doors.

The doctor's instructions must be carried out in every detail. To do this, the one giving care must understand the instructions given to her. She should never hesitate to ask for an explanation when an order is not clearly understood. A mistake on her part may have disastrous consequences to the patient.

### **Rehabilitation of Patient**

Rehabilitation of patient is of primary importance in good nursing care and should start at the onset of illness. Rehabilitation simply means the return of a patient to his normal way of life or the maximum recovery possible, according to his condition.

In assisting the patient to more rapid and complete recovery, it is important that he do as much for himself as possible to provide a mild form of exercise. Exercise may be incorporated with routine nursing care. While having a bed bath, for example, the patient may be encouraged to move his joints through their full range of motion.

The doctor should set the limits as to how much the patient may do for himself and the amount of activity he may have, in and out of bed. He

should be encouraged to the extent of his ability, within those limits, and activities should be increased as rapidly as the doctor permits. It is helpful to set definite, attainable goals for the patient, encouraging greater efforts but frustration and discouragement should be avoided.

Every member of the family has a key role to play in the rehabilitation of the patient by helping him to maintain a positive attitude and especially by fostering his independence. They should motivate the patient by giving him tasks which make him feel a useful part of the family unit. Feeling useful or needed is as important as feeling loved and wanted. Activities of a recreational nature within the limits permitted by the doctor, should be encouraged and some group activities, if possible, should be included.

### **Posture of Patient and Attendant**

Good posture is the correct use of all muscles, joints and other parts of the body, whether the person is physically active or inactive. Attention must be paid to the position of a patient confined to bed for a long time, to avoid muscle contractures and deformities. He should have a firm mattress to keep his body in proper position, maintaining the normal curve of the spine. A sagging mattress may lead to back strain and spinal curvatures. The patient's position must be changed frequently to increase circulation and prevent pressure sores. He should be supported with a back rest, foot board, pillows or folded blanket to maintain proper body alignment. There should be no strain on any of the joints. (See page 50).

It is equally important for the one giving care to maintain good posture. She will be more comfortable, will exert less strain on joints and muscles and will be less fatigued. She will reduce strain on herself by having a well organized work area and will save time and energy by collecting needed equipment before starting to give care. She should move the patient close enough to give care without having to reach beyond a point of good balance.

To ensure good posture in standing the weight should be evenly distributed on both feet with head erect, chest up and forward and shoulders back. In walking, the movement is a swinging one from the hips, the chest forward and head erect. When sitting the back should be straight, the

entire hip supported by the chair, feet parallel and resting flat on the floor or a foot stool, if necessary.

Lifting may cause strain unless it is done correctly. The back should be straight, feet apart, hips flexed and knees bent. The large muscles of the thighs should be used to lower and raise the body. The shoulders should not bear the weight. In stooping, the knees should be flexed and the back kept straight.

The head, neck and trunk should be kept in straight line when reaching for an object and the body should not be over-extended. A foot stool or ladder should be used if necessary.

### **Patient's Record**

A simple but accurate daily record to the patient's condition should be kept. All treatments should be recorded immediately after they are given. This report should be given to the doctor before he enters the sick room rather than in front of the patient.

The daily record should include:

Date and time.

Food and fluid taken.

Temperature, pulse and respiration.

Any action of the bowels, nature and composition of the stool.

Type and amount of urine passed.

Type and amount of sleep.

Any complaints of pain and steps taken to relieve it.

Any vomiting that has occurred and the nature and amount of material vomited.

Any cough and the nature of sputum coughed up.

Any medicine given and reaction to it.

Any signs of emotional or mental disturbances.

### **SUMMARY**

Home nursing, as a family affair, is emphasized. Normal relations are more readily maintained and family unity strengthened with each member playing a part in the care of the one who is sick.

The responsibility for organizing patient care will fall largely on one person and this will likely be the mother. She must not forget herself with this additional duty but give special thought to rest, food and diversion. The way she carries out her duties will reflect not only on the care she gives to the patient but also on the family and her own well-being.

Special emphasis is placed on the importance of the family doctor. All care is given under his direction and he is kept informed of the patient's condition and any change in it. The patient's record will give him his information.



## CHAPTER II

### Observation of the Patient

When a member of the family becomes ill, the first thought of those caring for him is—"What is wrong and how serious is the illness?" These two questions can best be answered in the light of the patient's comments about his own condition, what led up to it and the observations of those about him. This information will aid the doctor in determining the nature of the illness and its severity.



It is important then, that initial observations of the patient be factually and accurately recorded. Such information will not only provide the doctor with an account of the patient's immediate condition but, as time goes on, will indicate progress between the doctor's visits.

If the patient is able to describe his feelings and experiences, it is a comparatively simple procedure to listen attentively, observe carefully and record accurately. But if the patient is a child he may be too young to actually voice his complaints in which case the person responsible for care

must watch for clues—the rubbing of an ear, the banging of the head, the sudden squirm of pain.

If the patient is unconscious the attendant is completely dependent on her own observations and knowledge to recognize and record the patient's condition and progress.

A knowledge of what constitutes normal health and well-being is necessary in order to recognize the abnormal. For example, the skin, normally soft, pliable and cool, may be dry and hot; the tongue, usually pink, moist and flat, may be red, swollen, cracked or coated.

The rapidity with which changes occur is also significant. If the patient has a rash, when did it first appear? How much is the temperature elevated? If there is pain, was the onset severe or gradual and when was it first felt?

Important though the physical signs and symptoms may be, the patient's mental attitude is equally important. Is he interested and alert or languid and dull? Is his concern for himself and for those dependent on him greater than the condition warrants? Is he over-anxious or abnormally casual? The latter may be more indicative of deep-rooted fear than a normal anxiety.

It is especially important that the doctor be informed of the patient's symptoms and reactions, which may not be apparent to him, or which the patient, for one reason or another, may try to hide. Does the patient try desperately to "be himself" when the doctor is present? Pain or anxiety may be quietly borne. Even the patient's colour may appear normal due to the flush of excitement and stimulation of having an outsider present. Thus, the reactions, symptoms and complaints of the patient, when he is alone with the family may provide a more accurate picture of his true condition.

All observations, not only of the patient's physical symptoms but of his emotional attitude as well, go together to provide a complete picture of his condition during the twenty-four hours. It is the doctor's responsibility to determine the significance of the observations reported to him. They should assist in establishing a diagnosis and in providing effective treatment.

## **THINGS TO WATCH FOR**

### **General Appearance**

Note whether the patient appears ill, is anxious, relaxed or tense, rested or overtired. If he is up and about note posture and manner of walking. Do they indicate weakness or undue discomfort?

### **General Condition of the Body**

The patient may be well nourished, overweight or excessively thin. If there has been loss of weight, has it been sudden? If he is overweight, can it be explained? Usually it indicates nothing more than overeating or eating too much of high-caloric foods. In either case the diet should be reviewed.

Are the muscles firm or soft and flabby? Swelling or tenderness of any part of the body should be noted.

### **Condition of the Skin**

Note if the skin is hot or cold, moist or dry, flushed or pale, blue or yellowish. Is it smooth or are there rashes, abrasions, blotches and if so what is their nature? Any rash, itching, discolouration, or puffiness, particularly around the ankles or under the eyes, may be significant.

An unbroken skin is one of the body's natural defences against infection. Any break in it may allow the entrance of germs and should be reported to the doctor.

### **Facial Expression**

This is significant in illness. The face may be drawn and anxious and the expression dull, disinterested and listless. The cheeks may be flushed or they may have a bluish tinge with pallor around the mouth and nose. The mouth may show tension. The lips may be parched and dry. The eyes may appear heavy and dull or unusually bright. They may be blood-shot and inflamed or the whites of the eyes may be yellowish. It should be noted if there is any disturbance of vision, such as not being able to see clearly, seeing double, spots before the eyes or halos around lights.

## **Tongue, Mouth and Throat**

Deviations from the normal in any of these areas should be noted. The tongue, normally clean, moist and pink, may be dry, furred, bright red, brownish, swollen, cracked. The mucous lining of the mouth or gums may be swollen, ulcerated and sore. The throat may be red, swollen, covered with white or gray patches. The breath may have a peculiar odour that is sweetish or offensive.

If the throat is sore note also if the neck and glands are swollen and if earache is present.

## **Pain**

There is a great difference in the ability of individuals to bear pain. It may be helpful to keep this in mind when caring for someone who is ill.

It is important to observe:

The time at which the pain began, its duration and location.

Whether it is severe, mild, continuous, intermittent or stabbing.

Whether it has any relation to eating, change of position, coughing, noise or light.

## **Temperature, Pulse, Respiration**

These are indications of the patient's progress. They should be observed for any change in degree or rate and deviations from the normal should be noted. (See page 90).

## **Cough**

A cough may be harsh and dry or moist and accompanied by expectoration. It may be an irritating cough with a tickling sensation in the throat, or deep and hollow in sound. The frequency and time at which it is most disturbing should be noted, also whether it is spasmodic, accompanied by whooping or vomiting. Note whether the cough produces sputum and if so, the amount, colour and appearance. Note if it causes pain and change in the pulse rate and whether a change in position relieves or aggravates the cough.

## **Vomiting**

If a patient has nausea and vomiting, particularly if it is accompanied by cramps or abdominal pain, the doctor should be notified at once. The following should be observed:

The time of vomiting, particularly in relation to eating.

The quantity of material vomited and the general appearance of it. Unusual vomitus should be saved for the doctor to see.

Whether the vomiting is preceded or accompanied by pain or whether it relieves pain.

## **Stools**

The number, colour, and consistency of a patient's bowel movements should be observed. The normal adult stool is brown in colour and is usually soft but well formed. There is considerable variation in normal bowel action. Note whether:

There are marked changes in colour and consistency, especially if accompanied by other symptoms.

There are infrequent hard stools, indicative of constipation.

There are frequent watery, unformed stools associated with diarrhoea.

## **Urine**

Observations should include any urinary disturbances such as:

Increased frequency of urination, inability to urinate or to urinate only in small amounts.

Any pain or burning sensation when urinating.

Any change in usual amber colour, the presence of odour, blood or cloudiness in the urine.

Observation is an important responsibility of the person giving care. She should use all her faculties of sight, hearing, smell and touch. No observation should be regarded as trivial or unimportant until it has been brought to the attention of the doctor.

## SUMMARY

Observation of the patient's condition is emphasized as an important part of nursing care. Consideration should be given to his mental and emotional condition as well as to the recognition of physical symptoms.

The family is in a particularly advantageous position to assist in this regard, being familiar with the patient in health as well as in illness. Therefore, the members of the family are able to recognize even minor deviations from the normal.

The doctor should be given a complete picture of the patient's condition and reactions and should be informed immediately of any changes.



## CHAPTER III

### Nutrition

The patient's nourishment, like every other aspect of care, should be woven into the family's way of life. This will be easier from the house-keeping point of view but more important the patient will be happier if his usual diet is changed as little as possible.

This assumes that the diet of the family is good and provides the essential foods including minerals and vitamins. The patient, because he is not up to par, may require additional foods or less of one and more of another, but these will be indicated in the doctor's orders.

The person giving care will need an understanding of basic food requirements and know what constitutes a well balanced diet. All of this is outlined simply and reliably in the Food Guide on page 19.

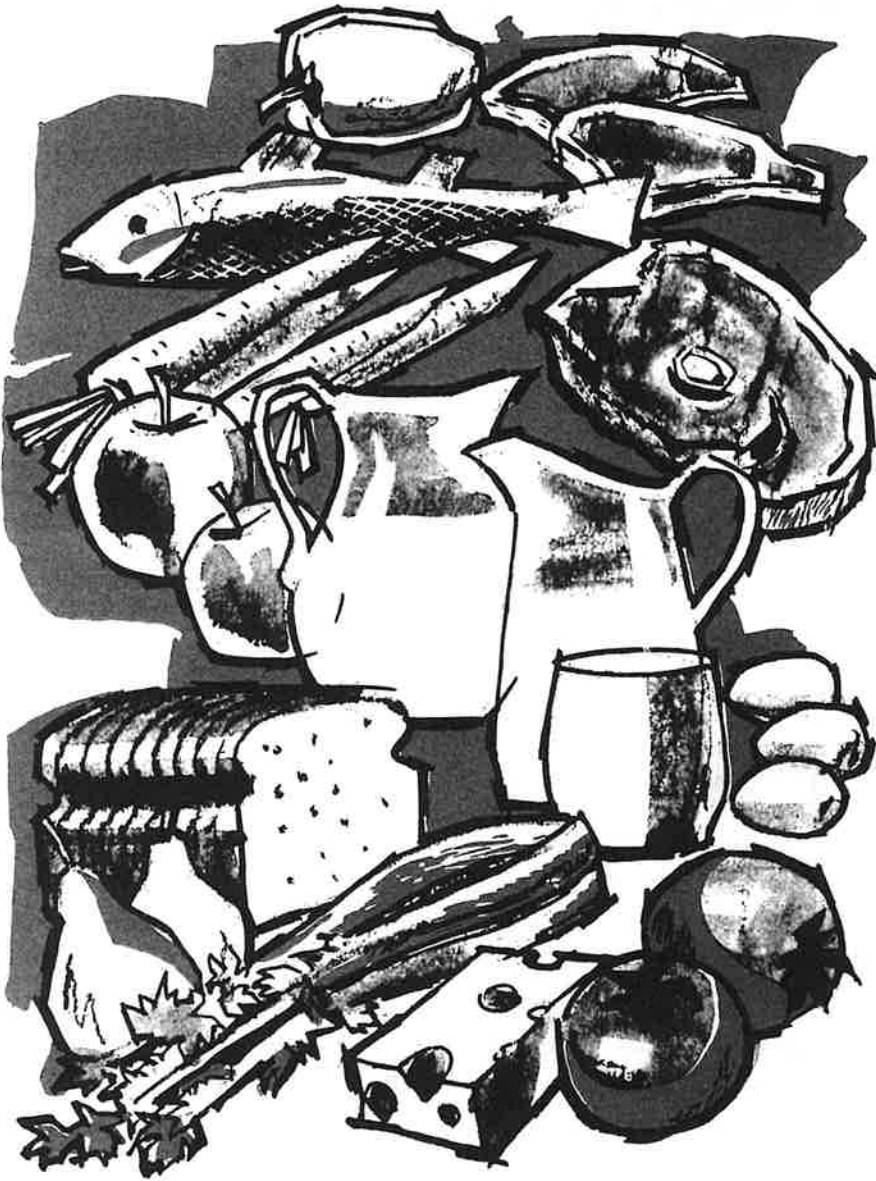
## FOOD GUIDE

THESE FOODS ARE GOOD TO EAT.  
EAT THEM EVERY DAY FOR HEALTH.  
HAVE THREE MEALS EACH DAY.

|                   |   |
|-------------------|---|
| Milk              | Children (up to about 11 years) . . . . . 2½ cups<br>(20 fl. oz.)<br>Adolescents . . . . . 4 cups<br>(32 fl. oz.)<br>Adults . . . . . 1½ cups<br>(12 fl. oz.)<br>Expectant and nursing mothers . . . . . 4 cups<br>(32 fl. oz.) |
| Fruit             | Two servings of fruit or juice, including a satisfactory source of vitamin C (ascorbic acid) such as oranges, tomatoes, vitaminized apple juice.  |
| Vegetables        | One serving of potatoes.<br>Two servings of other vegetables, preferably yellow or green and often raw.   |
| Bread and Cereals | Bread (with butter or fortified margarine).<br>One serving of whole grain cereal.   |
| Meat and Fish     | One serving of meat, fish or poultry.<br>Eat liver occasionally.<br>Eggs, cheese, dried beans or peas, may be used in place of meat.<br>In addition, extra servings of eggs and cheese, each at least three times a week.       |
| Vitamin D         | 400 International Units, for all growing persons and expectant and nursing mothers.   |

Reference Canadian Food Guide 1961.

A diet based on this guide will provide the essential daily food requirements of protein, carbohydrates, fat, minerals and vitamins.



## The Patient's Diet

The doctor will indicate on his first visit the foods best suited to the patient's condition. Diets are usually classified as liquid, soft, ordinary or full diet.

### Liquid Diet

Liquid diet includes all liquids—clear, strained or cream soups, gruel, fruit juice, ice cream or clear jelly. Strained white of egg may be added to drinks such as fruit juice to increase the food value or in the case of eggnog the whole egg may be added. Patients on liquid diet should be fed small amounts frequently.

Clear liquid diet includes clear broth or consomme, clear tea, ginger ale, etc.

### Soft Diet

Soft diet in addition to nourishing liquids includes bread and butter, custard, puréed fruits, eggs (except fried), with biscuits or toast. The doctor may also allow white meat of chicken or turkey, fish, scraped beef, strained vegetables.

### Ordinary Diet

Ordinary or full diet is the normal diet which the patient would ordinarily have. It includes a wide range of foods but rich pastries and other indigestible foods should be avoided.

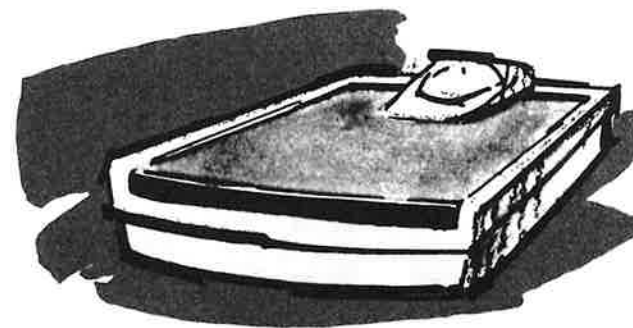
## Function of Foods and Calorie Control

Food performs various functions in the body. It provides heat and energy. It builds body tissues for growth and repair. It is the means by which the body receives minerals and vitamins required for growth, development, repair and good health.

Foods vary in caloric value—for example one gram of fat gives 9 calories, while one gram of protein or carbohydrate yields only 4. There-

fore the doctor may consider it desirable to limit the fat in the diet if there is any indication that the patient's calories should be restricted because of overweight or inactivity due to illness.

## Overweight



Weight control is a tedious and discouraging experience and the patient will need encouragement and understanding. If he is overweight the safest method of weight control is the reduction of the total food intake, not just elimination of some foods and indiscriminate quantities of others.

Loss of weight will not be drastic but the body will still be getting the necessary protein, carbohydrate and fat, minerals and vitamins. All faddish reducing diets should be avoided.

Caloric requirements vary with the type of activity of the individual, for example, a man doing heavy labour will require many more calories than a person sitting at a desk. In either case, the diet should be based on foods outlined in the Food Guide. (See page 19).

## Special Diets

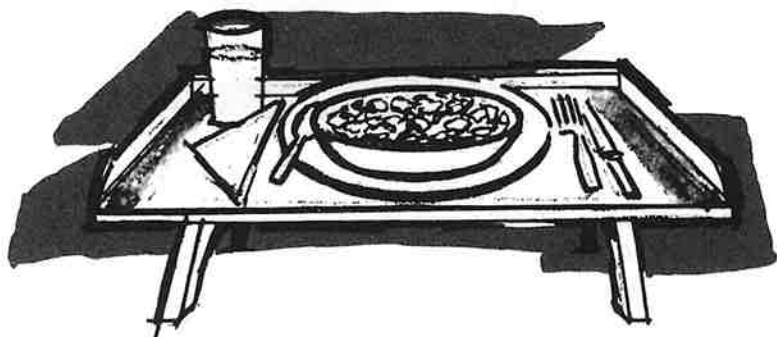
A special diet when prescribed by the doctor will be a modification of the normal diet. If, for example, the doctor orders a low sodium, (low salt) diet for the patient the food should be cooked without the addition of salt and the salt shaker should be removed from the patient's tray.

The person preparing the patient's meals should know the foods that have a high sodium content, so that they may be avoided. The patient's

doctor will advise regarding these high sodium foods or information can be obtained from the local or State department of health or the nutrition division of the Department of National Health and Welfare. The public health nurse is a ready source of such information also.

Similarly, if the doctor requests a low fat diet for the patient the person giving care must know the foods high in fat so that they may be avoided and no foods should be fried or cooked in fat. Sometimes, the doctor will permit the use of vegetable fats instead of animal fats in the patient's diet.

### The Patient's Tray



Attractiveness of food is always important but is especially so when a person is ill. The tray should be clean, large enough to accommodate dishes and food without a cluttered appearance.

The tray cloth should be clean and attractive. Table mats make excellent tray covers. If these are not available small linen or paper guest towels may be used.

Food should be tastefully arranged with consideration given to colours which complement each other. For example, avoid two vegetables of similar colour such as carrots and squash, or cauliflower and marrow. Hot foods should be served hot and cold ones cold. If the appetite is poor small servings should be given.

The patient's tray, especially if he has little interest in food or if the patient is a child, should present an element of surprise, a tiny bouquet, a rose bud or a change of dishes as well as surprises in the food served.

### Preparation of Patient for Meals

If the patient is able to come to the family table he should be encouraged to do so. If this should prove too exciting for him in his weakened condition, even though he is allowed out of bed, the meal can be served on a card table in the living room, in a bright spot in front of a window or if it is summer time, out of doors.

If the patient is confined to bed and meals must be served to him there, he should have an opportunity to wash his hands and comb his hair before the tray arrives. He should be in a sitting position, the back well supported with pillows or a back rest. A pillow under the knees at mealtime adds



greatly to the patient's comfort. A bed table that fits over the patient's knees provides an excellent support for the meal tray. However, if this is not available place a pillow on the lap. This serves to raise the tray to a more comfortable level.

The bedding should be well protected while the patient is eating. A large towel placed under the edge of the tray and over the bed linen serves the purpose well. The patient should be helped, if necessary, to put the serviette in place. Assistance may be required in cutting meat, buttering bread, etc. If so, it is kinder to do this before the patient receives his tray.

## Happiness at Mealtime

Pleasant conversation at meal time aids digestion. If a member of the family is free to sit and chat with the patient the inclination to eat too quickly will be avoided and the patient's mind pleasantly occupied while he enjoys his meal.

The patient's nutrition involves much more than just the provision of food served three times a day. It requires consideration of his likes and dislikes, his comfort and frame of mind and the over-all general atmosphere of the home. Meal time should be a happy time.

## SUMMARY

If the nutrition of the household is good, the family diet can be used as a basis for the patient's meals. There should be no need to prepare special meals for him, unless ordered to do so by the doctor.

The Food Guide (page 19) is provided to assist in meal planning. If it is followed, essential food elements, minerals and vitamins are assured in the daily diet.

Mental attitude has a direct bearing on appetite and digestion. Therefore, the importance of happiness at meal time and attractiveness of food are emphasized. The element of surprise in the preparation of the patient's tray also plays an important part.

If a special diet is indicated, the doctor will prescribe it. Examples of some of these are provided.



## CHAPTER IV

# Prevention of Illness and Control of Infection

Illness may result from a variety of causes. It may be due to accidents, malfunction of body organs or to disease germs. At one time, epidemics were common (an epidemic is a large number of cases of the same disease occurring at the same time). Today they are infrequent, due to the advancement of medical science in the prevention and control of communicable disease. However, infectious diseases still exist and it is only by the continuing use of known preventive measures that they are kept in check. At the end of this chapter there is a chart with information about some common communicable diseases. (See pages 32 to 37).

## Cause of Infection

Communicable or infectious diseases, including the common cold, are caused by the presence of disease germs and may be spread from one person to another. An infected person should protect others by observing the rules of personal hygiene. He should always cover his mouth and nose when coughing or sneezing and be sure of the safe disposal of secretions. Hand-washing is of particular importance when a person has an infection.

Germs thrive and multiply in warm, moist, dark places. Disease producing germs find ideal conditions for growth in the human body, where they produce harmful effects by releasing poisons, known as toxins. These may be carried through the body by the blood stream and cause damage to different tissues and organs.

Each kind of harmful germ can only produce its own disease,—diphtheria germs cause diphtheria; typhoid germs cause typhoid; measles germs cause measles, etc. The disease may be severe or mild—even so mild as not to be recognized as illness. This depends on the extent of infection and resistance offered by the body.

## **Ways by Which Germs May Enter the Body**

Disease germs enter the body in many different ways. The most common routes are the following:

Breathed in with air. This is probably the most frequent way.

Swallowed in contaminated food or water.

Through a break in the skin—chapped hands, abrasions, cuts, scratches, surgical wounds afford entrances unless proper precautions are taken. Germs may also be introduced through the skin by the bite of an animal or insect.

