Tissue Integrity and Hygiene NCLEX Review

I. Integumentary System

The integumentary system is the largest organ in the body. It includes not only the skin but mucous membranes, hair, and nails. Nurses must know the anatomy and functions of the components of the integumentary system to provide knowledgeable nursing care to clients.

A. Structures of the integumentary system

1. Epidermis (outer layer).

- In addition to skin, includes mucous membranes and lips.
- Contains melanocytes that produce melanin, which gives skin its color.
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2. Dermis.

- Consists of vascular fabric of collagen and elastic fibers that produce flexibility and strength.
- Contains touch receptors.

3. Glands.

- Eccrine: Sweat glands; secrete clear fluid through pores.
- Apocrine: Scent glands; found in axillary, mammary, and genital areas.
- Sebaceous: Sebum-secreting gland at base of hairs and open into upper portion of hair follicles.
- Mammary: Milk-secreting glands; discharges milk through nipples during lactation.

4. Mucous membranes.

- Lining of passages and cavities opening directly to the exterior of the body (e.g., oral cavity, rectum, nose, urethra, gastrointestinal tract).
- Consist of epithelial surface layer, basement membrane, and underlying layer of connective tissue.
- Secrete mucus, a thick, slippery material that keeps the membranes moist and protected.
- Condition of the mucous membranes is influenced by changes in oxygenation, circulation, nutrition, and hydration.

5. Hair.

- Keratinized, threadlike outgrowth from epidermal structures called follicles.
- Routinely shed and replaced; replacement may not keep pace of hair loss due to genetic predisposition, alopecia, radiation, chemotherapy.
- Distribution affected by gender, genetics, and age.

6. Nails.

- Hardened, horny cutaneous plates overlying the dorsal surface of the ends of fingers and toes.
- Consist of nail body, root, cuticle, and nailbed; grows about 0.5 mm a week; fingernails faster than toenails; growth faster in summer than winter.
- Contain abundant blood vessels and appear pink and translucent; easily monitored for signs of cyanosis.
- Condition influenced by local problems, systemic problems, and aging.

B. Functions of the integumentary system

1. Largest organ of the body, the condition of which reflects the effects of the body's metabolism and nutritional status.

2. Protects the body.

- Acts as a barrier between the internal and external environments.
- Prevents injury to underlying structures; nails protect distal appendages from mechanical injury.
- Provides protection from microorganisms; "acid mantle" (pH between 4 and 5.5).
- Cilia in nostrils filter and warm air entering the nasal cavities.
- Eyelashes and eyebrows keep sweat and debris out of eyes.

3. Regulates body temperature.

- Dilates blood vessels and activates sweat glands to cool the body via processes of perspiration, evaporation, conduction, and radiation.
- Constricts blood vessels and inactivates sweat glands to conserve heat.
- Hair on head, arms, legs, and torso provides thermal insulation.

4. Receives sensations of heat, cold, touch, pressure, and pain via nerve receptors.

5. Produces vitamin D when skin is exposed to ultraviolet light from the sun.

6. Secretes sebum from sebaceous glands, which lubricates skin and hair; reduces heat loss from skin because of its oily nature; and reduces bacterial growth.

7. Excretes water, sodium chloride, and nitrogenous waste via perspiration.

II. Assessment of the Integumentary System

When assessing the integumentary system, the nurse should know the normal and abnormal characteristics of skin, such as variations in color, temperature, moisture, texture, and presence of lesions that impair skin integrity. In addition, the nurse should know the normal and abnormal characteristics of the mucous membranes, hair, and nails, which are components of the integumentary system. This foundation of knowledge is necessary before the nurse can implement

a comprehensive assessment, identify problems, and plan and implement nursing interventions associated with the integumentary system.

A. Principles of assessment of the skin 1. Obtain the client's permission for assessment because it invades the client's personal space. 2. Ensure adequate lighting and that the color of curtains and wall paint does not influence assessments. 3. Use inspection before palpation; rub hands to warm them before placing them on the client's skin. 4. Consider the mucous membranes, hair, and nails as extensions of the skin.

B. Assessment of skin color

1. Recognize that skin color varies according to age and race and that exposed areas are darker than unexposed areas; palms of the hands, soles of the feet, and nailbeds are the lightest areas.
2. Note variations in skin color.