## **HOW INFECTION IS SPREAD**

### **Direct Contact**

A common way of spreading disease is by coughing, sneezing or by kissing a person who is infected. Every time a person speaks, sneezes or coughs, droplets of moisture are sprayed from the nose and throat. This spray may be carried a distance of several feet. If there are disease germs in the mouth or nose they will be present in these droplets and any susceptible person within that area will be exposed to the infection. This is called droplet infection.

Certain disease germs may also be discharged from the body in excretions from the bowels and kidneys, in ear or eye discharges or any discharge from open wounds.

### **Indirect Contact**

Germs may live for some time outside the body. The time varies with the type of germs,—tuberculosis and tetanus may remain in the soil for years.

Following are the most frequent means of spreading infection by indirect contact:

Fingers or hands: If the hands or fingers have touched the patient or articles contaminated by him, they may spread the germs to one or several persons.

Food: Germs grow and multiply quickly in food. It should be kept well refrigerated or in a cool place. Food from an infectious patient's tray should be disposed of at once, preferably by burning. If this is not

possible it should be wrapped in newspaper, securely tied and placed in garbage disposal.

Flies: The common house fly is responsible for carrying many diseases. Everything possible should be done to protect the home against this pest. Doors and windows should be well screened. Food should never be left uncovered and garbage should be wrapped in paper and placed in covered containers.

Contaminated Articles: This refers to articles contaminated by discharge from the patient and is sometimes known as fomites. Such articles include instruments, dressings, bedding, toilet articles, toys, books and handkerchiefs.

Human Carrier: Germs may also be spread by a well person known as a carrier. A carrier is a person, himself immune to the disease but who harbours the germs and passes them on to other people through excreta or soiled hands.

## **Measures to Prevent the Spread of Infection**

When it is known how a disease is spread, it is often possible to take measures to control it. In the past epidemics have taken many lives and caused individual and community suffering. Today, modern communities take precautions to prevent disease by enforcing public health measures to ensure a safe food and water supply, sanitary sewage and garbage disposal.

Australia has special laws governing the control of communicable diseases. Most infectious diseases are notifiable and must be reported so that the health authorities may know when there is an unusual number of cases in a community and take the necessary preventive measures.

Certain diseases, especially in the acute stage, require isolation and the doctor will advise regarding this. However, until the doctor arrives, the patient should be kept away from others as a precautionary measure if there is any question of communicability.

## **Natural Defences of the Body**

Nature has supplied the body with certain defences against germs. The unbroken skin and healthy mucous membrane help to keep out most disease germs. Moreover, certain body secretions such as tears, mucous and gastric

juices are mildly antiseptic and check the germs until they can be eliminated from the body. Even when germs succeed in penetrating these natural defences, they do not always cause disease because body tissues immediately react to protect themselves. The white blood cells of blood and lymph go into action. These cells have the power to destroy germs. Also, the body manufactures protective materials known as antibodies which neutralize the poisons and in some cases actually kill the disease organisms.

Health should be maintained at a high level so that, should one become ill, physical stamina is high and resistance to infection thereby increased.

### **Immunity**

The power of the body to resist infection is known as immunity. It may be natural or acquired.

**Natural Immunity:** That with which one is born. A new born baby has a natural immunity to some diseases because of his mother's immunity.

**Acquired Immunity:** This may be induced in a variety of ways:

By having the disease. In some diseases, one attack gives lasting protection because antibodies, which have been manufactured to fight the germs, remain in the body, e.g., mumps, measles, etc.

By repeated exposure, in small doses, to the disease over a long period of time, e.g., poliomyelitis.

Immunity may be developed by artificial means such as vaccination or inoculation. In this way the body is stimulated to produce antibodies, thus acquiring protection. This is what happens when diphtheria toxoid or smallpox vaccine are administered.

### **Immunization**

The most common and reliable means of acquiring immunity to many diseases is by vaccination or inoculation.

By this means, smallpox and diphtheria have been almost eliminated in many parts of the world. However, there is a continuing need for immunization if these diseases are to be kept under control.



Epidemics are likely to follow any great disaster as a result of overcrowding, the disruption of sanitary facilities or the contamination of drinking water. In most diseases it takes considerable time after inoculation to develop immunity. Inoculations, therefore, should be given well in advance of possible exposure to disease in order to establish protection.

### **Air Travel**

Air travel presents a new avenue for the spread of infection. A person who has contracted a disease in one part of the world and is still in the early stages of infection, may be in another part of the world, thousands of miles away, within a few hours. The true symptoms of his disease are not apparent during this time but he may expose those, with whom he comes in contact, to his infection. Many may have no immunity to his disease and therefore run the risk of contracting it.

There is also the possibility of disease bearing insects carrying diseases to areas of the world hitherto untouched by that particular infection, e.g., malaria.

Children should be immunized at an early age for diphtheria, tetanus, whooping cough, smallpox and poliomyelitis. An additional or booster

inoculation should be given before children commence school and again during school life. The family doctor may wish to do this himself or he may refer the child to the child health clinic for this purpose. In any event, immunization should be discussed with him during the child's early months of life. Adults should be re-vaccinated regularly.

### **Individual Measures for Protection Against Infection**

Resistance to infection can be increased by following good health habits and personal hygiene such as:

Hands should always be washed before eating, before handling food and after going to the toilet. They should also be washed before and after giving care to a sick person. Hands should be kept away from the mouth and face. Pencils, pens, money or other such objects should never be put in the mouth.

Cuts, abrasions and other skin lesions should be kept covered with a clean dressing.

People who are known to be suffering from an infectious disease, including the common cold, should be avoided.

One should obtain sufficient rest and sleep, eat an adequate amount and the proper kind of food, get sunshine, fresh air and exercise each day.

Protection should be obtained against those diseases for which immunization is available.

### **Nursing Care of Patient with a Communicable Disease**

The general principles of good nursing care apply to all patients including those with a communicable disease. The main problem when giving care is to prevent the spread of infection to other members of the family. If at all possible the patient should have a room to himself so that he can be kept away from others. However, this separation or isolation is of limited value as the members of the family may frequently have been exposed to the same infectious source before the diagnosis has been made.

If it is not possible for the patient to have his own room, he may be separated from others in the same room by putting a screen around his bed. When possible one person should be responsible for the patient's care and all others except the doctor excluded from the room.

Hands should be washed before and after caring for the patient. The doctor will advise if it is necessary to set up handwashing facilities within the room. If so, a wash stand is placed just inside the patient's door with a hand basin, jug of water, soap, waste pail and paper towels. A table should also be arranged with patient's toilet articles, thermometer, paper tissues, etc.

Squares of clean paper may be kept on the washstand for use in handling door knobs, handles of pail or jug.

A washable smock or gown should be worn and care should be taken not to touch the inside when taking it off. Hang it up clean side in, in patient's room.

Waste material should be disposed of immediately, preferably by burning. If this is not possible, wrap it securely in newspaper and place in garbage disposal.

The patient should be taught to turn his head and cover his mouth when sneezing and coughing. Paper tissues or old cotton should be used once and discarded into a paper bag pinned to the bed for ease in reaching.

Soiled articles should be handled as little as possible. Squares of clean paper tissue, forceps or snap clothes pins can be used when handling soiled articles.

The thorough washing of dishes and linen will usually eliminate the possibility of transmitting infection. However, it is a safety measure to keep these articles separate from the family's linen and dishes until they are washed and also to wash them separately.

Soap, hot water, sunshine and fresh air are considered sufficient disinfectant in most cases of communicable disease. Thorough cleanliness should be adhered to during the course of the disease and efficient disinfection carried out upon its termination. If further measures are required specific directions will be given by the doctor and public health officials.

SOME COMMON COMMUNICABLE DISEASES

| Disease    | Signs and Symptoms  | Method of Spread  | Incubation Period   | Period of Communicability  | Method of Control  |
|------------|---|---|---|--|--|
| Chickenpox | In mild cases rash may be first sign. It appears as small separated pimple like, raised, red spots which become filled with clear fluid, later turning to pus and then to a scab. The rash may be preceded by mild fever, headache, loss of appetite, about 24 hours before the rash appears. | From one person to another by droplet infection; or by articles freshly soiled by discharges from patient.                                    | 2 to 3 weeks after exposure to infection, commonly 13 to 17 days. | Very communicable during first week of disease or from one day before rash appears.                                  | 1. Isolation of patient during infectious early stages of the disease.<br>2. Disinfection of discharges from nose and throat of patient and of articles soiled therewith.  |
| Diphtheria | Onset acute with fever, sore throat, hoarseness or croup. Greyish patches appear on mucous membrane of infected area such as nose and throat. These are surrounded by dull red inflamed areas. Lymph glands of neck are swollen and sore.   | By direct contact with a patient or "carrier", by droplet infection, by articles soiled by infected person; or by drinking contaminated milk. | 2 - 5 days  | Usually 2 weeks, seldom more than four; until germs have disappeared from discharges and lesions of infected person. | 1. Patient isolated until swabs from nose and throat are negative for diphtheria germ.<br>2. Contacts isolated until proven negative for disease.<br>3. Disinfection of discharges from nose and throat of patient and of articles soiled therewith.<br>4. Primary immunization in early childhood with booster doses as recommended by the doctor gives protection against the disease. |

SOME COMMON COMMUNICABLE DISEASES—Continued

| Disease        | Signs and Symptoms  | Method of Spread   | Incubation Period | Period of Communicability   | Method of Control   |
|----------------|---|--|-------------------|---|---|
| Red Measles    | Fever, general malaise, discharging nose, sore eyes, typical spots on lining of mouth. On 4th day of symptoms a dusky, red, blotchy rash appears on face and spreads to other parts of body. Rash lasts from 4 to 6 days. | Directly from one person to another by droplet infection or indirectly by articles freshly soiled with patient's nose and throat secretions. | 10 to 11 days.    | During catarrhal symptoms, usually about 9 days. Infections in early stages, frequently before disease is recognized. | 1. Observation of contact and isolation of patient on first appearance of symptoms.<br>2. Disinfection of nose and throat secretions and articles soiled therewith.<br>NOTE: The doctor can prevent or modify the disease in very young or sickly children by giving an injection of immune serum during early part of incubation period. |
| German Measles | Mild catarrhal symptoms with swollen glands behind ears and on sides of neck (enlarged lymph glands). Symptoms similar to red measles but milder.   | Same as for red measles.   | 14 to 21 days.    | Highly communicable for one week before and at least 4 days after rash appears.                                       | Same as red measles. Disease not serious except to women in first 4 months of pregnancy, when it may have harmful effects on unborn baby.<br>NOTE: Pregnant women should avoid contact with German Measles.   |

## SOME COMMON COMMUNICABLE DISEASES—Continued

| Disease  | Signs and Symptoms  | Method of Spread   | Incubation Period                | Period of Communicability  | Method of Control  |
|--|---|--|----------------------------------|--|--|
| Infectious Hepatitis also known as Epidemic Hepatitis or Epidemic Jaundice | Fever, nausea, general malaise, abdominal discomfort and jaundice.  | Contact with patient's discharges, especially feces and urine and by blood; also by contaminated water and food.         | 15 to 50 days, commonly 25 days. | Unknown, greatest from several days before to not more than 7 days after onset of disease. | <ol style="list-style-type: none"> <li>1. Isolation of patient during first week of illness.</li> <li>2. Disinfection of all body excretions and discharges and articles contaminated therewith.</li> </ol>  |
| Mumps  | Sudden onset with fever and painful swelling in front of and below the ear on one or both sides of face. (swelling of salivary glands). | By direct contact with a patient; by droplet infection or by contact with articles freshly soiled with patient's saliva. | 12 to 26 days, commonly 18 days. | From 7 days before swelling of glands to 9 days after swelling.                            | <ol style="list-style-type: none"> <li>1. Isolation of patient for 9 days from onset of illness.</li> <li>2. Boiling of patient's eating and drinking utensils.</li> <li>3. Disinfection of articles freshly soiled with excretions from patient's nose and throat.</li> </ol> |

## SOME COMMON COMMUNICABLE DISEASES—Continued

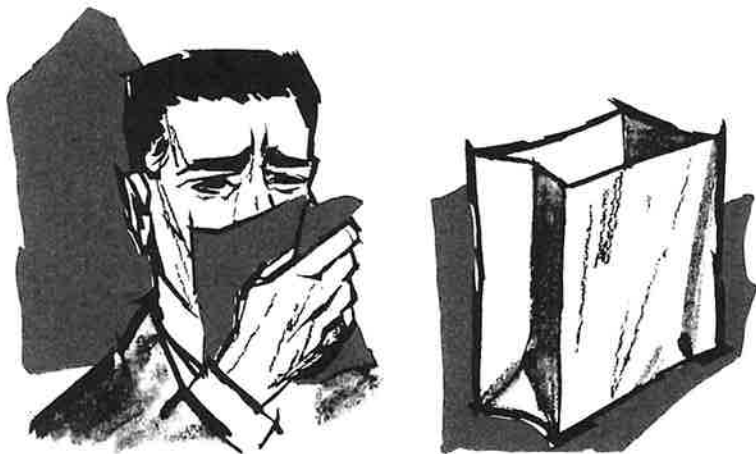
| Disease        | Signs and Symptoms  | Method of Spread  | Incubation Period                    | Period of Communicability  | Method of Control   |
|----------------|---|---|--------------------------------------|--|---|
| Polio-myelitis | Fever, headache, vomiting, stiffness of neck and back, muscular pains and cramps, progressing in some patients to muscular weakness and paralysis. Disease has wide range of symptoms and severity. | By direct contact with patient or through discharges from patient's nose, throat and bowels. The disease may be so mild as to be unrecognizable as poliomyelitis yet these patients are infectious to others. | 3 to 21 days, commonly 7 to 12 days. | From throat secretions 1 week after onset of illness and feces 3 to 6 weeks. | <ol style="list-style-type: none"> <li>1. Isolation of patient for 7 days after onset of illness.</li> <li>2. Disinfection of throat discharges, feces and articles soiled therewith.</li> <li>3. Avoid over fatigue during an epidemic.</li> <li>4. Protect children and young adults during an epidemic from contact with persons outside their usual acquaintance by curailing unnecessary visiting and travelling.</li> <li>4. Postpone nose and throat operations such as tonsilectomy during an epidemic and during polio season.</li> <li>5. Provide protection against disease by vaccination.</li> <li>7. Gamma globulin used 2 days after onset may limit extent of paralysis.</li> </ol> |

## SOME COMMON COMMUNICABLE DISEASES—Continued

| Disease       | Signs and Symptoms   | Method of Spread  | Incubation Period | Period of Communicability                     | Method of Control   |
|---------------|--|---|-------------------|---|---|
| Scarlet Fever | Fever, headache, sore throat, reddish "strawberry" tongue. A fine bright red rash usually appears 24 to 72 hours after first symptoms. Appears on neck, armpit and groin, (not on face). Begins to fade in 3-7 days and is followed by desquamation "peeling". Streptococcal sore throat is same disease but without rash. | From one person to another by; droplet infection by handling articles recently soiled with patient's nose or throat secretion. By contaminated milk or other foods. | 1 to 3 days.      | Approximately 10 days in uncomplicated cases. | <ol style="list-style-type: none"> <li>1. Isolation of patient during infectious early stage of the disease.</li> <li>2. Disinfection of all nose and throat secretions and articles soiled therewith.</li> </ol> |

## SOME COMMON COMMUNICABLE DISEASES—Concluded

| Disease        | Signs and Symptoms  | Method of Spread  | Incubation Period                    | Period of Communicability   | Method of Control  |
|----------------|---|---|--------------------------------------|---|--|
| Smallpox       | Onset sudden with fever, headache, malaise, severe backache, abdominal pains, prostration. After 3 to 5 days temperature drops to normal and rash appears. Rash passes through successive stages from pimple in the skin to pustule and scab. Appears on face, forearms and wrists and is more abundant on shoulders and chest than in groin and abdomen. | By direct contact with a patient. Germs may be carried through the air over short distances. Indirect contact through persons or articles freshly contaminated. | 7 to 16 days, commonly 9 to 12 days. | From first symptoms to disappearance of all scabs, usually 2 to 3 weeks.                        | <ol style="list-style-type: none"> <li>1. Isolation of patient until all scabs have disappeared from rash.</li> <li>2. Sterilization of all articles coming in contact with patient by boiling or high pressure steam.</li> <li>3. Thorough terminal cleaning; mattress and bedding including pillows must be sterilized.</li> <li>4. Vaccination against the disease early in childhood and re-vaccination every 3 to 5 years.</li> </ol> |
| Whooping Cough | Fever and cough becoming spasmodic with "whoop", developing about second week of the disease.   | By direct contact with patient; by droplet infection or by contact with articles freshly soiled by a patient's nose or throat discharges.                       | 7 to 10 days.                        | Highly communicable in early stages then gradually decreasing till non-communicable at 3 weeks. | <ol style="list-style-type: none"> <li>1. Isolation of patient during early infectious stages of the disease.</li> <li>2. Disinfection of nose and throat secretions and articles soiled therewith.</li> <li>3. Primary immunization in early childhood with booster doses as recommended by the doctor.</li> </ol>  |



## SUMMARY

An alternate title for this chapter might well be "An Ounce of Prevention is Worth a Pound of Cure".

Disease germs enter the body, grow, multiply and cause illness. They are spread to other individuals chiefly by direct contact. The means by which this takes place and some of the measures of control are outlined in this chapter.

Whether or not the person develops the disease, depends largely on his immunity. This may be natural or acquired. Because of the uncertainty of natural immunity, it is important for everyone to acquire immunity for those diseases for which it is available.

Children should be immunized at an early age. In any event, the family doctor should be consulted about vaccination and immunization soon after the baby is born. Adults should be revaccinated regularly.



# CHAPTER V

## Care of the Sick Child

Fortunately most illnesses in children do not last long and are not serious. Usually the onset is abrupt and is recognized by a sudden change in behaviour and disposition. A young child cannot always tell you that he feels ill and an older child may not want to admit that he is sick enough to go to bed. Although the symptoms of illness vary from child to child, he is usually fussy, irritable and often refuses food. The child may have nausea, vomiting, diarrhoea, a cough or a rash. He may appear pale and tired. If he has a fever his skin may be hot and dry and his face flushed. He may complain of pain such as headache, earache or stomach ache.

### General Care of Sick Child

When a child becomes ill, it is essential to follow the same general rules that apply to any other sick person.



The doctor should be called as soon as the child appears sick. Even mild signs of illness should be reported as they may quickly become more serious. It is dangerous to try to treat a sick child without the doctor's advice and no medicines or treatments should be given unless ordered by him.

The child should be kept as quiet as possible since rest is important in recovery. It may be necessary to hold a small child or baby or to rock him until he falls asleep.

Other members of the family, especially children, should be kept away from the child who is ill until the doctor has diagnosed his illness. It is always possible that his illness is infectious and this is a precaution against spreading the illness to others. If possible he should have a room by himself.

If the child is vomiting or has diarrhoea, it is wise to give him no food. Small amounts of boiled water may be offered until the vomiting has stopped. Do not force him to eat or drink large amounts. Let the child's appetite be the guide in offering him food or drink. Any child who is ill has special needs for fluids and these should be given to him at frequent intervals.

A record should be kept, for the doctor, of the child's symptoms, including temperature, frequency and nature of bowel movements and urination, any vomiting, the amount of food or fluids taken and the amount of sleep.

Young children often become more dependent when they are ill and may appear to forget some of the things they have learned, such as toilet training. These lapses should be handled with understanding as they will disappear with recovery. While love and affection are essential, discretion should be used as it is easy to spoil a sick child, particularly if the illness is prolonged. Usually the child will respond to calm authority. Treatments, to be given successfully, require the co-operation of the child. This may usually be obtained if the following methods are used:

Approach the child in a friendly, confident manner taking it for granted that the treatment will be accepted willingly and bravely.

Tell the child what you are going to do and let him know that it may hurt.

It is not wise to mislead him about any discomfort involved as he may lose his trust and confidence in those looking after him.

Always praise a child when he is brave but do not scold him when he is not.

## Preparing Child for Hospitalization

Hospitalization need not be an unhappy experience for the sick child but it may present crucial emotional problems for him. If hospital care is necessary, he should be told in simple terms what a hospital is like. He should have some idea of what the doctors and nurses do and the kind of clothes they wear. He should know that the hospital routine for looking after him will be different than at home. For example, he should know that he will probably be wakened early in the morning to have his temperature taken. Other hospital routines should be explained to him.

It should also be explained that separation from his parents and family is only temporary. It is helpful if he is allowed to have with him a favourite toy or some other cherished possession to lessen his feelings of isolation.

However, it is not wise to have him think that there are no unpleasant experiences in going to hospital. He should be told that his parents and friends will visit him as often as hospital rules will allow.

## Care of Child in Convalescence



Children who are convalescing, those with a long-term illness or a physical handicap, require special nursing care. The objective should be to permit them to live, as much as possible, as other children do. (See pages 6 and 50). A program should be planned that will help each child to

## CHAPTER VI

# Special Needs of Aged and Patients with Long-Term Illness

Those who are responsible for the care of aged persons require an understanding of the special problems and needs of these people. Tolerance, patience and tact are essential, as the elderly may sometimes appear unreasonable. As a person becomes gradually more infirm they are able to do less for themselves and rely more and more on other people for their daily needs. This frequently creates a sense of frustration and helplessness. However, their helplessness may be lessened with kindness, patience, and understanding.

Patients with a long-term illness include both young and old who suffer from illnesses that are of a chronic nature and for which there may be no cure. They especially, need sympathetic understanding care as they are often depressed because of the apparent hopelessness of their condition.

### SPECIAL NEEDS OF THE AGED

#### Emotional Needs

Old age may be a serene and happy time if there is an awareness of some of the problems associated with it. The elderly need security, love, recognition and a feeling of being wanted. Their personal freedom is very dear to them and they should be allowed as much independence as is consistent with safety. Family and friends should avoid being over-helpful and should encourage the elderly person to do as much as possible for himself.

The older person is likely to suffer from loneliness and to have a feeling of being pushed aside, not wanted or needed. The family should encourage the older person to take part in household activities, according to his physical capabilities. It is helpful to the older person's morale and sense of usefulness if he is asked to assume definite and regular responsibilities such as doing the dishes, setting the table, etc. Such diversions not only help him to feel needed but give enjoyment as well.

follow his normal pattern of living as closely as possible. He may be able to keep up with part or even all of his school work. His teacher may send assignments home for him or a visiting teacher may come in to give him lessons.

The child should have interesting but quiet occupations and should not be allowed to become over-tired. Picture books, cut-outs, making a scrap book are all favourites. Listening to the radio, watching selected television programmes and story telling help to control over-activity, fatigue and boredom.

### SUMMARY

Although illness in children is usually not serious, symptoms should not be treated lightly. It is wise to consult the doctor as soon as the child becomes ill. In this way proper treatment may be started early and if the illness is of an infectious nature, steps may be taken to protect others. It is advisable to keep other children away from the sick child until the nature of the illness is known.

Hospitalization may prove a traumatic experience for the young child. Therefore, it is important that the parents carefully and tactfully explain to him why he must go to hospital and what to expect while there. Sincerity, truthfulness and affection are necessary to help the child realize that these changes in his way of life are temporary and do not indicate a lessening of parental love.

It is easy to spoil the handicapped child or the one with a long-term illness. Special planning is essential to provide security and at the same time foster independence.

The child's normal pattern of life should be followed as much as possible, even to school work, although he is confined to home and inactivity.





## PHYSICAL NEEDS

### Fresh Air and Exercise

Some times older people do not want to go outdoors because they are afraid of going alone. Then it is more satisfactory if the daily routine of home duties includes a definite time to take the older person for an outing, either walking, driving or in a wheel chair. Sometimes it is possible to rouse their interest in going out of doors by asking them to do an errand. The aged usually enjoy sitting on a porch or in a garden where they can observe growth or activity around them. They love to watch children at play.

Exercise should be moderated as a person grows older. However, daily exercise and when possible in the outdoors, is important as it helps to reduce stiffness of joints and loss of muscle power. The element of safety in any form of exercise should be considered. Care should be taken that shoes fit properly, are securely laced and that the heels are not run down. Rubber tipped canes and walking chairs help older people to move about. Gentle massage and exercise will be found helpful where stiffness tends to develop in the limbs.

### Relaxation, Rest and Sleep

Older people are usually more susceptible to cold, so ventilation must be modified to their needs, screens being used to cut off any draughts. They need plenty of rest but should be prevented from sleeping their days away. Unless the doctor has given orders to the contrary, they should be out of bed as much as possible. Wakefulness at night may be due to too much sleep during the day. Interesting activities will help to prevent this and will keep them happily occupied. Jig-saw puzzles, simple card games, checkers, etc., are relaxing diversions. In preparing for sleep at night, allow the older person to follow life long habits, such as a warm drink at bed time, reading, etc.

Short visits from neighborhood companions or relatives are also helpful as it keeps the older person interested in the outside world and day to day events. Sometimes they enjoy the company of children and young people as much or even more than those of their own age.

### Clothing

Those who are up and about should be fully dressed in their usual clothes and should be encouraged to take pride in their appearance. Cloth-

The elderly are apt to repeat themselves many times, when memory begins to fail. The listener may find this boring, but should remember that a sympathetic person will listen patiently to their reminiscences, no matter how often the same tale is repeated.

When the elderly become hard of hearing they are apt to become morose, and suspicious. Care should be taken to speak clearly and distinctly.

Time should be set aside for reading to the blind or those with impaired sight. This can be a pleasant occupation for a child or teen-ager. Older people frequently enjoy listening to the radio or watching television and often have their favourite programmes.

Talking books, prepared on records, especially made for the blind, may be borrowed from the appropriate State Institute for the Blind. Encouragement should be given with activities that do not require keen eyesight, such as knitting, weaving, basket work.

ing should be comfortable, light weight and free from restricting bands. As far as possible garments to which the individual is accustomed should be worn since changing life long habits will often do more harm than good. Also, they should be allowed to choose their own clothes and to voice a preference regarding colour and style of new clothes that may be purchased. Shoes should fit well and provide adequate support.

Older people are inclined to react severely to extremes of temperature and they should be advised tactfully about suitable clothing, but never forced. Assistance in dressing is often necessary but again tact should be used to prevent a feeling of helplessness.

## **PERSONAL HYGIENE**

### **Bathing**

The aged should be encouraged in their natural tendency to take pride in their appearance. Some of them find bathing tiring and are apt to neglect themselves, but they should bathe regularly, at least once a week. They should be assisted, if necessary, so they may bathe quickly and avoid fatigue.

### **Care of the Skin**

The skin of an older person needs particular care as it may become uncomfortably dry or wrinkled. The skin should be lubricated with a mild cream or lotion to keep it soft, pliable and in good condition. Alcohol preparations may tend to dry the skin. Soap should be used sparingly.

If exposed to even a moderate amount of pressure the skin of an older person quickly breaks down. If he is not able to move about sufficiently to prevent pressure, the susceptible areas should be rubbed gently to stimulate circulation.

### **Care of Feet, Hands, Hair and Mouth**

An older person should be encouraged and helped to give proper care to his feet, hands and hair, so that he may be comfortable and present a well groomed appearance. Proper care of the mouth and teeth is also important. Elderly people who have their own teeth should visit a dentist regularly. Dentures should fit well and be kept clean.

## **Elimination**

Sometimes older people tend to become constipated. This condition should be reported to the doctor who will prescribe measures to relieve it. It may be that the diet should contain more roughage, such as raw or stewed fruit, but this should be decided by the doctor.

Frequency of urination can also be a problem in the elderly, causing them much mental distress. Every effort should be made to consider their feelings and prevent humiliation. The doctor should be notified of frequency so that he may prescribe treatment, if necessary.

## **Diet**

The diet of an older person should follow the same general rules of good nutrition that are essential to everyone in the maintenance of health. Sometimes they are finicky about certain foods, but their meals in most instances should fit into the general pattern of the family menu with whatever adjustments are necessary.

Some of the disabilities of the elderly, such as depression, fatigue, anxiety, etc., may be traced to improper nutrition. Proteins, minerals and vitamins in adequate amounts are particularly important in maintaining their health.

Older people sometimes do not eat adequately because of poor teeth or because of poor eating habits established in their youth. Those with poor teeth should have their food, especially meats, prepared so they can chew it easily. Those with poor eating habits, such as having several snacks a day of toast, jam and tea, should be encouraged to eat three well balanced meals a day. For the elderly, as for everyone, eating should be a source of both health and pleasure. Meals, attractively served in pleasant surroundings and in a congenial atmosphere, will help to promote good health in the elderly.

## **PREVENTION OF ACCIDENTS**

Extra care is needed to guard the elderly from accidents as age seems to make them more susceptible to these hazards. They may not see well or hear clearly; they tire easily and become forgetful; they frequently move much more slowly in avoiding danger and may have poor balance. Where an elderly person is moving around the house, special care should be taken not to leave toys or other articles in their path. (See page 57).

It is much easier for an elderly person to get in and out of a low bed. The bed is safer without castors. If it is necessary to move a patient to a high bed for nursing care, every precaution should be taken to prevent him falling out, especially if he has been accustomed to a wide bed previously. Side boards may be necessary.

The bathroom is the scene of many accidents to older people. A rubber mat in and beside the tub lessens the danger of slipping. Hand rails should be fixed to the wall for support while getting in and out of the bath tub. The bathroom door should not be locked and someone should remain within hearing distance.

## **SPECIAL NEEDS OF PATIENTS WITH LONG-TERM ILLNESS**

People at any age, the elderly, young adults and even children, may have illnesses of long duration. The nursing care of such patients, whether they are young or old, calls for patience, skill and understanding. Encouragement and kindness toward them is always the hallmark of good nursing care.

### **Emotional Needs**

A patient with a long-term illness is apt to be bored, irritable, resentful and frustrated because of his helplessness and because of the apparent hopelessness of his condition. He may be afraid of becoming a burden on others and of being unwanted. Often he will have little or no hope for the future and will not help himself or help others to improve his condition.

It is important for the one looking after the patient, as well as for the whole family, to try to understand the fears that lead to this irritability and apparent unreasonableness.

Every effort should be made to keep the atmosphere of the home normal. It is important for the family to keep a balance between being over-solicitous of the patient and neglectful of the other members of the family. The home should not be gloomy nor should the family assume an artificial cheerfulness. The attitudes of those close to the patient will do much to establish a wholesome attitude toward his problems. The effect of illness on children is also largely determined by the attitude of their parents and those about them.

It is important to remember that a child, although suffering with an illness of long duration, goes through the normal development of childhood, both physically and emotionally.

Children grow even when they are sick and it is necessary to make periodic adjustments of sick-room equipment, such as bed table, back rest, crutches etc. It is necessary also to change the bed side table from one side of the bed to the other to help maintain the normal curvature of the spine.

Children differ in their emotional reaction to illness. For example, a two year old, because of his age and other factors, may have a negative approach to his sickness and to those caring for him. A four year old child, because he has more understanding, may respond with greater readiness to the situation. Each child must be cared for according to his individual needs.

The person with a long-term illness, whether young or old, must be taught how to live with his handicap and to make the best use of the abilities and faculties that remain. Emphasis should be placed on what the patient has left, not on what he has lost.

### **Bed and Bedding**

If he is to be confined to bed for some time, a hospital bed may be bought from a hospital supply firm, or hired from a hire service.

One advantage of a hospital bed is that it is high enough so that the person giving care may do so without strain to her back and shoulder muscles. Another advantage is that it may be operated mechanically to provide a back rest and an elevated support for the knees. If, however, a hospital bed is not available, an ordinary bed, elevated on blocks is satisfactory.

It is essential to the comfort of a patient with a long-term illness that a firm mattress is used. If it is necessary to use a waterproof cover, it should fit the mattress snugly to prevent wrinkles. A cotton mattress pad or flannelette sheet placed over the waterproof covering adds to the patient's comfort.

The mattress should be turned regularly from side to side and from end to end to prevent it from sagging in one spot. It may be necessary to

use bed boards to keep the mattress firm. Masonite or plywood is satisfactory for this purpose. The boards should be cut large enough to cover bed-springs.

The bedding should be kept clean and free from perspiration and body discharges. A draw sheet placed across the centre of the bed helps to protect the bottom bedding and is an aid in moving the patient in bed.

Blankets should be clean, soft, light in weight, but at the same time provide sufficient warmth for the patient's comfort. If an electric blanket is used, the directions for its use should be followed carefully. A light weight cotton bed spread, that can be laundered easily, will make the bed and room more attractive.

## Rehabilitation

The primary aim in the care of a patient with a long-term illness, must be to assist in promoting his maximum recovery. The first step in this rehabilitation is learning to do for oneself and the patient should be helped to help himself. This may cause some delay or inconvenience but it will help him to overcome his fears and aid in developing a feeling of independence that will give him new hope.

Doing everything for him is far from the best way to help him and does not encourage self-reliance. Even though he cannot complete an action without help, it is good for him to do as much of it as he can. For example, encourage him to wash or dry his face, even if he is not able to do both. He should be allowed to feed himself although he may need help cutting his meat. The patient himself must have a compelling desire to re-learn how to care for himself, for without this drive to succeed he may fail. Encouragement and kindness toward him are always essential.

## Posture

The maintenance of correct body position or good posture is vital to a patient who is in bed for a long period of time. Good posture helps to promote circulation, to prevent body deformities and to preserve flexibility. The head, shoulders and trunk should be in the same relative position to one another whether the patient is lying down, sitting up or standing. The spine should be straight when lying in bed. In a sitting position, the head and shoulders should be supported with pillows. Pillows or pads should be placed under the fore-arms to relieve strain, and the hands, if



inactive, should be placed on a support such as a rolled towel. The knees should be slightly flexed and the hips supported with a small pillow or folded towel placed under the thighs. The feet should be supported by a covered box placed at the foot of the bed (See page 125). This support will help to keep the feet in standing position and assist in strengthening the muscles in feet and legs. The box will also protect feet and legs from pressure of bed clothes. If a patient's leg is paralyzed, it should be held in proper position by placing a rolled blanket or a sand bag along side it.

If a patient is going to lie on his side for some time the upper arm and leg should be supported with pillows.



## Exercise

Exercise is necessary in preventing body deformities, as contractures are apt to develop fairly quickly if a patient is in bed for a long period of time. He should be encouraged to move about in bed as much as possible.

The doctor may prescribe exercises for the normal range of motion of the patient's joints and someone in the family may have to help with them. The doctor, the visiting nurse or a physical therapist can teach the patient and someone in the home how to carry out the exercises by explanation and demonstration of them. The doctor will decide how often and how many times the exercises are to be done. In making this decision it is important for him to know the progress the patient makes in performing the exercises. Since the prescribed exercise is actually a form of treatment, it should be carried out exactly as ordered by the physician.

Some of the exercises may be carried out in activities of daily living. It has been found that self-care involves about one hundred motions; for dressing, for getting in and out of bed, going to the toilet, and in performing other ordinary daily activities. These activities, done automatically by a person who is well, become complex tasks for the person who is handicapped. It takes perseverance, determination and repeated practice for him to do such apparently simple things as feeding or dressing himself or getting in and out of bed. Such a patient needs praise and encouragement for even small accomplishments so that he may be stimulated to attempt greater achievements. When he realizes he is able to help himself, his will to improve is strengthened and his morale is bolstered.

## Incontinence

Some patients with a long term illness may have incontinence as a result of their condition. Care should be taken that they do not suffer embarrassment because of it. Incontinence is the inability to control the flow of urine from the bladder or stool from the bowel. It is a medical problem and the doctor is responsible for any treatment that may be given to control it. However, good nursing care is of particular importance for the patient with incontinence and the problems associated with it.

The patient should be kept clean, dry and free from odour. In addition to regular bathing, his back, buttocks and genitals should be cleansed

carefully each time he becomes wet or soiled. If necessary, the bed linen should be changed. The use of disposable absorbent pads helps to cut down on changing of sheets. These pads may be made from an old crib pad, or other thick but soft material, cut into convenient size and placed over a piece of waterproof sheeting. (See page 129).

The skin must receive special care and attention because the urine may be very irritating to it. It may be protected by the application of vaseline, lanolin or oil. If the skin becomes unusually red or irritated, or if there is a break in it, the condition should be reported to the doctor.

## Prevention of Pressure Sores

Patients who must be in bed for a long time, as well as the elderly, are particularly susceptible to pressure sores. A cast, a splint, a tight bandage or even the bedding can create enough pressure so that the skin will break down and develop sores that are difficult to heal. Paralyzed patients lose their sensitivity to pressure and may need special attention. The areas most likely to be affected are the end of the spine, shoulder blades, elbows, hips, heels, toes and areas where the skin rubs together. The prevention of pressure sores depends almost entirely on good nursing care and the following essentials should be observed:

The skin should be rubbed gently with cold cream, skin lotion or oil every morning and evening and more often if the skin is dry or chafed.

The bottom sheet should be dry, clean, free from wrinkles and crumbs. The weight of the bed clothes should be removed from the body by a bed cradle. (See page 124).

The bedpan should be placed and removed carefully. It should be put under the buttocks gently and if the skin is moist, talcum powder should be dusted on the pan. A soft pad between the patient's buttocks and the bedpan will help to avoid irritating the skin.

The patient's position should be changed frequently and he should be encouraged to move about in bed as much as possible.

Foam rubber pads placed under susceptible areas help to reduce pressure.

If a pressure sore does develop, the doctor should be notified at once so that he may prescribe treatment.

## SUMMARY

The more normal life is the happier the elderly person will be. Although special care may be indicated, it should be given in such a way that the patient is not made to feel that he is failing, is incapable or becoming a burden.

Activity within the capabilities of the older person is important and he should be encouraged to go out of doors daily. If this exercise can be of a useful nature, such as going to the store, so much the better.

Rehabilitation should begin with the onset of illness, especially for the patient with a long term illness. He should be encouraged to do as much for himself as possible even if it is more time consuming for the person giving care.

Nutrition is of special significance for the aged. His diet should be based on that of the family with the necessary adjustments being made because of the patient's loss of appetite or special nutritional requirements.

This chapter outlines the salient points in the care of the aged and a patient with a long-term illness.



## CHAPTER VII

### Prevention of Home Accidents

More accidents occur in the home than anywhere else, and in many instances there are tragic results. Nearly all of these could be prevented by a knowledge of accident hazards and observance of some basic precautions.

#### Special Hazards to Little Children

Small objects that a little child might put into his mouth should be kept out of reach, such as thimbles, nails, buttons, marbles, safety pins and small removable parts of toys.

Soap detergents, insect poisons, cleaning substances, knives, matches, drugs, (including headache tablets) can be fatal to the young child. All precautions should be taken to keep these articles out of his reach, especially if he is a toddler or of pre-school age.

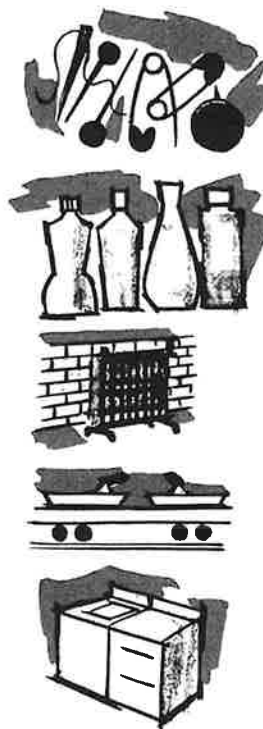
If a child does take poison or any medicine not prescribed for him, the doctor should be notified immediately, or the patient taken to the nearest hospital emergency department. Advice may also be obtained by telephoning to the nearest poison control centre, day or night.

Fireplaces should be properly screened to prevent the toddler from falling in and being burned.

Saucepan handles should be turned to the back of the stove so that small children cannot reach them.

Firearms should be unloaded and kept in a locked cupboard so that a child cannot play with them.

A child should never be left alone in a room where a washing machine or any other mechanical device is in operation.





Many children are hurt from falling and therefore, babies and small children should never be left alone on tables, beds, or in a crib unless the sides are up. Small children should never be left alone in the bathtub as there is a possibility of burning with hot water, falling when trying to climb out or slipping under water.



The toddler is a great explorer and it is sometimes hard to keep track of him. A gate placed at the top and bottom of stairway will prevent him from falling downstairs.



Plastic clothes bag or any plastic film material should never be used on a child's bed as a mattress cover or for any other purpose. There is the hazard of death from suffocation if the child pulls the plastic bag over his head or inhales small pieces of plastic.

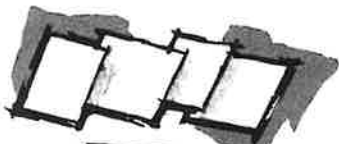
Another hazard of death from suffocation is the unused refrigerator stored in the basement, on the back porch or left in the yard. The doors should be removed or padlocked to prevent the child from crawling in and closing himself in an air-tight box.

Soft pillows are also dangerous for a small baby as they may cause suffocation.

Electric appliances and electric cords intrigue the young child. Because of this special fascination he should be taught early that he is not to play with them.

All lamp sockets should have electric bulbs in them as a precaution against electric shock and unused outlets should have safety plugs that the child cannot remove.

Every room in the house should be examined carefully for safety and all objects that are hazardous should be put out of sight and out of the child's reach. These include all medicines and poisonous substances. Bottles and containers that held substances harmful to the child should be disposed of and not given to him as a plaything.

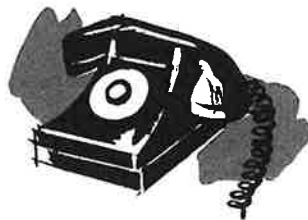


The baby's furniture should be inspected frequently to see that safety devices are in proper condition. These include the safety belt in the carriage, the tray catch on the high chair and the lock that holds the side of the crib in position. If they are not in working order, repairs should be made immediately. Non-poisonous paint should be used on the child's crib, high chair, stroller and toys.



Parents should always be careful about their own habits regarding safety as a child is a born mimic and will learn from example.

If small children are left in the care of an older child or sitter, careful instructions should be given as to who is to be called in case of an emergency. It is a wise precaution to place the following telephone numbers in a conspicuous place:



The Fire Department.

The family Doctor.

The Hospital.

Where the family can be reached.

### General Accident Hazards

Many accidents are caused by people slipping on highly polished floors or scatter rugs. Floors, therefore, should not be highly polished and if rugs are used they should be secured in place to prevent slipping. This can be done by using rubber mats under the rug or by sewing rubber gem jar rings under the corners and along sides of rug.

Falls are frequent causes of accidents in all age groups. Certain precautions should be taken to prevent them.

For example:

Stairways and floors should be kept free from unnecessary articles such as toys, mops, brooms, etc.

When reaching for an article from a high shelf, a safe stepladder or a sturdy chair should be used and a person should not try to stretch too

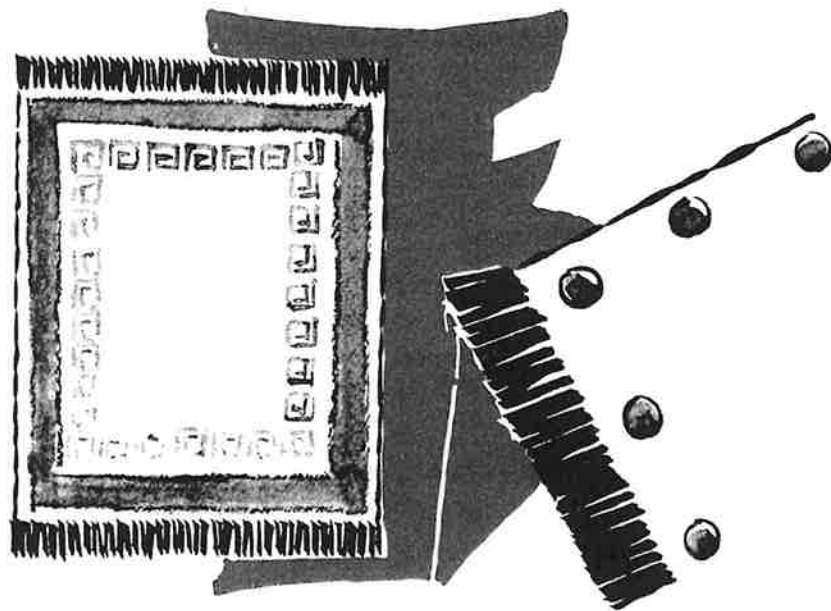
far to obtain the article. The ladder or the chair should be moved closer, if necessary. When using a ladder of any kind and for any purpose care should be taken to see that it is anchored securely so it will not slip. It should be examined to see if it is safe and not in need of repairs.

If anything is spilled on the floor, verandah, or outside walk, it should be wiped up immediately.

Clothes lines should be sufficiently high to allow enough room to walk safely underneath.

### Special Hazards to the Elderly

(See page 47)



### SUMMARY

Much illness and suffering are the result of accidents and the home is the place where the majority of them occur. These could be prevented, with rare exception, if care is taken to eliminate all accident hazards. These include, clutter on stairs or throughways, slippery floors, equipment in poor repair, poor lighting in hall and stairways, etc.

When there are children and elderly persons in the home, special care must be taken because of the curiosity of the young and the impairment of the aged.

If anyone, but especially a child, takes a poison or any medicine not prescribed for him, the doctor should be notified immediately or the patient taken to a hospital emergency department.



**PATIENT CARE IN THE HOME**

**PART TWO**

*Simple Nursing Procedures*

## CHAPTER VIII

### General Care of Patient

The care that is given to a patient will vary according to his needs and the severity of his illness. However, whether a patient is seriously ill and in bed all the time or whether he is out of bed for part or all day, it is desirable to have a plan for his general care. It is easier for all concerned if the plan is flexible.



#### Hand Washing of Attendant

**PURPOSE** To help prevent the spread of infection. The person looking after the patient should wash her hands thoroughly before and after giving any care and before handling food.

**EQUIPMENT** Running water.  
Soap.  
Nail brush and orange wood stick.  
Clean linen or paper towels  
Container for soiled towels.

**PROCEDURE** Fold up sleeves and remove wrist watch. Take off any jewellery that may hurt the patient or carry infection.  
Wet and soap hands, wrists and forearms.  
Use friction to work up a lather over entire surface of hands and well above wrists.  
Wash well between fingers and around and under nails, using nail brush.  
Rinse well under running water with hands lowered to allow soiled water to drain off.  
Clean nails as necessary.  
Soap hands well again, then rinse cake of soap so it will be clean when used again.  
Rinse hands well.  
Dry hands thoroughly with a cloth towel to avoid chapping.  
If cloth towel is not available use a soft paper towel.  
Discard soiled towel in laundry or waste container.  
Rinse basin with fresh water.

## **DAILY ROUTINE**

### **Morning Care**

The time at which care is given to patient in the morning depends on individual circumstances. Regularity is desirable but after a disturbed or wakeful night, rest may be more important.

Morning care includes taking patient's temperature, pulse and respirations, giving a bedpan or urinal, (the doctor may have requested a morning specimen of urine), washing patient's hands and face, caring for mouth and teeth and putting patient in a comfortable position for breakfast.

The patient should be encouraged to do as much for himself as possible to help develop his independence (See

page 6 and 50). However, exertion that leads to fatigue and exhaustion should be avoided. After breakfast he should rest at least half an hour before his bath.

If a treatment is to be given in the morning, that might soil the bed, it is advisable to carry it out before giving bath and changing bed clothes.

After the bath, the room should be dry mopped or vacuumed, dusted, tidied and aired and flowers freshly arranged.

The patient's record should be brought up to date in readiness for the doctor's visit.

Mid-morning nourishment should be given at a time that is in proper relation to breakfast and lunch.

Other details of morning care will depend on patient's needs and the doctor's orders.

### **Afternoon Care**

The patient should have at least one hour's rest after lunch. Before his rest period the bedpan or urinal should be given, his hands washed and teeth cleaned.

The back and all pressure areas should be gently rubbed with a good skin lotion using palm of hand, not finger tips. Crumbs should be brushed out of bed, bottom bed-clothes tightened and smoothed. The upper bed-clothes should be straightened and position of pillows, pads and supports adjusted comfortably.

Curtains and shades may be drawn to help patient relax and sleep.

If patient is left alone, he should always have a bell or a cane with which to signal.

Following mid-afternoon nourishment, pleasant diversional activities may be arranged. If visitors are allowed, they should be told how long they may stay. Care should be taken that the patient does not become excited or overtired.

### **Evening Care**

The patient should be prepared for sleep at a reasonably early hour whenever possible.

Excitement, stimulation or disturbances of any kind, should be avoided just before bedtime.

The temperature, pulse and respirations may be taken and patient given bedpan or urinal.

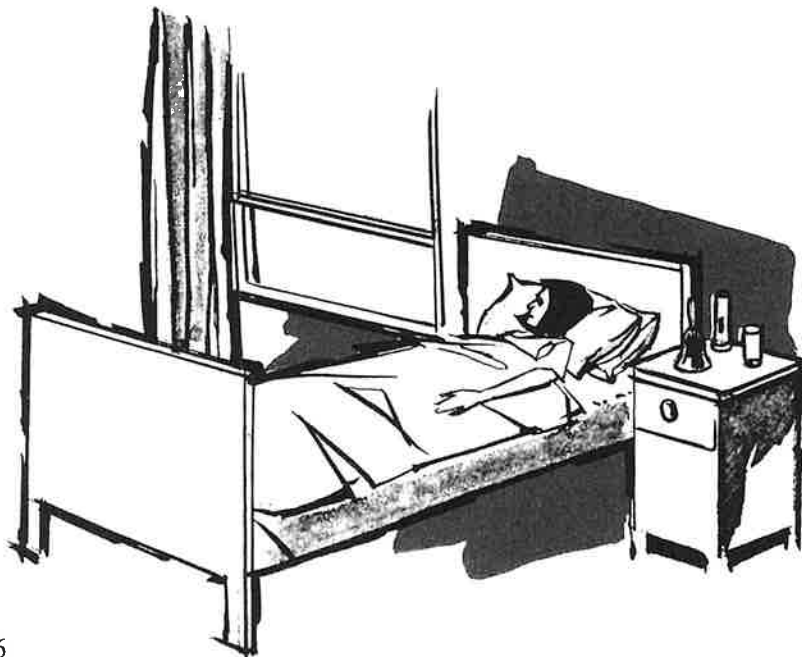
Mouth care should be given.

A partial or complete bath helps to make patient more comfortable and relaxed. In any case, hands and face should be washed, back sponged and again gently rubbed. Special attention should be given to all pressure areas.

The bottom sheet should be tightened and crumbs removed. The upper bed-clothes should be tidied and an extra blanket provided if required. Pillows should be shaken up and adjusted in a comfortable position for sleep. A warm drink given just before bed-time helps to promote sleep.

A bell, fresh water and a flashlight if necessary, should be left conveniently within reach.

The window should be opened to allow sufficient ventilation and fresh air.



## SUMMARY

There should be an overall plan for the care of the patient. It should provide morning, afternoon and evening care and leave time for rest and relaxation for patient and attendant. The patient may require additional nourishment between meals and this should be provided at hours which will not interfere with regular meals or lessen appetite.

Visitors are important to a patient but undue fatigue should be avoided. The patient's wishes with respect to visitors and the doctor's opinion regarding their effect on the patient's well-being should be the determining factor. Friends and relatives will appreciate knowing whether or not the patient may have visitors and if so the length of time they may stay.

Handwashing of the person looking after one who is ill, is of prime importance. Hands should be washed before and after giving treatment and before handling food.



## CHAPTER IX

### Care of Patient Not Confined to Bed

Many patients, with the doctor's permission, are encouraged and helped to get out of bed regularly because of the benefits of moving, sitting up, walking, etc. Such activity may be time consuming, especially for the one giving care. However, physical activity increases circulation, helps to prevent stiffness of joints, increases mental alertness and encourages a patient to assist in his own recovery.

#### Preparing Patient to Get Out of Bed

The first step for the patient who is to get out of bed, is to be helped to a sitting position, with his feet dangling over the edge of the bed. This helps to increase the blood flow to the lower extremities and lessens the tendency to dizziness. It also helps to strengthen the arm, leg and back muscles for further physical activity. At first this may be all the exercise the patient is permitted.

**PROCEDURE** The patient should lie on his back with his knees slightly flexed and head and shoulders raised forward.

Bearing the weight of his upper body on his elbows have him slide both elbows back on bed as far as possible.

Have him straighten his right elbow and with his right hand push against mattress.

Have him do the same with other elbow and hand until he is in a sitting position.

Help him put his legs over side of bed.

When patient wants to lie down, the same procedure is used only in reverse.

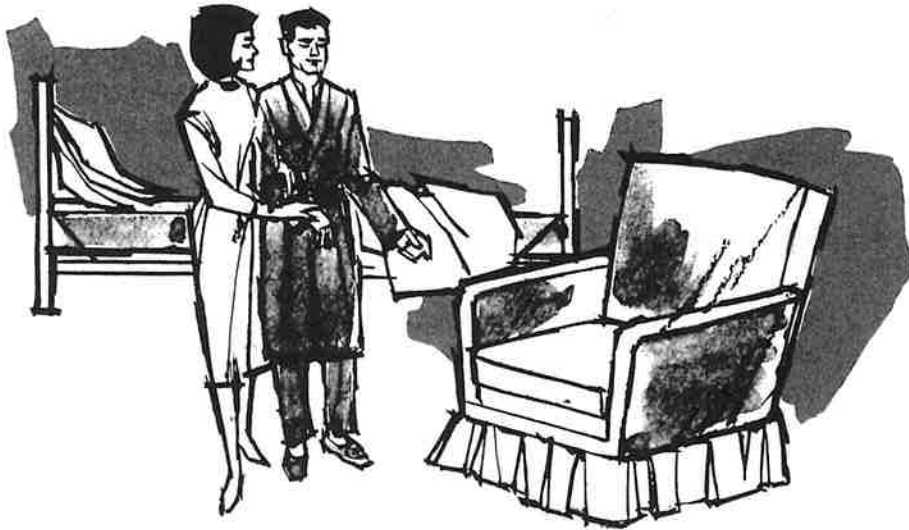
#### NOTE

An alternative method of getting into a sitting position is to have him pull on a rope attached to the foot of the bed.

This method is not as helpful in strengthening the muscles required to support body weight but may be used if patient is partially paralyzed.

The patient should be allowed and encouraged to do as much for himself as possible but should be helped if necessary.

### Getting Patient into a Chair



The chair should be comfortable and strong. A firm pillow on seat of chair will raise the height. A pillow at the back will give support to head and shoulders.

A foot stool beside the bed may be necessary if bed is elevated or patient is a child.

**PROCEDURE** Have room warm and patient comfortably dressed in a warm dressing gown. Later in his convalescence, if he is going to be up for any length of time, it is desirable to have him dressed in his ordinary clothes. This will add to his feeling of accomplishment.

Place chair at right angles to bed. Brace chair, if necessary, so it will not move as patient sits down on it.

Have the patient come to a sitting position and put his legs over side of bed.

Place patient's arm on your shoulders and support him to a standing position.

Assist him to chair and to a sitting position in chair.

Put a blanket over his knees and place a footstool if necessary.

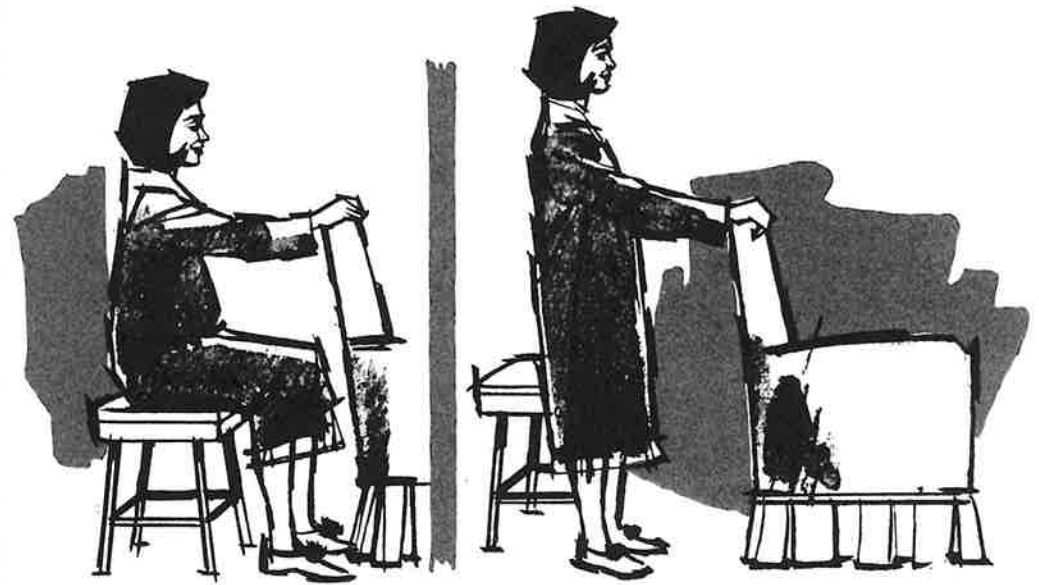
Leave a bell within easy reach.

### Helping Patient to Walk

If a patient has been ill for any length of time he may have to re-learn how to walk.

Although he may prefer to stay in bed, he should, if permitted by the doctor, be encouraged to get up and do as much for himself as possible.

He should not attempt so much that he becomes fatigued or discouraged and the doctor should determine for how long he may be up and the extent of his activity.



**PROCEDURE** Before walking, patient should practice standing and maintaining balance.

Low-heeled shoes or oxfords should be worn for proper support. Bedroom slippers do not give sufficient support.

It is important that patient maintain good posture; head erect, neck, chest and lower extremities in alignment and body weight evenly distributed on both feet. It is usually better to support patient from the back when helping him to walk, unless he has some disability. This allows him to maintain his normal walking position. A belt around his waist provides a good grip for the helper, and eliminates strain as she alternates steps with patient.

**NOTE** If a patient is weak or timid he will need additional support at first. The helper should take patient's arm providing support under armpit. As he gains strength he should be gradually offered less support.

### **Patient's Tub Bath**

**PURPOSE** To cleanse and refresh patient.

**EQUIPMENT** Towels and wash cloths.

Necessary toilet articles.

Clean clothing.

Chair or bathroom stool covered with bath towel or blanket.

Bath mat for floor.

Mat with rubber suction for bottom of tub.

**PROCEDURE** See that bathroom is warm and free from draughts.

Place wash cloths, towels, toilet articles and clean clothing within easy reach.

Place covered chair near tub and bath mat on floor.

Test temperature of water with elbow.

Have patient hold edge of tub or a grab bar and help him into tub if necessary.

Leave bathroom door unlocked if patient is managing his own bath and remain within hearing distance. Do not let him remain in tub longer than 10 minutes.

If necessary a male member of the family may be taught how to bathe, dry and dress a helpless male patient.

Remain with a child, a depressed person or one who is unsure.

If a patient faints in tub, support his head and shoulders until water has drained out of tub. Cover him with a blanket until assistance can be obtained.

Do not leave an electric heater attached while patient is having a bath because of danger of shock from touching cord or heater with wet hands or towels.

### **Patient's Shower Bath**

**PROCEDURE** Place floor mat in position and provide a stool or bench on which patient may sit to wash his feet.

Protect hair of a female patient with shower cap or plastic bag.

Regulate the temperature of water before patient steps into shower.

### **Making an Unoccupied Bed**

**EQUIPMENT** Mattress cover or pad.

Sheets and draw sheet as required.

1 waterproof sheet if necessary.

Pillows and pillow cases.

1 or 2 blankets.

1 washable spread.

**PROCEDURE** Arrange a chair conveniently near bed and place clean linen on seat of chair.

Turn mattress as necessary and place it squarely on springs.

Never fold a spring mattress.

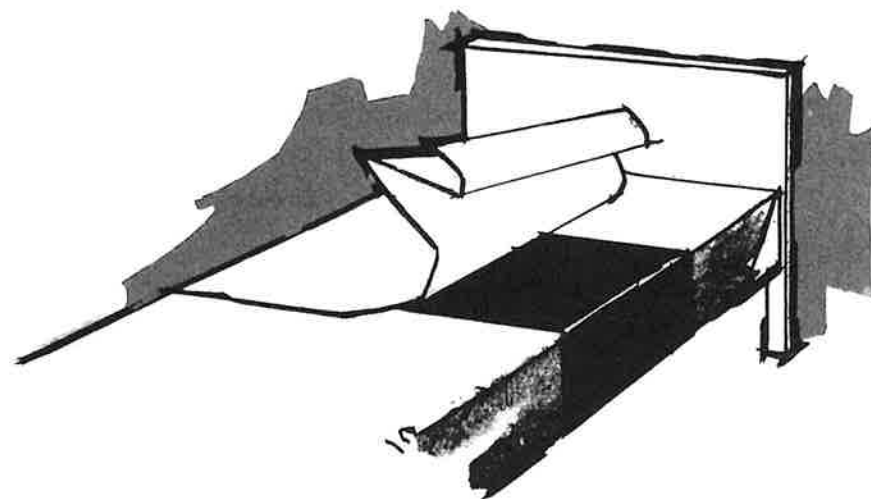
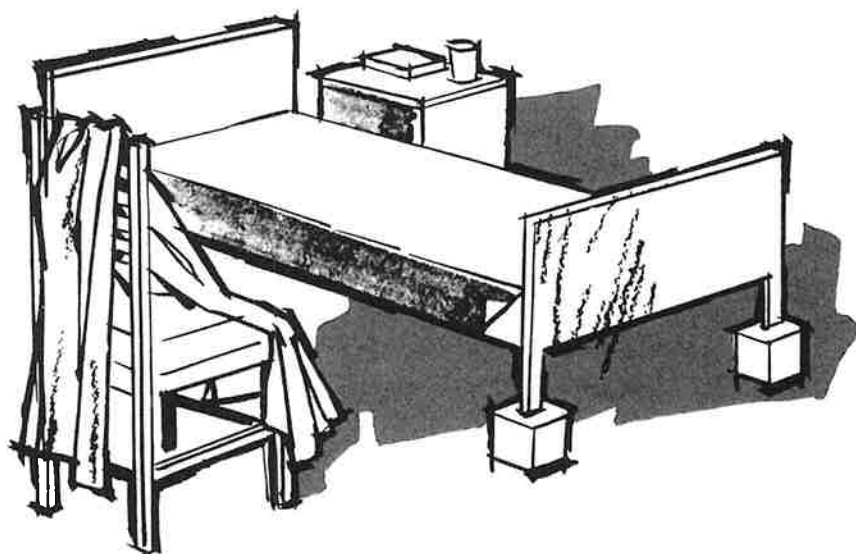
Place mattress cover squarely on mattress.

Place bottom sheet, right side up, evenly on mattress, allowing enough sheet to tuck well under top of mattress.

Tuck sheet securely under mattress at head of bed and make a mitred corner (See page 76). Tuck in along the side of bed and make mitred corner at foot, if sufficiently long. Place waterproof sheet on bed so that it will reach from patient's shoulders to his knees.

Place draw-sheet so that it completely covers waterproof sheet. Tuck in together on one side. Go to opposite side of bed. Pull under-sheet tight.

Mitre sheet at head of bed, tuck in firmly all along the side.



Pull waterproof sheet very tight so that there are no wrinkles and tuck in securely, then do same with draw-sheet.

Place top sheet, wrong side of hem uppermost and allow about 6 inches to fold back over blanket, at the same time leaving enough sheet to tuck securely under mattress at foot of bed. A box pleat in the sheet provides room for patient's feet.

Place blankets singly so that upper edge of blankets will cover patient's shoulders. Tuck them under at foot of bed and mitre corners. Fold topsheet back at least 6 inches over top of blanket.

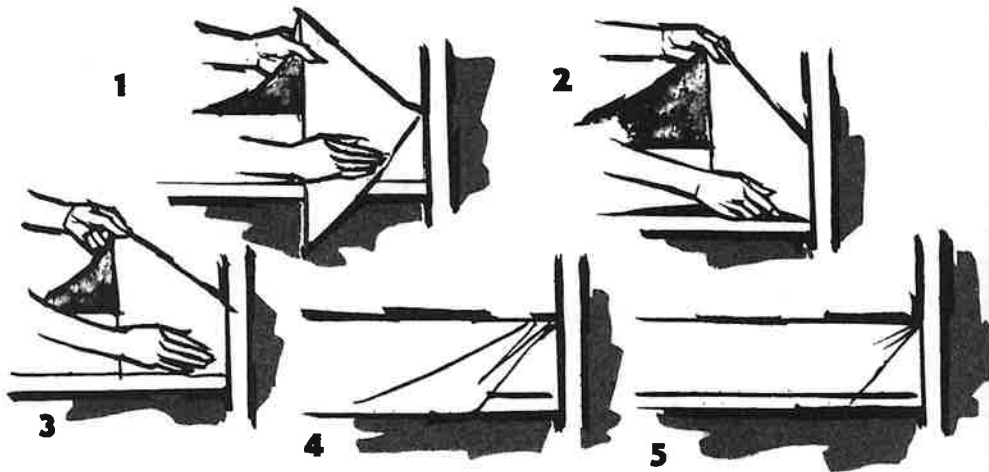
Place spread with centre fold straight in middle of bed. Tuck it under at foot of bed and mitre corners.

Arrange pillows so that seams and open ends are out of sight. If pillow-slips are large make a pleat on seam side of slip.

See that bed table is within easy reach of patient, that bureau and furnishings are tidy and that work has a finished appearance.

## Making a Mitred Corner

- 1 Tuck sheet well under end of mattress and with left hand pick up edge of sheet about 2 feet from end of mattress and place it on top of bed at right angles to edge of bed.
- 2 Tuck in portion of sheet hanging below mattress.
- 3 Hold sheet in place against side of mattress with right hand.
- 4 Drop corner of sheet over right hand.
- 5 Tuck sheet under and along the side of mattress.



## SUMMARY

Getting out of bed after an illness may be an important step in the patient's recovery. But it may be more difficult than he expects. Therefore, he should be prepared for this step, especially if he has been confined to bed for a long time.

Whether ill in bed or up and about, the posture of both patient and attendant is important. In this way fatigue is lessened and muscles are strengthened.

The assistance given to the patient should be gradually withdrawn but only as he is able to do for himself.

Bed making, whether the patient is in bed or up in a chair, is important. Detailed instructions for this and other nursing procedures are outlined in detail.



## CHAPTER X

### Care of the Patient in Bed

The person caring for a patient in bed should remember the principles of posture and body mechanics, not only as they apply to the patient but to herself as well. (See page 7). She should also be aware of the principles of rehabilitation (See page 6 and 50).

#### Patient's Bed Bath

Some patients, particularly older people or those whose skin is dry, do not want or need a daily bath. As an alternative, a gentle rubbing, using talcum powder or skin lotion may be given. Judgment should be used in deciding the frequency of the bath.

- PURPOSE** To cleanse and observe condition of patient's skin.  
To refresh and relax patient.  
To stimulate circulation and provide a mild form of exercise.
- EQUIPMENT** Basin of warm water and a jug of hot water.  
Waste pail if patient's room is not near the bathroom.  
2 bath towels, 1 face towel, 2 wash cloths, soap in a dish.  
Flannelette sheet or cotton blanket to be used as a bath blanket.  
Tray with toilet articles: tooth brush, drinking glass, small basin, tooth paste, mouth wash, nail file, brush and comb, rubbing alcohol or skin lotion, dusting powder or corn starch.  
Clean pyjamas or night gown, sheets and pillowcases.  
Newspapers, table, chair.

**PROCEDURE** See that room is comfortably warm, free from drafts and that patient has privacy.

Cover table with newspaper and place newspapers on floor for soiled linen.

Assemble necessary equipment.

Give mouth care if necessary. (See page 86).

Remove top bed clothes and replace with bath blanket.

Remove unneeded pillows.

Give necessary help in removing patient's gown or pyjamas.

Place one bath towel across patient's chest, folding one-half of it under top of blanket. Place other bath towel under head to protect pillow.

Wash and dry face or assist patient to do so.

Remove towel from under head and use it to protect bed linen as bath progresses.



Wash patient's arms and hands, one at a time. Hands may be washed in basin which should be held securely on the bed. Dry thoroughly and gently rub elbows, using skin lotion.

Using second wash cloth, wash front of body and sides of chest, paying particular attention to armpits, umbilicus and deep folds of flesh. Dry thoroughly and dust with powder.

Wash patient's legs and feet, one at a time.

Rinse feet in basin of water in same manner as hands.

Help patient to lift his foot into bath basin, supporting knee and ankle for safety and comfort. Be careful to dry well between toes. Gently rub knees, ankles and heels with palm of hand.

Change bath water so that it is clean and warm.

Turn patient on his side or help him do so.

Protect bed with towel.

Wash and dry back of patient's neck, back and buttocks with long firm strokes. Examine skin carefully for any signs of redness, tenderness or break in skin.

Rub well, using skin lotion or talcum powder, paying special attention to hips, shoulders and end of spine. Rub with palms of hands, using a circular motion. Lotion may be warmed by standing it in basin of warm water.

Help patient, or have him turn on his back.

Place bath towel under patient's hips. Move basin of water, soap and wash cloth within easy reach and have him complete bath. If patient is unable to do so, wash and dry genitals and groin. Dry parts thoroughly and dust talcum powder in the groin of heavy patients.

Assist patient in replacing gown or pyjamas and remake bed.

Give care to nails and hair or have patient do so.

Remove bath articles and soiled linen. Tidy bedside table, place in convenient position and bring fresh drinking water.

Make sure bell is within reach.

Air room and adjust window shades.

**NOTE**

Be sure patient is warm and comfortable if bath is interrupted and he is left alone.

**Making Bed with Patient In It**

**PURPOSE** To add to the patient's comfort and well being by having a clean smooth surface to lie on and clean light weight warm covering.

**EQUIPMENT** Mattress cover or pad.  
Waterproof sheet to protect mattress if necessary.  
Clean sheets and pillow cases as necessary.  
Draw sheet.  
1 or 2 blankets, depending on room temperature.  
1 washable spread.  
Laundry basket or bag or newspaper for soiled linen.

**PROCEDURE** Shut windows and see that room is warm enough to avoid chilling patient.  
Assemble necessary linen and laundry basket or bag.

Newspapers placed on the floor may be used for soiled linen if basket or bag are not available.

Arrange chair conveniently near bed and place clean linen on chair seat.

Loosen bed clothes around mattress. If mattress has slipped down, have someone help pull it up into position.

Remove spread, folding it crosswise for ease in replacing it and put over back of chair.

Remove top blanket similarly.

Slide top sheet down under second blanket and remove it.

The patient may hold top edge of blanket while this is being done, or blanket may be tucked under his shoulders to hold it in place. If top sheet is to be used on bottom of bed or as a draw sheet, fold it and place over back of chair.

Remove all pillows, or all but one, supporting patient's head and shoulders with one hand and arm.

Remove soiled pillow slips and place with soiled linen.

Place pillows on chair.

Help patient, or have him turn to other side of bed, to change bottom sheet. Tuck blanket closely around patient so that it will be out of the way.

Remove all crumbs from bed.

Gather draw sheet into a flat roll and push it close to patient's back. Do the same with waterproof sheet, if one is used.

Gather bottom sheet lengthwise into a flat roll and push it close to patient's back.

Pull mattress pad smooth under patient.

Center clean sheet lengthwise, place and unfold it with bottom hem even with end of mattress. (It does not have to be tucked in at the foot). This will allow enough sheet to tuck well under top mattress to protect it and to keep the sheet smooth under patient's shoulders.

Tuck sheet in down full length of bed.

Put other half of clean sheet in a flat roll against patient's back and under soiled sheet.



Tuck in other half securely at head of bed.

Mitre corner and tuck in under mattress and along side of bed. Draw waterproof sheet back over clean sheet and tuck it under the mattress.

Place draw sheet on bed with folded edge under pillow.

Push it in a flat roll against patient's back and tuck in other half under mattress.

Roll patient or help him move to clean side of bed.

Go to other side of bed and draw out soiled sheets, handling as little as possible.

Smooth mattress pad, tuck sheet in securely and mitre corners (See page 76).

Pull waterproof sheet tightly and tuck it in under mattress.

Pull clean draw sheet through and tuck it in securely under mattress.

Have patient move or help him move to center of bed.

Shake pillows and put on clean pillow slips. Replace them under patient's head and shoulders.

Place top sheet over blanket, allowing at least a 6 inch fold at top.

Pull blanket from under top sheet and replace blankets separately on bed, allowing sufficient at top to cover patient's shoulders. Mitre corners.

Place spread on bed turning top under blanket and folding sheet over spread at least 6 inches. Mitre corners of spread.

When bed is complete, loosen bed clothes over patient's feet to provide ample space for toes.

Make sure that patient is comfortable and the bedside table and bell are within easy reach.

Remove soiled linen and see that room is neat and tidy.

### Feeding a Helpless Patient

Even if a patient needs some help at meal time, he should be encouraged to do as much for himself as possible. Frequently he can manage to feed himself if his meat is cut and bread buttered. However, whether assistance is much or little it should be cheerfully given. He should not be hurried and should be praised for even minor accomplishments. Patients who are completely helpless will have to be fed.



**EQUIPMENT** A suitable tray and tray cloth.  
Attractive dishes for food.  
Cutlery as required.  
Drinking tube, if necessary.  
Serviette.

**PROCEDURE** Prepare patient by propping him up comfortably with pillows, as close as possible to a sitting position.  
Bring tray to bed side and place serviette under patient's chin.  
A spoon rather than a fork can be used if this is more practical.  
Be sure that foods are not so hot as to burn patient and that he has time to swallow before more food is offered.  
If a drinking straw is used, it is placed in patient's mouth, to one side. The bottom end should be below the level of liquid in cup to prevent air from being swallowed.  
If he is unable to raise his head a feeding cup should be used, as follows:  
    Attendant's left arm is placed under pillow and patient's head raised slightly.  
    Hold feeding cup in right hand and allow only a little food at a time to pass into mouth.  
Record kind, time and amount of food eaten and observations about patient's appetite and enjoyment of food.  
Rinse drinking tube in cold water or discard straw.  
Wash dishes and cutlery in warm soapy water, rinse, scald and drain.

### **Care of Patient's Mouth and Teeth**

**PURPOSE** To cleanse and refresh patient's mouth, teeth and gums.  
To stimulate circulation of gums to keep them healthy.  
To prevent accumulation of waste food particles around teeth and gums.

**EQUIPMENT** Tray containing the following:  
Tooth brush.  
Tooth paste or powder.  
Glass of warm water containing half a teaspoon each of salt and baking soda or other mouth wash.  
Small basin for patient to spit into.  
Lubricant of glycerine or equal parts paraffin oil and lemon juice in medicine glass or small jar.  
Cotton applicators. (These may be made by winding absorbent cotton around end of small clean stick or tongue depressor).  
Glass of cool water.  
Paper wipes.  
Towel or paper serviettes.

### **If Patient is Able to Clean His Own Teeth**

**PROCEDURE** Protect bed and patient's gown by placing a towel well up under his chin, over shoulders and bedding.  
Give patient basin to hold and hand him articles as required.  
Have him clean his teeth in usual manner with up and down motion, rinsing his mouth with cool water if he is able to sit up.  
If patient is unable to sit up, have him turn his head to one side and place waste basin under his chin.  
Pour water over tooth brush and apply tooth paste, powder or salt and soda solution.  
Have patient brush his teeth.  
Let him wash his mouth with cool water using a feeding cup or drinking tube.  
Let patient dry his mouth and chin.

## If Patient is Helpless



### PROCEDURE Wash hands.

Place towel under patient's chin to protect gown and bed.

Examine mouth, tongue and gums. If they are dry apply lubricant to tongue and inside of mouth using applicator.

Place basin in convenient position under patient's chin or cheek.

Allow him to rinse his mouth, using feeding cup.

Gently cleanse upper and lower gums, tongue, inside surface of cheeks and well between teeth. Use a clean applicator for each section of mouth and discard used applicators into paper bag.

If patient is unable to rinse his mouth, use fresh applicators, dipped in water to rinse it for him.

Apply lubricant to lips if they are dry.

Wipe mouth and chin dry.

Clean equipment and wash hands thoroughly.

Reset tray and cover with a small towel.

### NOTE

Utensils used for care of patient's mouth should be used for that purpose only.

## Care of Dentures

**EQUIPMENT** Tooth or denture brush.  
Dentifrice or soap.  
Glass of cool water.  
Paper bag.  
Covered container.

### If Patient is Able to Care for his Dentures

**PROCEDURE** Place equipment within easy reach of patient.  
Assure patient of privacy.  
Remove, clean and put away equipment when patient is finished.

### If Patient is Unable to Care for his Dentures

**PROCEDURE** Accept dentures from patient in a paper tissue.  
Rinse dentures under warm running water (never hot), out of sight of patient, handling them with a tissue.  
Brush dentures with mild soap or tooth paste.  
Rinse them in cold water.  
Cleanse patient's mouth with water.  
Return dentures to patient after moistening them with cool water or place them in a container in a safe place out of sight.  
Wash hands, clean equipment and put it away.

## Shampooing Patient's Hair in Bed

Patients with long term illness, should have their hair shampooed at regular intervals, but never without permission from the doctor.

**PURPOSE** To clean hair and scalp.  
To increase patient's comfort and sense of well-being.

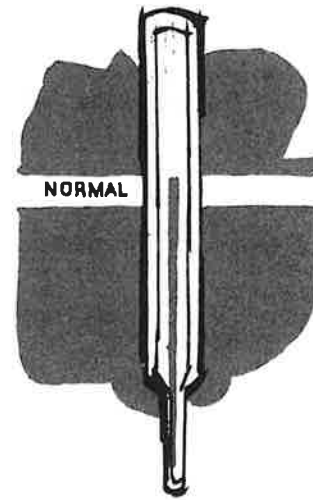
**EQUIPMENT** Waterproof protector for bed. Waterproof sheets or a plastic rain coat or apron may be used.  
Bath towels.  
Shampoo.

Container of warm water.  
 Pitcher.  
 Small pillow protected with waterproof material or folded bath towel.  
 Protection for floor (newspapers).  
 Chair or small low table.  
 Extra blanket if needed.  
 Clean hair brush and comb.  
 Waste pail or small tub.

**PROCEDURE** Have someone assist if possible, as two can give treatment more quickly, with less fatigue and strain for patient. If possible, have bed raised to a comfortable working height to avoid strain on persons giving treatment. Fold upper bed clothes back to patient's waist, remove pillows, and cover exposed area with a small blanket. Place patient with head at edge of bed on small pillow or folded bath towel. Make patient as comfortable as possible. Protect bed and patient's shoulders with waterproof material. Place this material to extend from under patient's head into pail or tub placed on low table or chair. Roll sides of material in like a trough. Floor may be protected with newspapers. Wash and rinse hair, rubbing scalp firmly but gently. Avoid tiring patient by working as quickly as possible. Slide waterproof material into pail or tub. Rub hair with a heavy towel until it is dry. Protect patient against chilling and make her comfortable. Brush, comb and dress hair in usual manner. Clean and put away equipment.

### **Taking Temperature, Pulse and Respiration**

Temperature, pulse and respirations are important indications of the patient's condition. They are measured and recorded at regular intervals throughout the course of an illness. The temperature of a healthy person may vary between 36°C in the morning to 37°C in the late afternoon. It must, therefore, be taken at the same time each day for an accurate comparison. Changes in temperature, pulse and respirations are important to the doctor in diagnosing an illness and judging its progress.



The temperature is taken by means of a clinical thermometer which consists of a glass bulb containing mercury and a hollow stem in which the mercury rises. There are two kinds of clinical thermometers, oral (mouth) and rectal. Oral thermometers usually have a long slender bulb and rectal thermometers a short stubby bulb. Body heat causes the mercury to rise in the glass tube. It remains at the highest point registered until it is shaken down. The stem is marked in degrees, usually ranging from 35°C to 43°C. The temperature is taken by:

- Mouth — normal temperature approx. 36.9° Centigrade.
- Axilla — normal temperature approx. 36.4° Centigrade.
- Rectum — normal temperature approx. 37.6° Centigrade.

### **Points to Remember When Taking Temperature**

Handle thermometer carefully. Stand away from furniture and other articles when shaking it down to avoid possible breakage. Hold thermometer firmly by the top between thumb and first two fingers. Shake with a quick snap of the wrist to bring mercury to 35°C before taking temperature. Remain with patient while temperature is being taken. If patient has had a hot or cold drink, wait 15 minutes before taking temperature by mouth.

Do not take temperature by mouth if patient is suffering from a mouth infection, is unconscious, is unable to keep his mouth closed or is under 5 years of age.

Do not take temperature by rectum if patient has diarrhoea, inflamed haemorrhoids, a rectal abscess or is very constipated.

Take temperature at regular intervals as prescribed by the doctor or if patient's appearance or complaints indicate an unexpected change.

Do not alarm patient by word or manner if thermometer reading is unfavourable.

Tactfully recheck temperature and notify the doctor if it registers a new high or low for patient.

If thermometer breaks in patient's mouth, remove all particles of glass and let him rinse his mouth. Examine mouth and notify the doctor.

Do not leave thermometer in disinfectant for more than half an hour as markings may be removed.

### **Taking Temperature by Mouth**

**PURPOSE** To obtain an accurate reading of patient's temperature.

**EQUIPMENT** Small tray (pie or shallow cake plate may be used) covered with fresh paper serviette.

Mouth thermometer.

Two small glass jars with cover  
—one containing absorbent swabs  
—one containing rubbing alcohol.

Cake of soap on saucer.

Small paper bag for used swabs.

Small glass of water.

**PROCEDURE** Have patient sitting or lying in a comfortable position.  
Read thermometer by holding it between thumb and first two fingers at eye level and rolling it slowly until the mercury is clearly visible.

Shake mercury down to 35°C with a quick snap of the wrist.

Do not touch bulb end of thermometer with bare fingers.

Dip thermometer in clear water.

Place bulb of thermometer well under patient's tongue a little to one side.

Instruct him to close his lips but not his teeth.

Caution him not to bite on thermometer or talk.

Leave thermometer in place for three minutes.

Remove thermometer, wipe off secretions with a moist swab using a rotary motion from tip to bulb.

Read, holding thermometer in swab. Do not touch it with bare fingers. Shake mercury down.

Moisten a swab and rub it on soap vigorously to make lather. Wipe thermometer from tip to bulb with rotary motion, making sure that lather is applied generously.

Rinse with clear water making sure all soap is removed.

Stand thermometer in rubbing alcohol for thirty minutes.

Reset tray and at end of thirty minutes, return thermometer to case or stand it in a glass of fresh water.

Record temperature.

### **Taking Temperature by Axilla (Armpit)**

Temperature taken by Axilla is about 1° lower than by mouth.

The normal axillary temperature is 36.4°C.

Do not take temperature by axilla immediately after patient has had a bath.

The patient's record should indicate that it is an axillary temperature.

**EQUIPMENT** Same equipment as taking temperature by mouth.

**PROCEDURE** Shake thermometer down to 35°C. Do not moisten or lubricate thermometer.

Dry area under arm gently.

Place bulb end of thermometer in axilla.

Hold or have patient hold his arm firmly against body, putting hand across chest.

Keep thermometer in place 10 minutes.

Remove, read, wipe and clean thermometer in same manner as when taking temperature by mouth.

Wash hands.

## Taking Temperature by Rectum

A rectal temperature is taken if patient is very ill, unconscious, has a severe mouth infection or is under 5 years of age.

The rectal temperature is usually one degree higher than temperature by mouth. The normal rectal temperature is 37.6°C. The patient's record should indicate that it is a rectal temperature.

**EQUIPMENT** Same equipment as for taking temperature by mouth, except a rectal thermometer is substituted for a mouth thermometer.

Add to tray, squares of tissue paper and a jar of lubricant such as vaseline.

**PROCEDURE** Explain procedure to patient to avoid embarrassment.  
Have him lie on his side with upper thigh and leg flexed.  
Shake thermometer down to 35°C.

Apply lubricant to bulb, using paper tissues.

Insert thermometer about one inch into rectum and hold in place at least 3 minutes.

Remove, read, wipe and clean thermometer in same manner as when taking temperature by mouth.

Wash hands.

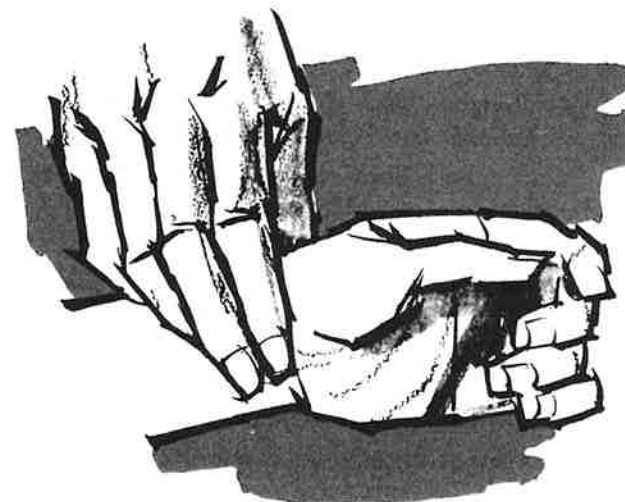
## Counting Pulse and Respirations

**PULSE** Every beat of the heart sends a wave of blood through the arteries causing them to expand. This wave is called the pulse beat and can be felt in any artery near the surface where it passes over a bone.

It is most easily felt on the thumb side of the wrist.

**RESPIRATIONS** Respiration or breathing is the process by which oxygen is taken into the body and a certain amount of carbon dioxide is given off. One rise and fall of the chest is a respiration and consists of an inspiration (breathing in) and an expiration (breathing out) and a pause.

Usually, as the temperature rises, the rate of the pulse and respirations increase. They are taken generally at the same time as the temperature.



The pulse and respiration rates vary with age, sex, size, physical or emotional activity.

Exercise, nervousness or excessive smoking may cause a temporary increase in the pulse rate.

## Normal Variations in Pulse Rate

Infants —100 to 120 beats per minute.

Children— 80 to 100 beats per minute.

Adults — 60 to 80 beats per minute.

## Normal Variations in Respiratory Rate

Infants —about 40 per minute.

Children—25 to 30 per minute.

Adults —15 to 18 per minute.

The pulse should be checked when a patient gets out of bed for the first time, is allowed increased activity or complains of feeling weak.

The doctor must be notified of any marked change in pulse and respiration rate.

**EQUIPMENT** Watch with a clear dial and a second hand.

**PROCEDURE** Have patient sit or lie down, with his arm and hand relaxed, thumb up and comfortably supported.

Place middle three finger tips on inside of patient's wrist just above base of thumb and press lightly.

Once pulse is distinctly felt, count number of beats for one minute.

Note whether beats are regular and strong.

Keep fingers on pulse and without patient's knowledge count respirations by counting rise and fall of chest for one minute.

Note whether breathing is regular, deep or shallow, sighing or wheezing.

Record rate of pulse and respirations per minute.

### **Bedpans and Urinals**

If the patient is unable to go to bathroom, a bedpan is required. A male patient needs a urinal also. These articles should be kept in a plastic bag or a bag made of newspapers. They should be out of sight when not in use.

### **Giving Patient Bedpan**

**PURPOSE** To provide toilet facilities for a patient confined to bed.

**EQUIPMENT** Bedpan and cover.

Bell for patient to call.

Protector for bed, newspaper pad or covered oil cloth, rubber or plastic sheet. (See page 133).

Urinal and cover if male patient.

Toilet paper.

Warm water in basin, soap, wash cloth and towel.

**PROCEDURE** Ensure privacy for patient.

Take all equipment except bedpan to bedside.

Warm bedpan by rinsing it with hot water, dry thoroughly, cover and take to bedside.

Fold back top bedclothes.

Have patient bend his knees.

Assist him to raise his hips and help him by placing one hand in the small of his back and with the other hand place bedpan in position.

The patient should be placed in a sitting position, with supports at his back.

Arrange toilet paper, basin of water, soap, towel, etc., where he can easily reach them.

Leave the room to provide privacy unless patient is too young or too ill to be left alone.

If able, have him complete his toilet. If unable to do so, ease him on his side, remove pan, cover it and cleanse him.

Remove bed protector.

Take covered bedpan to bathroom and note contents.

If unusual save for doctor.

Empty pan, rinse well with cold water, then wash with warm soapy water.

Have patient wash his hands and see that he is comfortable.

Tidy bed.

Record observations on patient's record.

### **NOTE**

If patient is very thin, place a folded towel or absorbent cotton on back rim of pan. Sprinkle top of bedpan with talcum powder or corn starch to prevent from sticking.

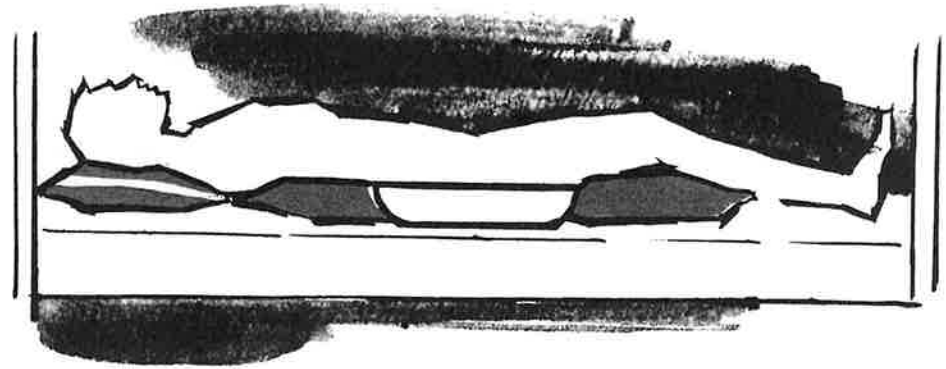
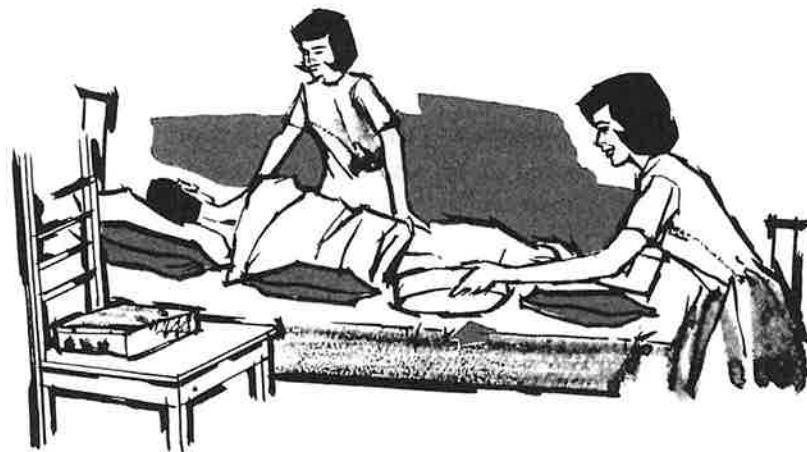
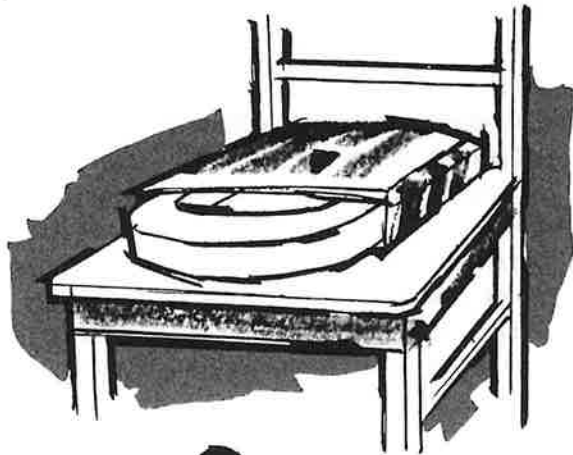
### **Putting a Helpless Patient on Bedpan**

A completely helpless person is not able to assist himself in using the bedpan. Therefore, an assistant will be needed to help in this procedure.

**EQUIPMENT** Same as listed above and in addition, several protected pillows or folded blankets.

**PROCEDURE** Take equipment to bedside and fold back top bedclothes. Turn patient on his side and have helper on other side of bed, support him in that position.

Put a large pillow or folded blanket against patient's back, reaching from his shoulders to upper part of buttocks. Place another pillow or folded blanket reaching from upper leg to feet. This is to elevate him from bedpan. Put bed protector in place, covering ends of pillows or blankets.



Place bedpan on its edge against patient's buttocks, in correct position.

Roll patient back on to pan and elevation of pillows.

After patient has used bedpan, hold it flat on bed and have assistant roll patient on his side, toward her and off pillows.

Remove bedpan and place it on a protected surface.

Remove pillows or blankets.

Wash and dry patient, putting soiled toilet paper in bedpan.

Cover pan.

Place patient in a comfortable position on either his side or back, using sufficient supports for correct body posture.

Take bedpan to bathroom and proceed as outlined on page 97 .

## Urinals

Urinals for the use of male patients may be purchased from a drug store or borrowed from a loan cupboard. However, an ordinary jar may be used as a substitute. It should be discarded when no longer needed.

**PROCEDURE** Assist patient if necessary in placing urinal, avoiding exposure.

Remove urinal immediately after use. Cover it and take to bathroom.

Note contents of urinal and if unusual, save for the doctor to see.

Rinse with cold water. Once daily, urinal should be washed with warm soapy water.

Have patient wash his hands.

Record observations.

## SUMMARY

Although the patient is confined to bed there is usually much that he can do for himself. The resourceful person giving care will arrange bath equipment, toilet articles and meal trays conveniently for patient and see that he is in a comfortable position to use these articles as required. This "Self-help" gives patient a feeling of accomplishment and provides a mild exercise which helps keep muscles in tone.

There are times when a patient will be unable to do anything or very little for himself and the person looking after him will have to give all the care he needs. When a patient is confined to bed there are many aspects to his daily care.

The skin must be cleansed by bathing. Rubbing with lotion or talcum powder refreshes the patient, keeps the skin soft, pliable and in good condition and gently exercises the muscles. Change of position relieves the weariness of being constantly in bed and fosters normal body functioning. Movement of limbs helps keep joints from stiffening and muscles in tone for the day when the patient will be up and about again.

Even the hair may be washed in bed. The feeling of being well groomed has an important therapeutic effect on the patient.

## CHAPTER XI

### Treatments with Heat or Cold

Applications of heat are used commonly in the treatment of illness. Heat usually has a soothing effect, relaxes muscles and relieves tension. Heat may be used to promote drainage from a wound, to reduce swelling and help in relieving pain.

When heat is applied to the skin, blood vessels become dilated drawing more blood to the surface of the body, thus accounting for redness of skin. Sweat glands are stimulated and the skin becomes moist with perspiration. Therefore, care should be taken that patient does not become chilled after a heat treatment has been discontinued.

Dry or moist heat treatments may be used. Some common dry heat treatments are: electric pads, electric blankets or sheets, hot water bag.

Moist heat, because it is wet conducts heat faster than a dry substance and is more penetrating in its effect. Some common moist heat treatments are: hot tub, foot or sitz bath, steam inhalations, moist compresses, irrigations.

#### Dry Heat Treatments

##### Electric Pad

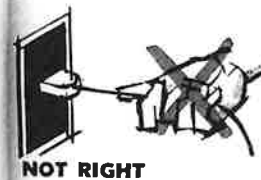
An electric pad is a convenient method of applying heat to one part of the body. Caution must be observed in its use as with all electrical appliances.

The pad should never become wet as moisture is a good conductor of electricity and may cause a shock or burn.

The pad should not come in direct contact with skin but should have a washable flannel cover. The cover should be heavy enough to prevent pad becoming wet from perspiration. The cover should be removed before it is used to see that pad is not defective.

Pins should never be used to fasten the pad in place and it should never be folded.

The pad should be disconnected when not in use so it will not become overheated. Pull on plug, not on cord when disconnecting it.



The pad should be used in accordance with instructions on label and never used unless it is known to be in perfect condition.

**Electric Blanket** The main advantage of an electric blanket is that it provides warmth without weight. The heat is regulated by setting the control to desired temperature.

The care in its use is the same as that followed with an electric pad.

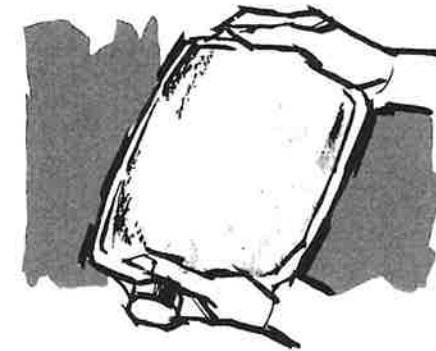
**Hot Water Bag** Dry heat may be applied locally by means of a hot water bag.

**PURPOSE** To provide comfort.  
To increase blood circulation to affected area.  
To reduce pain and promote healing.

**EQUIPMENT** Hot water bag with stopper, washer and cover.  
Wide mouthed pitcher.  
Hot and cold water.  
Cloth or paper wipes.

**PROCEDURE** Examine bag carefully to see that it is in good condition.  
Add hot water to cold water in pitcher and test temperature. It should be 115° to 130°F or bearable to hand.  
Pour water from pitcher into bag until it is about half full, so it will not be heavy.  
Place bag on a flat surface and expel air by allowing water to show in neck of bag.  
Screw stopper in place while water is still in neck of bag.  
Test for leaks by holding bag upside down and shaking it.  
Dry outside of bag and around stopper. Place it in a flannel cover or wrap in a towel.  
Apply bag as ordered being sure it is comfortable for patient.  
Refill bag whenever necessary to maintain desired degree of heat.

**NOTE** Never apply a hot water bag for abdominal pain unless ordered to do so by the doctor.



**CARE OF BAG WHEN NOT IN USE** Hang bag up to drain, screw stopper in place but do not expel air.  
Put bag in a cool place and protect it from damage by oils, acids or extreme heat.

#### **Substitutes for Hot Water Bag**

Heated bricks, sand or salt bags. They should be carefully wrapped to avoid burning patient.

### **Moist Heat Treatments**

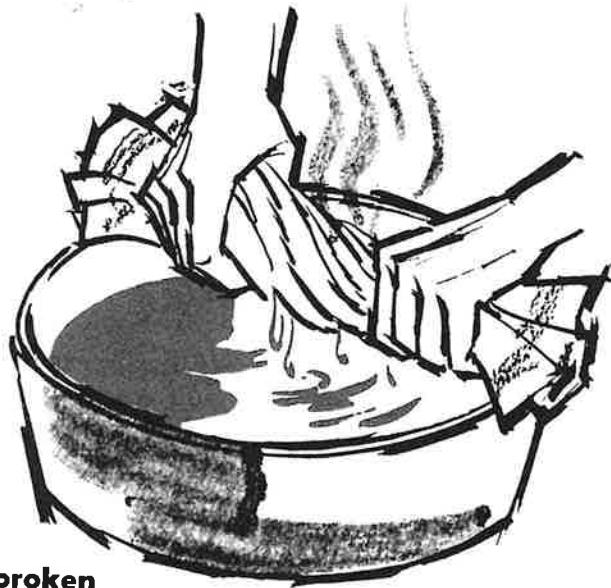
#### **Hot Moist Compresses**

Hot moist compresses are pads of flannel, gauze or other soft material wrung out of water or antiseptic solution. The doctor prescribes solution to be used.

Pieces of blanket, heavy flannel or other soft woollen fabrics hold heat longer than cotton.

**PURPOSE** To stimulate circulation and increase flow of blood to affected area, thus relieving inflammation.

**EQUIPMENT** Clean compress material folded to required size.  
Absorbent pad or piece of flannel large enough to cover compress.  
Forceps, (tongs, tweezers or spring clothes pins may be used as substitutes).  
Paper bag or waste basin.  
Small piece of waterproof material such as plastic, oiled silk, waxed paper or saran wrap.  
Towel or binder.



### When Skin is Unbroken

This procedure is usually done by a doctor or nurse but in any event, the doctor or nurse should demonstrate the first treatment.

- PROCEDURE** Pour boiling solution over compress in basin.  
Lift compress out of solution with forceps and wring dry.  
If a large compress is required, water can best be removed by placing compress in a bath towel and wringing out excess moisture.  
Shake steam out and apply gently to affected part.  
Cover compress with waterproof material and pad of flannel or absorbent cotton.  
Secure in place with towel or binder.  
Change compresses as needed to maintain heat and to make treatment effective.

### When Skin is Broken

This procedure is usually done by a doctor or nurse as it requires sterile technique. In any event the doctor or a nurse should demonstrate the first treatment.

**PROCEDURE** Boil forceps, bowl and compresses in a covered saucepan for at least ten minutes, being sure that each article is covered with water.

Drain off as much water as possible and carry equipment to patient's room in covered saucepan.

Wash hands thoroughly with soap and water.

Remove articles from saucepan, taking care not to touch inside of basin, tips of forceps or compresses.

Do not let boiled articles come in contact with other objects in case they become contaminated.

If there is a discharge, discard soiled compresses and dressings into paper bag and burn or wrap tightly in newspaper and place in garbage disposal.

A saline solution is most commonly ordered for hot compresses.

### NOTE

To make a saline solution use 1 teaspoon salt to 1 pint of water and boil in a covered container for twenty minutes.

### Steam Inhalation



### PURPOSE

An inhalation is usually given to relieve hoarseness, sore throat, coughing or difficulty in breathing, as warm moist air has a soothing effect on mucous membranes.

An inhalation is sometimes used for the administration of medicine.

**EQUIPMENT** Large jug containing about 1 pint of boiling water.  
Sturdy brown paper bag, large enough to fit over jug.  
Fair sized basin.  
Medication if ordered.

**PROCEDURE** Close window and see that room is warm.  
Support patient comfortably in a sitting position.  
Cover shoulders with a shawl or bed jacket.  
If patient is in bed, place a flat pillow across his lap on which basin may be placed.  
Cut small hole in side of paper bag near bottom.  
If ordered, add medication to water and place jug in basin.  
Invert paper bag and place over jug.  
Have patient place mouth over hole in paper bag and inhale steam.  
Continue treatment as long as steam rises from water.  
Do not leave patient alone during treatment in case he falls asleep, becomes faint or in any way upsets jug.

### **Cold Treatments**

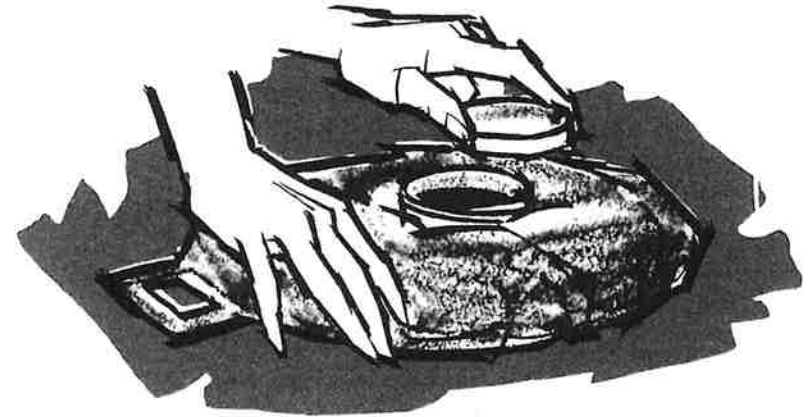
Cold is used to reduce body temperature, to improve circulation, to reduce swelling and to relieve pain.

**Ice Bags** A cold treatment, commonly used, is the application of an ice bag to the affected area. Chemical bags are available that can be used in same way as an ice bag. They are chilled in freezing compartment of refrigerator and re-chilled for another treatment.

**PURPOSE** To relieve pain, to prevent swelling and discoloration or to reduce inflammation.

**EQUIPMENT** Ice bag with cap and washer.  
Container of crushed ice.  
Cloth cover or towel.

**PROCEDURE** Inspect ice bag and be sure rubber washer is in place.  
Put crushed ice in bag until it is about half full.  
Flatten ice bag and push down on rubber to expel air.



Screw on cover.  
Test for leakage by turning upside down and shaking.  
Wipe ice bag dry and place in cover or towel.  
Apply as prescribed.

**CARE OF BAG WHEN NOT IN USE** Empty and dry bag.  
Fill it with air and screw on cap to keep sides from sticking together.  
Keep bag in a cool, dry place to prevent deterioration of rubber.  
Dry covers and put in soiled laundry.

### **Cold Moist Compresses**

**PURPOSE** Applications of cold moist compresses are frequently ordered to relieve a headache or reduce swelling.

**EQUIPMENT** Compresses, folded to required size.  
Basin of ice with small amount of water.  
Waterproof protector for bed or pillow.

**PROCEDURE** See that patient is in a comfortable position and protect bedding against moisture.  
Moisten compress in water.  
Wring dry and apply gently but firmly as ordered.

Place another compress in ice water to cool.  
If patient is able to change compresses himself, place the equipment so that it is convenient for him to reach.  
Change compress when it feels warm to patient or at least every two minutes.  
Continue treatment as ordered by the doctor, usually for about 15 to 20 minutes.  
Soiled compresses should be discarded.

### **Tepid Sponge Bath**

- PURPOSE** To reduce temperature.  
To relieve restlessness and induce sleep.
- EQUIPMENT** 2 flannelette sheets.  
1 waterproof bed protector.  
2 wash cloths.  
Bath and face towels.  
Basin with tepid water.  
Jug with extra water to maintain solution at desired temperature.
- PROCEDURE** Remove top bed clothes, covering patient with flannelette sheet.  
Protect bed with waterproof bed protector and cover with second flannelette sheet.  
Bathe patient's entire body with long sweeping strokes starting with face and upper extremities.  
Continue sponging for 20 minutes.  
Pat dry with towel, avoiding friction from rubbing.  
Remove flannelette sheets and bed protector.  
Replace patient's gown or pyjamas.  
Re-arrange bed clothes and make patient comfortable.  
If sponge bath is given to reduce temperature, take and record temperature after one hour, unless patient is sleeping.

### **Points to Remember about Heat and Cold Treatments**

Both heat and cold treatments should be given only when ordered by a doctor.

The patient should be given a simple explanation of what is to be done before any treatment is started.

Special care and observation are necessary in the application of heat and cold to unconscious patients, those under an anaesthetic, those with poor circulation, diabetic or paraplegic patients as well as children and older people.

Patients who have had repeated applications of heat and cold may begin to tolerate a degree of temperature that could damage body tissue.

Every precaution should be taken so that application does not cause a burn or frost bite. Any sign of damage to body tissues should be reported to the doctor immediately.

Avoid getting electrical appliances wet and use caution always. They should be kept in good condition and worn parts should be repaired or replaced.

Dry hands before grasping and pulling plug to connect or disconnect electrical equipment.

### **SUMMARY**

Heat and cold treatments have soothing and therapeutic effects by relaxing muscles, relieving tension and easing pain. These, including dry and moist applications, are not without hazards and should be carried out with care and caution.

The various types of treatment in the application of heat and cold and the methods of administering them are outlined in this chapter.

Baths for the treatment of the sick are as old as mankind. The procedure for giving a tepid sponge bath as a means of soothing a restless patient and reducing fever is described in detail.



## CHAPTER XII

### Administration and Care of Medicines



#### General Precautions and Instructions

The administration of any medicine is always a serious responsibility. The doctor's orders regarding dosage, time and method of administration must be followed exactly.

Medicines should never be given without a doctor's order.

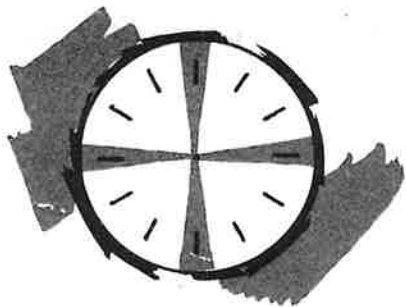
Medicine ordered for one person should never be used for another unless the doctor approves it.

Medicines may be ordered to be taken once or several times a day, before or after meals or at bed time. If directions regarding giving of medicine are not clearly understood, the doctor should be consulted.

Medicines should be clearly labelled and those with no label or an unreadable label should be disposed of.

Bottles should be tightly corked.

Medicines should not be left at patient's bedside.



Always give medicines on time. Those ordered to be given before food should be given 20 minutes before, unless otherwise specified. Those ordered to be given after meals should be given immediately after.

If a patient misses a dose, do not give a double dose next time. Record on patient's record that medicine was omitted, refused or vomited.

Do not waken patient for any medicines unless the doctor has given such instructions.

A drinking tube or straw may be used to give medicines that may discolour the teeth.

Medicines with a disagreeable taste should be made as unobjectionable as possible by adding only a little water to it and by giving patient a drink of cold water immediately afterward. Cough medicines should never be diluted.

All poisons should be labelled "poison". They should be kept in bottles of distinctive colour and shape out of reach of children and, if possible, they should be kept under lock and key.

A change in colour, consistency or odour of any medicine should be reported to the doctor and a new supply obtained if necessary.

Unused medicines should be discarded by emptying down the toilet.

Some medicines, such as oils and ointments may spoil easily and should be kept in a cool place.

Medicine taken by mouth may be in liquid form, powder, tablet or capsule.

Other methods of giving medicines are by inhalation, (See page 105), by hypodermic, by rectum and by absorption through skin.

Children, because of their curiosity, may take medicine, even headache tablets or common laxatives and quickly become poisoned.



If a child or an adult has taken, or is suspected of having taken poison or an overdose of any drug, the doctor should be called immediately or the patient taken to a poison control centre or hospital emergency department. It is important to take vomitus and drug label with patient.

### Administration of Medicine by Mouth

**EQUIPMENT** Tray (cake tin lined with a paper serviette is suitable) containing the following:

Medicine as ordered.

Medicine glass.

Teaspoon or medicine dropper.

Glass of cold water.

Napkin or paper serviette.

Drinking tube or straw.

### PROCEDURE



Read label and directions carefully, comparing them with the doctor's orders, every time a medicine is given. Shake bottle well, remove cork or cap and place it top side down on tray.

Read directions again.

Hold medicine glass at eye level and pour medicine, measuring it accurately. When pouring medicine keep labelled side of bottle uppermost, so that no fluid will stain label.

If a dropper is used, hold it vertically when measuring drops, so that liquid will not run into bulb of dropper.

Recork bottle and read label for third time.

Add a little water to medicine if it is allowed.

Give patient medicine and see that he takes it all.

Give him a drink of water after medicine unless it is a cough mixture.

Record time and dosage of medicine immediately.

## Tablets, Pills and Capsules

**PROCEDURE** Check label on box or bottle with the doctor's orders.  
Remove medicine from container into a spoon or medicine glass.  
Close box or bottle and read label again.  
Give medicine to patient from spoon or medicine glass.  
The patient should place the medicine on the back of his tongue, take a sip of water, tilt head back and swallow the two together.

**NOTE** Patience and tact will generally induce children to take medicine. The medicine should be given without force, assuming that child will accept it.

Liquid medicines may have to be given in a small drink of juice. Choose a juice that is not part of child's daily diet in case he develops a dislike for it. Grape juice might be a good choice.

Most pills can be crushed and the powder mixed with a small amount of easily swallowed food, like apple sauce or mashed bananas. Follow this quickly with a favourite drink.

Medicines should be kept away from children between doses.

## Other Methods of Giving Medicine

### By Hypodermic Injection

Some medicines may be given under the skin, by hypodermic injection. The doctor may give the hypodermic himself. However, the doctor, public health or other professional nurse, can teach some one in family or patient himself how to prepare and give hypodermic, as, for instance, insulin for a diabetic patient.

### By Rectum

Drugs may be introduced into lower bowel in form of suppositories or by an enema (See page 119).

The suppository, (a small cone shaped preparation) and anus are lubricated with a little oil or vaseline.

The suppository is then inserted, point first, into anus by finger, protected by a piece of paper tissue.

The finger is withdrawn when suppository is felt to slip away from it.

An enema, containing a drug, is given in usual way, but very slowly. It is usually preceded by a cleansing enema. (See page 119).

## Medication by Eye and Nose Drops



### Eye Drops

The dropper should never touch any part of patient.

If this should accidentally happen, dropper should be washed and boiled before returning it to bottle or used for further treatment. Any unused medicine in dropper should be thrown away.

An eye dropper may be attached to top of bottle containing eye drops or it may be separate.

The patient should be instructed to hold as still as possible during treatment.

The drops may cause a stinging sensation or blurred vision and patient should be instructed not to shut his eyes tightly or rub lids forcefully.

**PURPOSE** Eye drops may be ordered by the doctor to treat an eye infection, to soothe and relieve pain and to dilate the pupil for the doctor's examination.

**EQUIPMENT** Solution prescribed by doctor.  
Eye dropper.  
Clean absorbent and swabs.  
Paper bag for discarded swabs.  
Clean towel.  
Small bowl with weak solution of saline, ( $\frac{1}{2}$  teaspoon salt to 1 pint water, room temperature).

**PROCEDURE** Wash hands carefully before starting treatment.  
Place towel across patient's chest.  
Have patient sit in a good light with head tilted back.  
Use absorbent swabs moistened in saline solution to wipe away any discharge from eyes.  
Use fresh swab for each eye and wipe from nose outwards.  
Discard swabs in paper bag.  
Check label on bottle, noting if there is an expiration date.  
Draw up required amount of solution into eye dropper.  
Stand behind patient, a little to one side.  
Gently draw down lower lid with left hand and ask patient to look up.  
Hold dropper in right hand, parallel to and about  $\frac{1}{2}$  inch above eye to avoid force.  
Insert drops on lower lid at inner corner of eye.  
Never let drops fall on coloured part of eyeball as this is startling and sometimes painful.  
Have patient close eyes slowly so that drops are distributed over surface of eyeball.  
Gently dry lids and cheek with cotton swab.  
Discard swab in paper bag.  
Clean equipment and wash hands.  
Record treatment on patient's record, noting time of treatment, condition of eye and any reaction on part of patient.

## Eye Ointments

**EQUIPMENT** As above with addition of prescribed ointment.

**PROCEDURE** Clean edges of eyelids of any discharge or secretions.  
Squeeze a small amount of ointment from tube into lower lid in same manner as drops are administered.  
The open end of tube should not touch anything or become soiled.

## Nose Drops

**EQUIPMENT** Prescribed medication.  
Medicine dropper.  
Small basin.  
Paper tissue.

**PROCEDURE** Have patient lie down without a pillow, head tilted well back.  
Insert drops in both nostrils. The dropper should not be inserted more than half an inch. Have basin and paper tissue at hand as some of solution will run into back of throat and may have a disagreeable taste.  
Have patient hold his head back for a few minutes so that liquid will not run out.  
Children should be held firmly but gently so that delicate tissues of nose will not be injured with glass dropper.

## SUMMARY

The administration of medicines is a serious responsibility and the need for caution cannot be over-emphasized. Because of the danger of giving the wrong medicine or dose, or the patient taking it by mistake, all medicines should be clearly labelled and safely stored.

Medicines should never be given to a patient unless prescribed by a doctor. The label should be read at least three times and checked with the doctor's orders before giving medicine to a patient. The person giving care should stay with the patient until he has taken the medicine.

Even the simplest medicine, such as aspirin, may be poisonous to a child if not given as prescribed. The child is curious and may take medicines by mistake and be poisoned. Should this occur, the doctor must be notified at once or the child taken immediately to a Hospital Emergency Department.



## CHAPTER XIII

### Other Common Treatments

**ENEMATA** The enema, as with all treatments, should be ordered by the doctor.

**PURPOSE** The cleansing enema is given:  
To relieve constipation by removing feces from the lower bowel.  
To relieve discomfort due to gas or intestinal irritation.  
The most common solutions prescribed are:  
Saline: 1 teaspoon salt to 1 pint water.  
Soap Suds: Mild soap dissolved in 2 or 3 pints of warm water. Froth should be removed from solution.

**EQUIPMENT** Irrigating bag or can with attached rubber tubing, clamp and hard enema tip;  
or  
Funnel with attached soft rectal tube and clamp (spring clothes pin may be used as clamp).  
Jug containing prescribed solution.  
Bedpan and cover if patient is unable to go to bathroom.  
Toilet paper and lubricant.  
Small waterproof sheet and cover, or several thicknesses of newspaper, covered. (See page 129).  
Flannelette sheet.

**PROCEDURE** Before commencing treatment, tell patient what is to be done and ensure privacy.  
Prepare 2 or 3 pints (if for child, one pint) of prescribed solution and test temperature. It should be comfortably warm to inside of wrist.  
Clamp tubing and pour solution into bag or can.

Unclamp tubing and allow a small amount of fluid to run through tubing to test equipment, to warm tubing and to expel air.

Reclamp tubing.

Apply a small amount of lubricant to rectal tip or tube with toilet paper.

Place chair near bed and cover seat with newspapers.

Place warmed bedpan and toilet paper on chair.

Fold top bed clothes to foot of bed and cover patient with flannelette sheet.

Turn patient on his left side, knees flexed and hips close to edge of bed.

Place rubber sheet or substitute under patient's hips.

If patient is unable to turn, he may be given the enema on his back. If he is unable to retain fluid, he may be placed on a padded bedpan.

Insert tip gently into rectum, about 3 or 4 inches, (if child, 2 inches) taking care not to use force. Hold tip in place or have patient do so. Allow solution to flow slowly and clamp tubing before bag becomes empty to prevent air entering bowel.

If a funnel is used, do not allow it to become empty.

Do not fill it to the top as solution will spill if patient expels gas.

The bag should be held not more than 18 inches above bed, as raising bag increases rate of flow.

If solution does not flow, withdraw tube slightly until flow is established.

Watch patient's reactions carefully. If he appears distressed or complains of pain, stop flow temporarily by pinching tube.

Encourage patient to retain solution for at least 5 minutes.

Withdraw rectal tube or tip into several folds of toilet paper, drain tubing over bedpan and wind around can. If patient is child or unable to retain solution, place him on bedpan before withdrawing tube.

Place can on chair.

Give patient warm bedpan. Place toilet paper and bell within reach and leave patient alone unless he is weak, very ill or young child.

After enema is expelled, remove bedpan and cleanse patient.

Wash hands and air room.

Note contents, empty and clean bedpan.

#### CARE OF ENEMA EQUIPMENT

Wipe rectal tube with toilet paper.

Rinse equipment well with cold water, then wash thoroughly with hot soapy water.

Run cold water through tubing.

Hang up to drain and dry.

Store in cool place, leaving clamp open and tubing free from kinks.

#### NOTE

Prepared, disposable enema kits are available from drug store. Directions for use are provided with them.

### Simple Dressing

Dressings are usually applied or changed by a doctor or graduate nurse. However, it may be necessary for the person looking after patient to change a simple dressing or prepare articles for the one who is to do it.

#### PURPOSE

To keep wound clean.

To prevent wound from being further injured.

#### EQUIPMENT

Basin.

Clean towel.

2 forceps or clothes pins.

Paper bag.

Paper towel.

Scissors if needed.

Cotton swabs.

Package of sterile dressings.

Bowl with required solution.

Adhesive, bandage or binder.

Ointment if prescribed.

**PROCEDURE** Boil basin, forceps and other instruments in a covered container for at least 10 minutes.

Drain off excess water and bring instruments, in container in which they were boiled, to patient's bedside.

Have patient in a comfortable position.

Protect surrounding area with clean towel.

Place paper bag and paper towel in convenient place.

Remove binder or bandage.

Unwrap dressings taking care not to touch inside of package.

Remove soiled dressing with forceps or clothes pin handling by outside only and discard in paper bag.

Put soiled forceps aside on paper towel.

Wash hands thoroughly.

Cleanse area with swabs moistened in prescribed solution.

Wipe away from wound and discard each swab as used into paper bag.

Lift clean dressing from package with clean forceps and apply to wound.

Secure dressing in place with adhesive, bandage or binder.

If ointment is prescribed it may be applied to dressing with a table knife which has been boiled with other instruments.

## SUMMARY

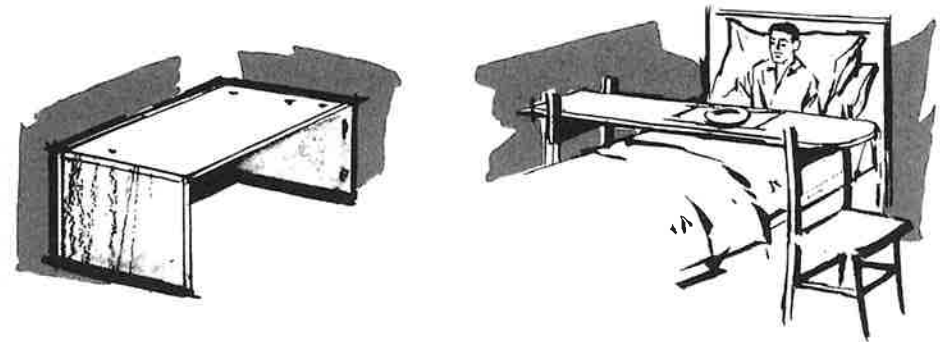
This chapter outlines the procedures for giving an enema and applying a simple dressing to a wound. These treatments are commonly used in the care of the sick and probably every mother is familiar with them. However, the proper procedure should be followed in detail, if the patient is to receive the maximum effects and have a minimum of discomfort during the treatment. It is emphasized that the doctor should order the enema and the solution to be used. Sterile dressings are usually applied by a doctor or nurse but if not the doctor or nurse should demonstrate the first one.



## CHAPTER XIV

# Adapting Home Equipment for Patient Care

When a patient is ill at home, certain equipment may be needed to make him comfortable, as well as to save time and energy of person giving care. Equipment such as a hospital bed with changeable positions, may be bought, rented or borrowed. However, simpler items of equipment may be improvised or adapted from articles in the home.



### Bed Table

**PURPOSE** To provide a more comfortable arrangement for patient when eating meals.

To provide a surface for writing, playing cards, doing puzzles, placing toilet articles, books, etc.

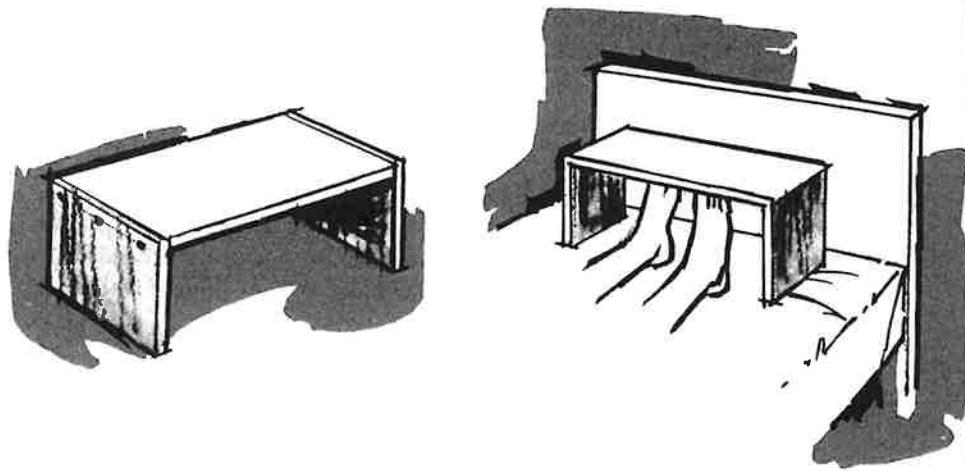
**EQUIPMENT** Ready made bed tables may be bought or substitutes may be made from:

A light wooden box or firm cardboard carton, approximately  $10 \times 12 \times 24$  inches with the two sides removed.

An ironing board, extended across bed with the ends resting on backs of two chairs.

A bed table should be high enough to fit over knees but low enough to work on easily.

## Bed Cradle



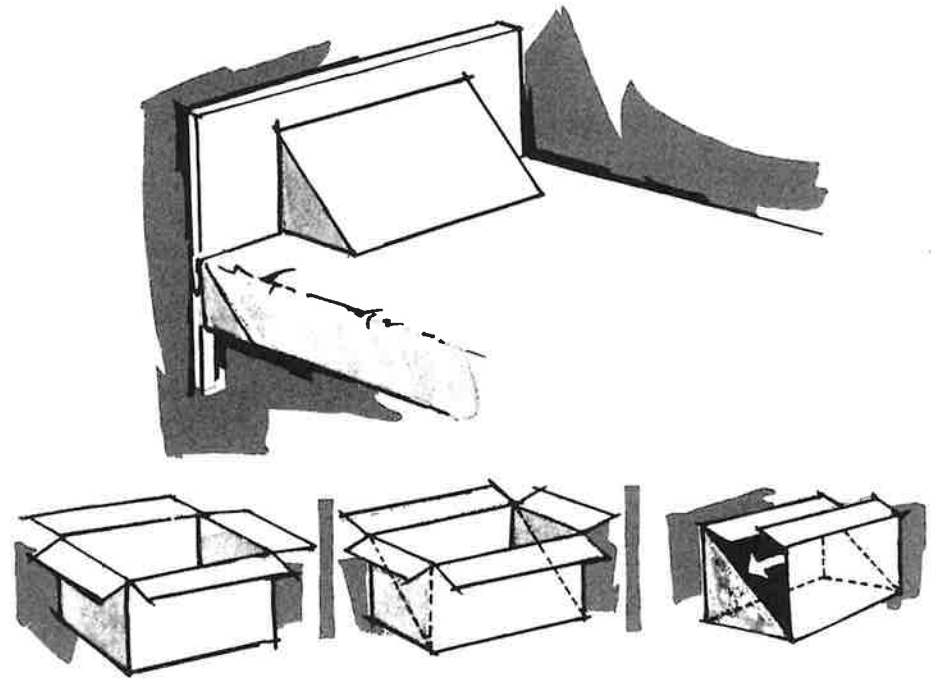
**PURPOSE** To protect a sensitive part of the body from weight of bed clothes.

**EQUIPMENT** Bed cradles may be purchased or made at home from a firm cardboard carton, lightweight box or wire. The same method, used to make a bed table, may be used to make a cradle from carton or box. Place cradle over sensitive part of body which has been covered with a light blanket or shawl. The bed clothes are brought over cradle.

**NOTE** If the foot of bed is a suitable height, bed clothes may be elevated by placing them over it. The bed clothes may also be raised by placing a wide board on its edge across bed at foot of mattress. Pillows or folded blankets may be used also.

## Back Rest

**PURPOSE** To provide support and comfort when a patient sits up in bed.



**EQUIPMENT** Various types of back rests may be purchased or substitutes may be used as follows:

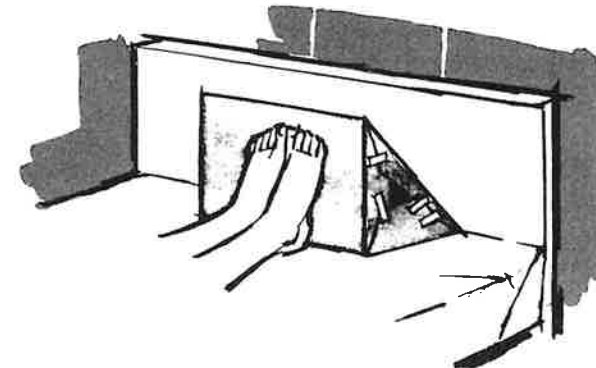
A straight backed chair placed upside down at head of bed and securely tied to bed.

A triangular bolster or pillows from a chair or chesterfield.

A covered card table with legs folded and slanted against head of bed. It should be tied securely in place.

A strong cardboard carton, approximately 24 × 24 × 18 inches, may be made into a triangular back rest.

## Foot Rest



**PURPOSE** To prevent weight or pressure of bed clothes on patient's toes.

To maintain proper position of patient's feet.

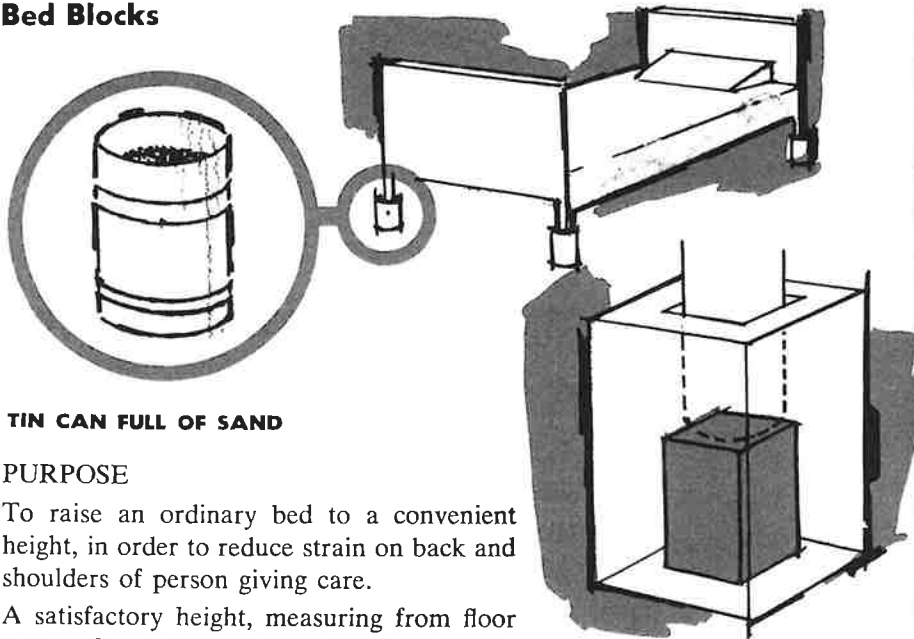
**EQUIPMENT** A hard pillow braced against a board, placed at foot of bed usually gives adequate support.

A triangular foot rest made out of a strong cardboard carton may be used.

The support should be approximately 2 inches higher than patient's feet.

If patient is paralyzed or has a long-term illness, a foot rest adapted to his particular needs may be required.

### Bed Blocks



**TIN CAN FULL OF SAND**

#### **PURPOSE**

To raise an ordinary bed to a convenient height, in order to reduce strain on back and shoulders of person giving care.

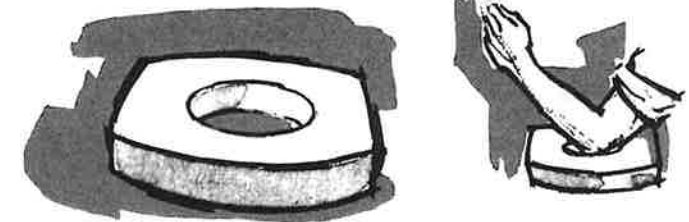
A satisfactory height, measuring from floor to top of mattress is usually 30 to 32 inches, but will depend on height of person giving care.

**EQUIPMENT** Four wooden blocks, approximately 8 × 8 × 12 inches with a hole 3 or 4 inches deep in top of block to hold bed leg securely.

Four tin cans, from which tops have been removed and about half or two-thirds filled with sand, pebbles or gravel, may be used. All cans should be filled to same level.

The castors should be removed from bed legs, as a precautionary measure, before bed is elevated. Protect end of bed legs by wrapping with piece of heavy cloth.

### Pressure Pads



#### **PURPOSE**

To prevent skin on elbows, heels and end of spine from becoming irritated by pressure against bed or bedding.

#### **EQUIPMENT**

An air ring may be used to relieve pressure on end of spine and buttocks. It should be partially inflated so that it is soft and pliable. The cover should always be free from wrinkles.

Foam or sponge rubber may be purchased by the square foot from which pads of suitable size may be cut to protect heels, elbows or back of head.

A sheet of sponge rubber across mattress provides comfort, especially to very thin patients.

### Newspaper Bag for Waste

#### **PURPOSE**

To prevent spreading infection by using a disposable bag to hold waste material from a sick room.

Paper bags from a store may be used or disposable newspaper bags.

**EQUIPMENT** Double sheet of newspaper.



**PROCEDURE** Open 2 double sheets of newspaper and fold in center. It is now 4 thicknesses of paper, page size.

With folded edge toward you, pick up 2 pages and turn back  $\frac{1}{3}$  of width of page, forming a cuff. Crease fold well.

Turn paper over so that cuff will be underneath and on far side.

Fold paper in three, from sides to center and crease folds well.

Pick up one side and tuck under fold on other side.

Fold back flap on top and crease well.

Place hand in bag and force out sides and bag will stand.

Fold bottom third of paper up and tuck it in securely under double cuff.

## Newspaper Pad for Bed

**PURPOSE** To protect bottom sheet and bedding:  
 —during a treatment  
 —if patient is incontinent  
 —if patient has a discharging wound.

**EQUIPMENT** Underpads cut into a convenient size may be used over a piece of waterproof sheeting as bed protectors. (Never use thin plastic if patient is a child).

Bed protectors may be made economically from newspapers, old soft cotton and heavy brown paper.

## Bed Protector of Newspaper

**PROCEDURE** Cut newspapers (15 to 20 thicknesses), old cotton and brown paper to desired size.

Cotton should be at least 2 or 3 inches larger all around than newspaper and brown paper.

Spread cotton flat on table.

Cover it first with newspapers, then with brown paper.

Fold cotton back over papers and baste in place.

A layer of cotton wool may be placed between cotton and newspaper to give added softness.

The brown paper is used as a backing as it is more moisture proof than newspaper. It also prevents newspaper ink from rubbing off on bottom sheet.

## NOTE

Loan cupboards are established in many communities to provide equipment for patient care in the home.

## **SUMMARY**

Imagination and ingenuity are valuable assets in caring for a person who is ill at home. Not many families have a bedtable, back or foot rest, or other sickroom equipment which adds to the comfort of the patient and lessens strain and fatigue on the one giving care. However, this equipment may be improvised by using articles in the home, such as wooden box, a card table, carton, etc.

The average bed in the home is low, which is not a comfortable height for giving treatments and care. There are different ways by which an ordinary bed may be elevated without disturbing the patient. These are enumerated and described.

Other simple equipment which will add to the comfort of the patient and increase the efficiency of nursing care are, pressure pads, bed protectors and paper bags for waste. These may be made inexpensively from foam rubber, old linen and newspapers.



## **PATIENT CARE IN THE HOME**

### **PART THREE**

#### ***Care Under Emergency Conditions***

## CHAPTER XV

# Management of Emergency Delivery

(Prepared by Jean F. Webb, M.D., D.P.H.,  
Chief, Division of Child and Maternal Health)

This outline is intended to be a guide to an untrained person faced with the emergency of giving assistance at a delivery without proper preparation or facilities. It need scarcely be said that the person in charge should continue to seek medical or nursing assistance.

The most important aspect of emergency management is the safe handling of the baby so that he breathes and is protected from infection. The mother needs reassurance but, if the labour is a normal one, her life is not in any danger, and she does not require any very special care. If the labour is an abnormal one, it is imperative that the mother receive medical care if at all possible.

Some indications of an abnormal labour are listed below:

- 1) Labour which has begun at least a month before expected.
- 2) Labour which is accompanied by a free flow of blood.
- 3) Labour which has been going on for many hours and from which the patient is obviously exhausted.

It is sometimes necessary to attempt to judge the imminence of delivery and determine whether there is time to get the patient to better facilities.

### Stages of Labour

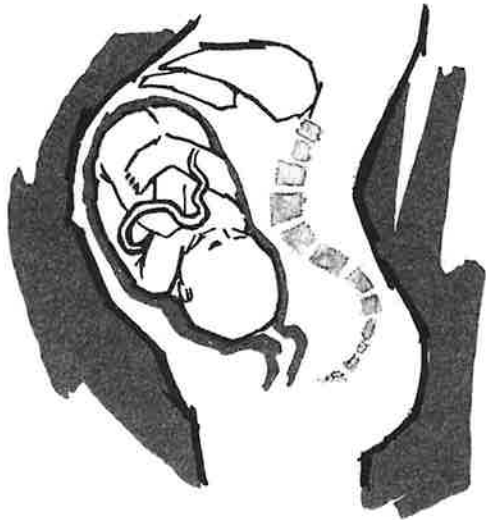
There are three stages of labour, and an understanding of these will help determine the amount of time available before actual delivery occurs.

#### First Stage

The first stage is when the mouth of the uterus is being stretched to a size to let the baby through. This stage may last many hours. Mothers of first babies are often more than 12 hours in this stage.

The first stage of labour is characterized by contractions of the uterus which usually are felt first in the lower back and later in the lower abdomen. They may be very mild at first and somewhat irregular in timing, but as labour progresses they become regular, stronger and more frequent. They may first be noticed at 20-minute intervals, but when labour is well established they are no more than ten minutes apart. If a patient is in this stage of labour and is not yet pushing or straining, delivery is probably not imminent, and there is some time to spare, particularly if the baby is a first baby. This time should be used to find a warm, sheltered spot for the mother to lie down, or to rest in a semi-reclining position. Something in which to wrap the baby should also be sought as the baby should be wrapped first in a clean cloth, such as a towel, sheet or cotton garment, and then with a warm covering such as a sweater, jacket or blanket. If at all possible these wrappers should be warmed before the baby arrives.

If the mother has had children previously, the labour will progress much more rapidly than in the event of the first baby.



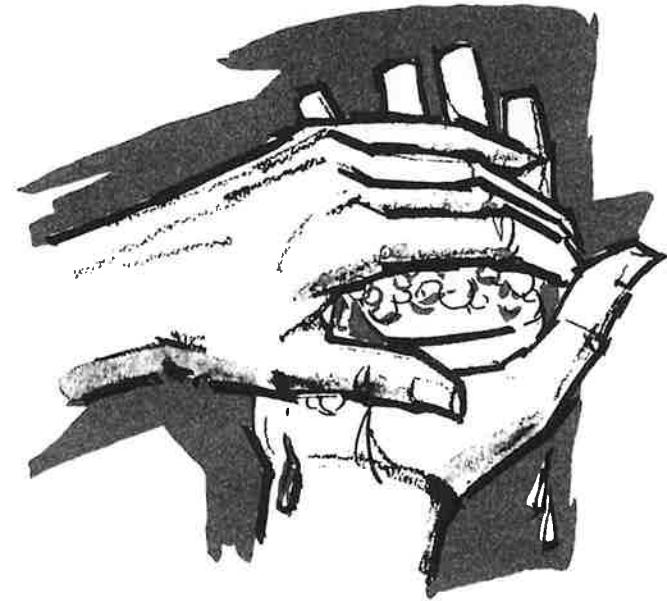
## Second Stage

The second stage is when the baby is being pushed through to the outside. This stage lasts from a few minutes to a few hours, but is much shorter than the first stage. This is the stage when the emergency helper most frequently arrives. The mother, who probably has had previous babies,

realizes that there is little time to get to a hospital or to get in touch with a doctor and calls for emergency aid.

The second stage of labour is characterized by frequent strong contractions of the uterus five minutes or less apart with which the mother is seen to be pushing or straining to push the baby out into the world. If the bag of water in which the baby has been floating has not broken before, it will at this stage.

There is little to be done for the mother except to see that she has a comfortable spot and privacy and to assure her that all is going well. If water and soap are available, the person in charge should take this time to wash her hands thoroughly just before the baby is born in order to protect the baby from infection.



## Delivery of the Baby

Most babies are born head first. It may take several strong contractions to deliver the whole body but if the head appears the body will surely follow so nature must be left to take her course. Do no more than wipe the baby's face with a clean cloth if available, to clear his nose and mouth to breathe.

Sometimes a baby is born with the umbilical cord wound around his neck. If this occurs the cord should be loosened gently to relieve the pressure on the baby's throat as soon as the head appears. If it is easily loosened the loop may be slipped over the baby's head. Very rarely babies are born with the membranes in which they have been growing still intact over the face, that is, born with a caul. If so, this membrane should be broken with the fingers so the baby can breathe.

The helper should try to hold the baby as he is being born so that he will not drop into space between the mother's legs. This area is often a pool of fluid (the fluid in which the baby had been floating) and may be contaminated by feces which have been forced out of the rectum by the pressure of the baby's head.



### Care of the Baby

Most babies will cry right away and begin to breathe. All babies, however, have fluid in the nose and throat passages which must be drained out. The best way is to hold the baby gently, with his feet elevated, a few minutes, supporting the head and shoulders with the other hand.

This is easier than it sounds. The left hand is used for the feet; the forefinger is placed between the ankles, the thumb around one ankle and the remaining fingers around the other. The right hand supports the back of the baby's head, neck and shoulders. The baby is very slippery because of the white, cheesy material on the skin, so both hands are needed. After this brief period of drainage, the baby should be wrapped in whatever has been found, and put across his mother's abdomen, lying on his side and facing away from his mother. While these things are being done, care should be taken not to pull on the umbilical cord, which still attaches the baby to the mother. It should be handled as little as possible.



### Third Stage

This stage is when the afterbirth or placenta is expelled. This stage lasts usually less than twenty minutes after the baby has been delivered.

After a few minutes the umbilical cord will seem to get longer and the afterbirth will appear at the end of the cord. This will be followed by a small gush of bloody fluid.

The afterbirth or placenta is a round, flat organ about 8 inches in diameter and about the colour and consistency of liver. Like the baby, the placenta should not be allowed to drop into the soiled space between the mother's legs.

The afterbirth and cord should be wrapped with the baby. This is messy but it is safe. It is dangerous to the baby to tie and cut the cord without sterile ties, scissors and dressings. Blood stops flowing through the cord as soon as the afterbirth is delivered so there is no danger of the baby losing blood in this way. The baby may be left twenty minutes or so on the mother's abdomen as the pressure helps the uterus to contract down to normal size and prevents bleeding. The mother can see the baby and hold him, and she is reassured by this.

Sometimes by the time the helper arrives, the baby will have been born and lying where he arrived between the mother's legs where there may or may not be a pool of fluid.

As it is important to be immediately certain that the baby's mouth and nose are clear of fluid, the baby should be raised gently and held as described previously to ensure proper drainage. Again the cord should not be touched or pulled on until the afterbirth appears. The baby should be kept warm, resting on his mother's abdomen and the afterbirth wrapped with him when it appears.

### Care after Delivery

There is only one risk which remains. Sometimes the muscles of the uterus do not contract to bring the organ back to normal and the mother haemorrhages. Putting the baby on the mother's abdomen helps to stimulate the uterus to contract. Gentle massage of the lower abdomen, which the mother can do herself, also helps to do the same thing. After an hour has passed the danger of such bleeding is pretty well over. The mother can then be moved to wherever she intended to be for her baby's delivery—the hospital or her home. If she is at home, the only problem is to get medical care to tie and cut the baby's cord. This, however, is not a great emergency. The baby will be alright for several hours just as he is.

If, because of severe interruption of transportation, the mother cannot be moved or assistance brought to her, this is not serious. The baby needs to be kept warm and secure and will need to be fed within a few hours.

The mother is able to provide all this, and she should be reassured of this. Nursing the baby, as well as satisfying him, also helps the mother's uterus to get back to normal.

Both mother and baby are comforted and reassured by it.

### SUMMARY

The objective of the helper is to reassure the mother while interfering very little with the natural process of delivery. The helper sees that the baby breathes, is kept warm and is handled as little as possible. It is important to be as clean as circumstances allow, by washing hands and using clean materials to care for the baby.



## CHAPTER XVI

### The Roller Bandage

The roller bandage is used to —

- Retain dressings in position.
- Control bleeding.
- Afford support.
- Restrict movement.

Roller bandages are made from strips of different materials of varying lengths and widths according to the part of the body to which they are applied.

The recommended materials include muslin, calico, flannel, winceyette or crepe.

The ideal length is 6 yards and the usual widths used are:

Fingers — 1 inch.

Head — 2 inches.

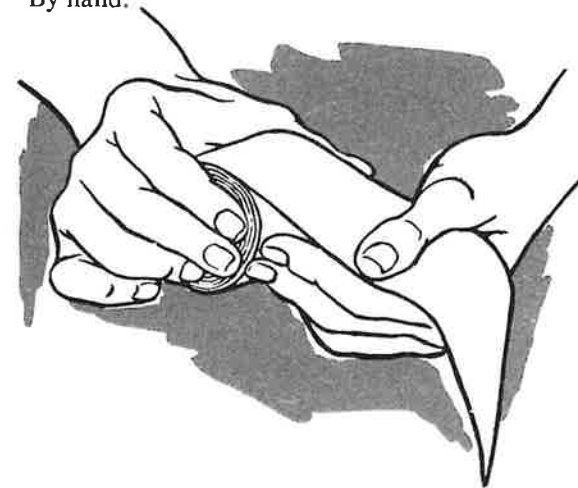
Arm — 2-3 inches.

Leg — 3-4 inches.

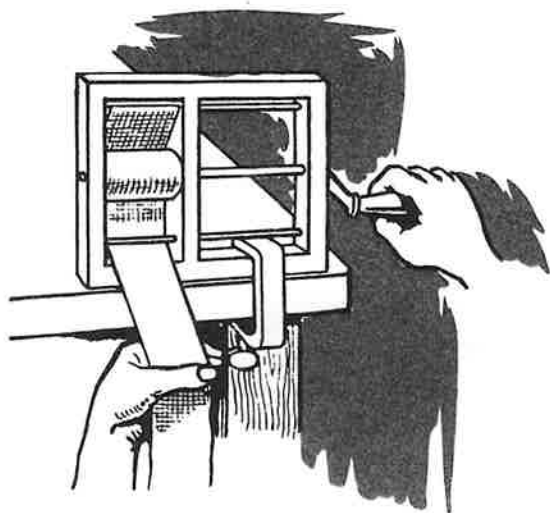
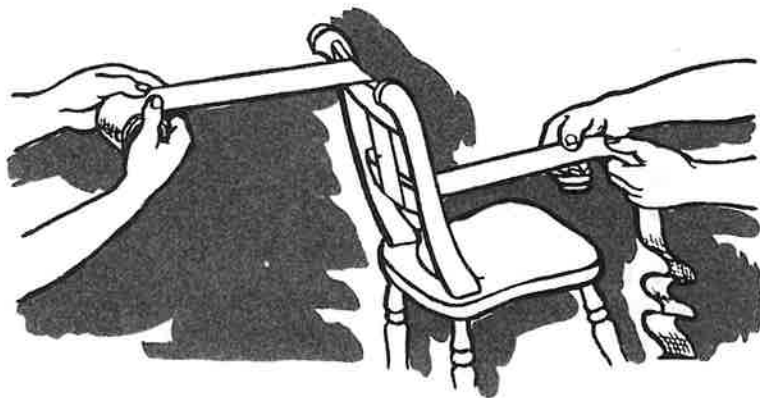
Trunk — 4-6 inches.

Before use bandages should be firmly and evenly rolled by one of the following methods —

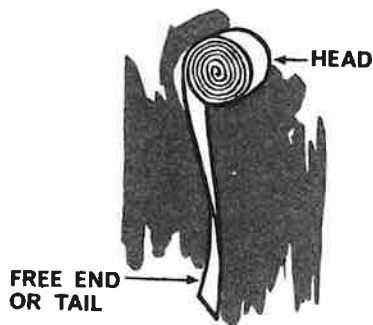
By hand.



By two persons rolling a bandage over the back of a chair.



By a roller bandage machine.



When a bandage is partly unrolled, the roll is called the head and the unrolled part the free end.

## Rules of Application

Use a firmly rolled bandage of the correct width.

Stand or sit opposite the casualty.

Support the part to be bandaged.

Position the part correctly before bandaging.

When bandaging near the armpit or groin pad to prevent two surfaces of the skin touching.

Hold the bandage with the head uppermost and apply the outer surface of the bandage to the part.

Bandage from within outwards and from below upwards over the front of the limb.

Unroll only a few inches at a time, maintaining even pressure throughout.

Fix the bandage with a firm turn, allowing each successive turn to cover two-thirds of the previous turn.

Finish off with a straight turn above the part, fold in the end and fasten.

## Points to be Observed

The comfort of the casualty is the first consideration except when controlling bleeding.

The bandage must completely cover the dressing.

Watch for signs of interference with the circulation —

- An absent pulse below the bandage.
- Swelling.
- A bluish tinge or pallor to the extremity.
- Numbness of the extremity.
- Pain.

If any of these signs appear, loosen the bandage.

## URNS USED IN ROLLER BANDAGING

### Simple Spiral

Is used when the part to be bandaged is of uniform thickness. The bandage is carried obliquely around in a spiral fashion; each turn covering two-thirds of the preceding one, and the edges being kept parallel.

### Reverse Spiral

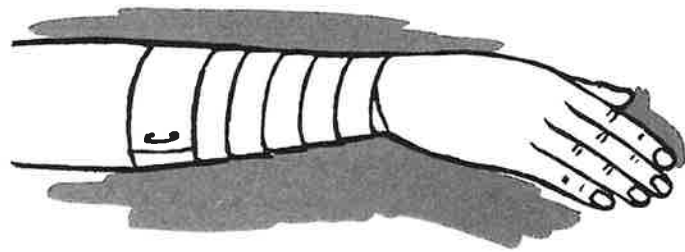
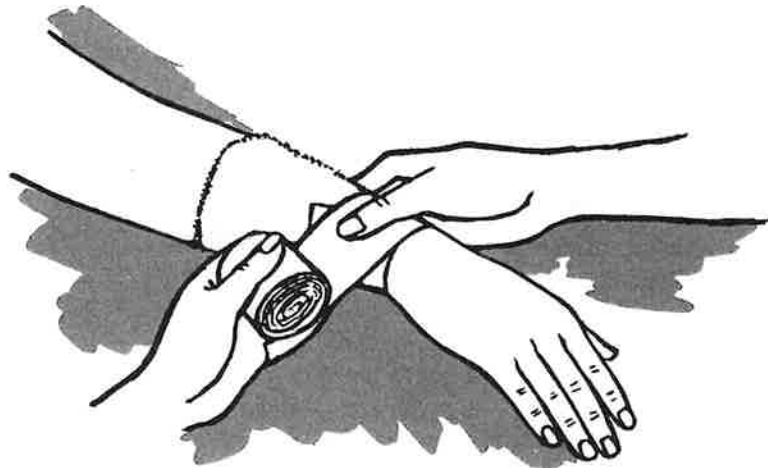
Is used in bandaging parts of the limbs where, owing to varying thicknesses, a simple spiral will not lie evenly.

## The Figure of Eight

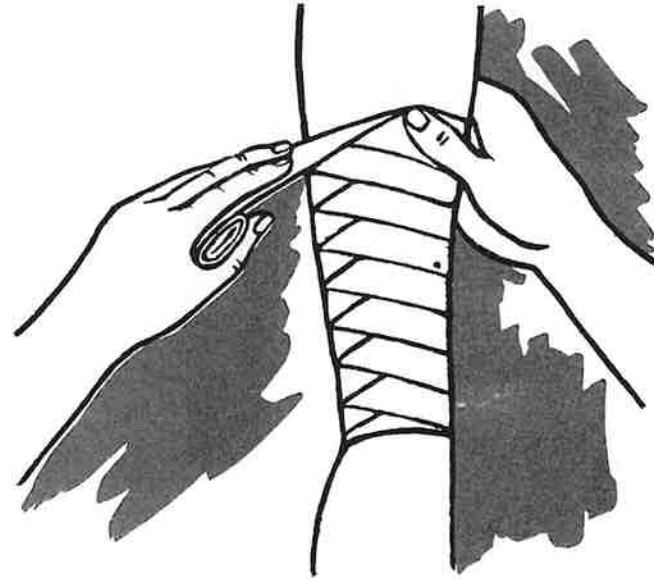
Is used for bandaging at or in the neighbourhood of a joint such as the knee or elbow. It may also be used instead of a reverse spiral for a limb.

## The Spica

The spica is a modified figure of eight in which one turn is much larger than the other and is used for bandaging the shoulder, groin or thumb.



The simple spiral bandage.



The reverse spiral bandage.

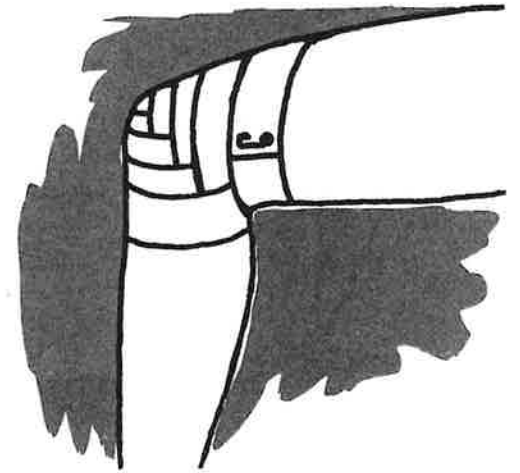
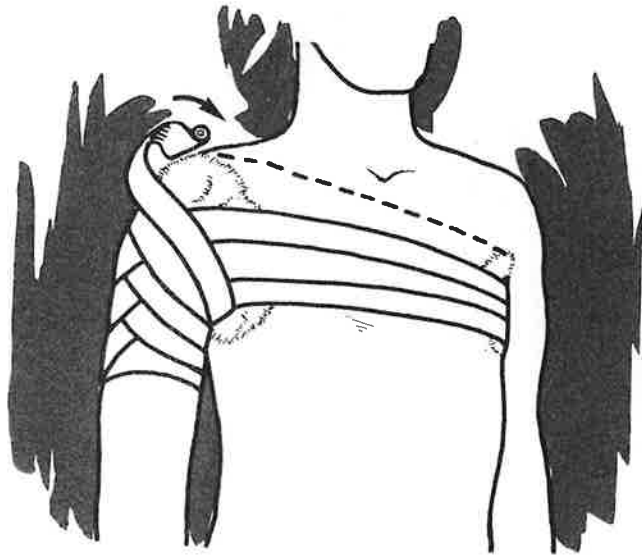


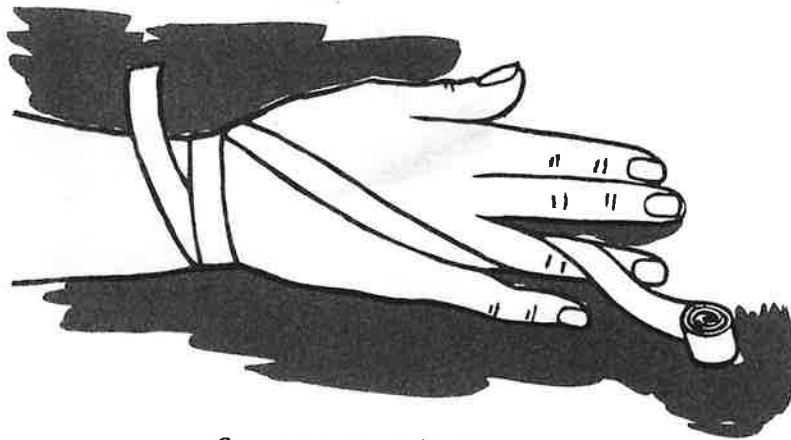
Figure of eight bandage to the knee.



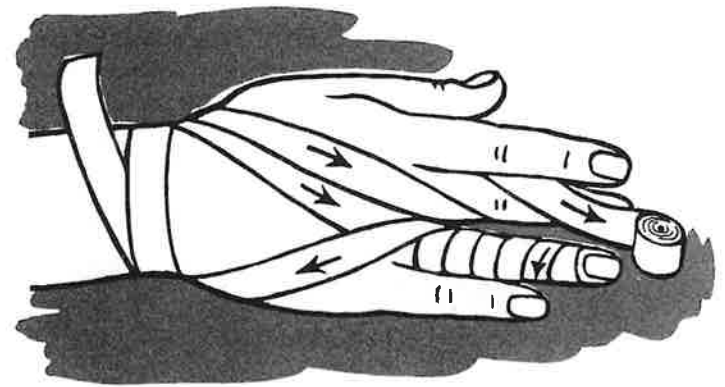
Spica bandage for shoulder.

### Simple Spiral Bandaging to Fingers

Pronate the forearm (palm down).  
Fix the bandage by two circular turns around the wrist, leaving  
the end free for tying off afterwards.



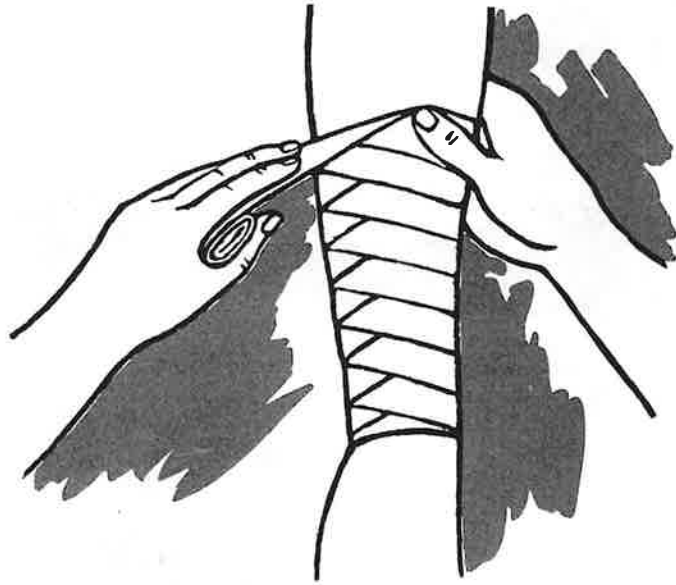
Commencement of the finger bandage.



Bandage carried to the second finger.



Completion of finger bandage.



Reverse spiral of the forearm.

Carry the bandage obliquely over the back of the hand to the base of the finger to be bandaged.

Take one spiral turn to the base of the fingernail and then cover the finger by simple spiral turns.

Carry the bandage across the back of the hand to the wrist, complete with a straight turn around the wrist and secure.

If more than one finger is to be bandaged take a turn around the wrist between each two fingers.

### Reverse Spiral of the Forearm

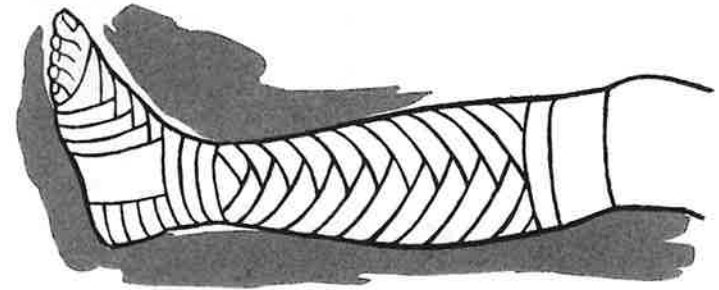
Apply one or two simple spiral turns around the wrist.

The upper edge of the last spiral is fixed with the thumb in the midline of the limb.

Reverse the bandage and bring down and around the limb.

Reverse the bandage immediately above the former fold, the bandage covering two-thirds of the previous turn.

Repeat these reverses as far as necessary and complete the bandage with one or two spiral turns around the limb.  
This method is also used for bandaging a leg.



Reverse spiral bandage of the leg.

### Figure of Eight Bandage to the Hand

Pronate the forearm.

Fix the bandage by a turn around the wrist.

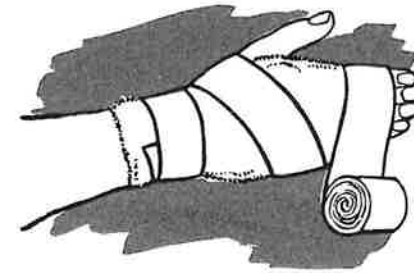
Carry the roll obliquely over the back of the hand to the side of the little finger.

Carry the bandage around the palm and encircle the fingers with a horizontal turn at the level of the base of the little fingernail.

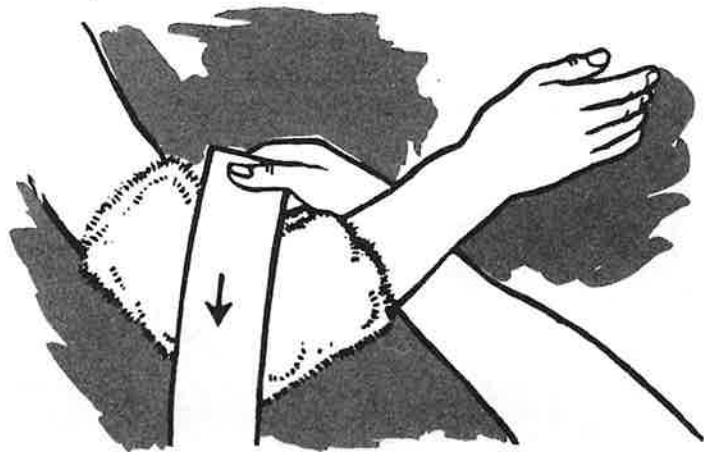
Carry the bandage around the palm and then return obliquely to the wrist.

Repeat the figure of eight turns until the hand is covered.

Complete with a spiral turn around the wrist.



The figure of eight bandage of the hand.



Commencement of the elbow bandage.

### Figure of Eight Bandage to the Elbow

Bend the elbow at right angles.

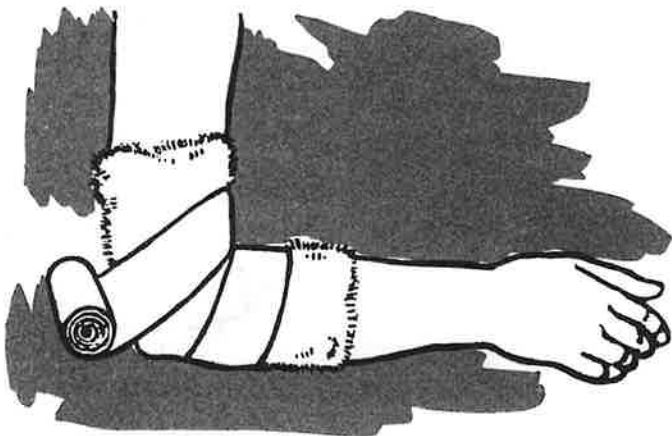
Lay the outer side of the bandage on the inner side of the joint and take one straight turn.

Carry the bandage over the elbow tip and around the limb at the elbow level.

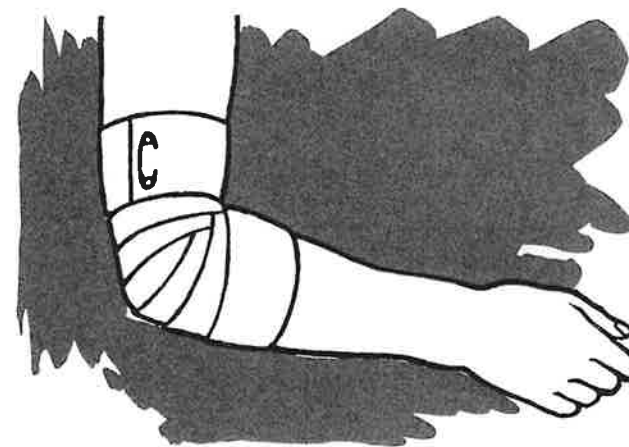
The second turn encircles the forearm, the third the arm.

Continue the turns alternately below and above the first turn.

Finish above the elbow.



Early turns of the elbow bandage.



The completed elbow bandage.

Similar techniques can be used for bandaging —

### The Knee

Flex the knee.

Lay the outer side of the bandage against the inner side of the knee.

Take one turn above the knee cap.

Bring the bandage around the knee just below and then just above so that the margins of the bandage covering the knee cap are covered.

Repeat until the whole knee is covered.

Complete with one straight turn around the thigh.

### Foot and Ankle Bandage

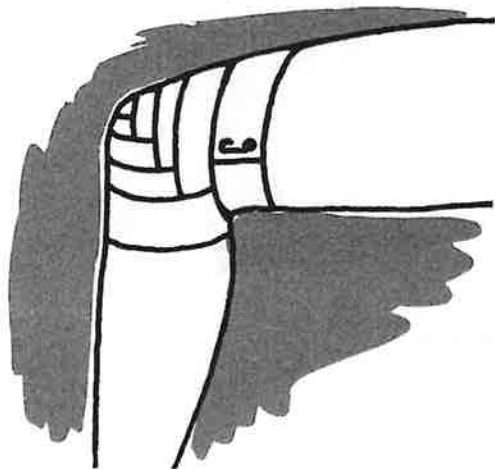
Take one or two turns around the ankle.

Then take the bandage obliquely across the foot to the root of the little toe.

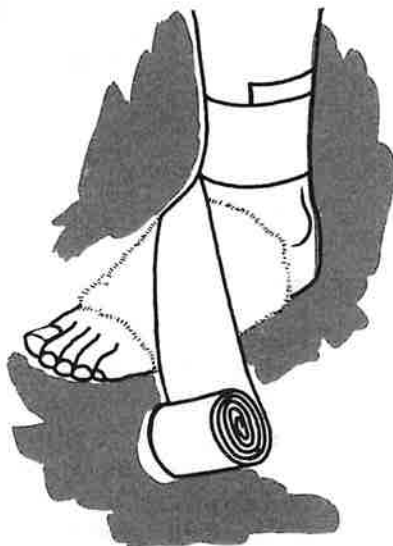
Make a horizontal turn around the foot.

Carry the bandage back over the foot and take a turn around the ankle just above the heel.

Repeat figure of eight turns overlapping the preceding turns until the foot is covered.



Knee bandage.



Early turns of the ankle bandage.



Complete ankle bandage.

### Spica of Shoulder Bandage

Place a small pad of cotton wool in each axilla.  
 Using a 3-4 inch bandage fix it with two spiral turns around the upper arm.  
 Make two reverse spiral turns around the upper arm to reach the point of the shoulder.  
 Carry the bandage over the shoulder, across the back and under the opposite armpit.  
 Cross the chest and arm and bring it around under the armpit on the affected side and over the shoulder.  
 Repeat the figure of eight until the whole shoulder is covered.

### Spica of Hip Bandage

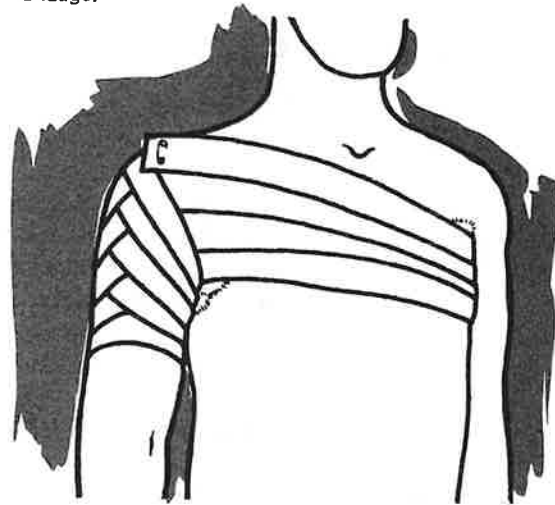
If the casualty is lying down, place suitable support under pelvis.  
 Place the outside of the bandage on the inner side of the thigh 3 in. to 6 in. below the groin.  
 Carry the bandage horizontally around the limb and make three or four ascending reverse spiral turns around the thigh.  
 Carry the bandage from within outwards over the front of the groin and up around the hips and the back.  
 Pass it over the prominence of the hip bone on the opposite side.  
 Bring the bandage down over the abdomen to the outer side of the thigh.  
 Repeat the figure of eight turns as required.

### Spica of Thumb Bandage

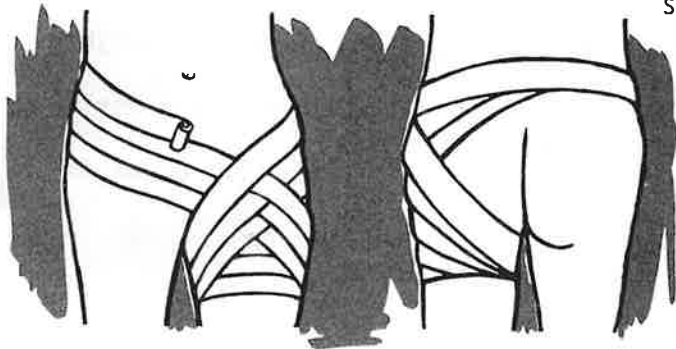
Pronate the forearm.  
 Take two turns around the wrist and carry the bandage over the back of the thumb.  
 Encircle the thumb with one or two straight turns with the lower border level with the root of the thumb-nail.  
 Carry the bandage back over the back of the hand and around the wrist.  
 Repeat figure of eight until the ball of the thumb is covered.  
 Finish with one straight turn around the wrist.



Spica of thumb bandage.



Shoulder Spica.



Hip spica bandage (front and back view).

## To Cover the Finger-tip

Commence as for a simple spiral bandage of the finger but take the bandage up the back of the finger and over the middle of the tip. Continue down the front to the level of the main joint.

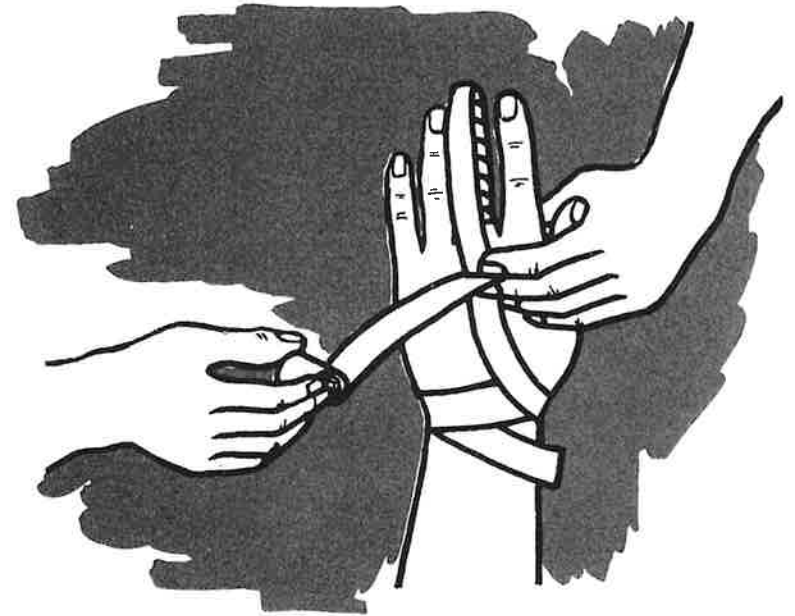
Hold the bandage and return over the tip to the back of the second joint.

Hold the bandage and repeat.

Fix the loop with a circular turn near the tip.

Make spiral turns to secure the loops.

Take a straight turn around the wrist and secure.



Bandage to cover tip of finger.



**NOTES**

**NOTES**