- **Cyanosis:** Bluish-gray color of the skin; may appear ashen gray in dark-skinned people; more obvious in the conjunctivae, tongue, buccal mucosa, palms of the hands, and soles of the feet; associated with hypoxia or exposure to extreme cold.
- **Ecchymosis:** Blue-purple area larger than petechiae that progresses to green-yellow; commonly called a bruise; due to shallow bleeding under the skin or mucous membrane; associated with blunt trauma.
- **Erythema:** Redness of the skin due to congestion of the capillaries; associated with inflammation, vasodilation, prolonged pressure, and application of heat or cold.
- **Flushed:** Redness of the skin due to dilated capillaries; most commonly associated with increased body temperature.
- **Jaundice:** Yellow-orange cast to the skin caused by deposition of bile salts; most obvious in sclerae of the eyes, mucous membranes, palms of the hands, and soles of the feet; associated with liver or biliary impairment.
- **Pallor:** Pale skin or ashen gray appearance in dark-skinned people; more obvious in oral mucous membranes, conjunctivae, nailbeds, palms of the hands, and soles of the feet; associated with anemia and malnutrition.
- **Petechiae:** Small, red-purple spots caused by intradermal or submucosal hemorrhaging; associated with thrombocytopenia and some febrile illnesses.

C. Assessment of skin temperature

1. Use the back of the hand or fingers to assess skin temperature; skin should feel warm to touch.
2. Assess extremities bilaterally and compare for symmetry.
3. Assess a client with excessively warm skin further because this finding may indicate a fever; obtain body temperature to verify.
4. Assess a client with excessively cool skin further because it may indicate conditions such as impaired circulation, shock, or hypothyroidism.

D. Assessment of skin moisture

1. Use inspection and palpation; skin usually is warm and dry.
2. Assess a client with excessively moist skin (profuse diaphoresis)further because this

finding may indicate conditions such as hyperthermia, anxiety, exposure to hot environment, or hyperthyroidism.
3. Assess a client with excessively dry skin further because this finding may indicate conditions such as dehydration, excessive exposure to the sun, overzealous bathing, or hypothyroidism.
4. Assess a client with oily skin further because this finding may be due to excessive sebaceous gland secretion or sebaceous gland inflammation (acne), commonly associated with adolescence.
5. Assess skin turgor to determine elasticity of the skin, which reflects hydration status; pinch skin on anterior chest below the clavicle, sternum, forehead, or inner thigh and note how long it takes to return to its original position.

- Prolonged tenting (longer than 2 to 3 seconds) is associated with dehydration and aging.
- Resistance to pinching is associated with edema; client may report that the skin “feels tight” or that rings and shoes do not fit.

E. Assessment of skin texture

1. Recognize that skin texture varies according to age and the area being assessed.

- Exposed areas and elbows and knees tend to be drier and coarser than unexposed areas.
- Skin of infants and children is softer and smoother than that of adults because of lack of exposure to the environment and extent of hydration of tissues.

2. Identify changes in skin texture related to impaired circulation to the lower extremities.

- Peripheral arterial insufficiency is associated with pale-colored skin when the legs are elevated and reddish-blue colored skin when dependent. Additional clinical manifestations include dry, scaling skin; yellowed, brittle nails; loss of hair; ulcerations near the toes; and pain with activity (intermittent claudication).
- Peripheral venous insufficiency is associated with thick, rough skin that frequently is hyperpigmented; edematous; superficial vein dilation; and ulcerations around the ankle. Red blood cells exit ruptured vessels and then degenerate, leaving a brownish discoloration of the tissues.

F. Assessment of skin lesions

1. Use standard precautions when assessing skin lesions.

- Wash hands before and after.
- Wear gloves.

2. Identify the type of lesion.

- Primary lesions occur in response to a change in the internal or external environment of the skin due to a disease process.
- Secondary lesions occur as a result of changes in a primary lesion due to trauma, scratching, or infection.

3. Identify the size and shape of the lesion.

- Note size in millimeters.
- Identify whether the lesion is circumscribed or diffuse, round or oval.
- Identify the depth of the lesion.

4. Identify the texture of the lesion: Depressed, flat, or elevated; hard, solid, or soft; rough or thickened; fluid filled or flakey.

5. Identify the presence and characteristics (e.g., color, odor) of exudate.

6. Identify the color of lesion: May have no color, one discrete color, or several colors; color may be red, brown, black, blue, purple, or yellow.

7. Identify the distribution of lesions: Document the location of the lesion(s); symmetry or asymmetry of lesions.

8. Identify the pattern (configuration) of lesions: Arrangement of lesions in relation to each other, such as circular, linear, clustered, arcing, merged together, or following the course of cutaneous nerves.

G. Assessment of mucous membranes

1. Inspect oral cavity, rectum, nares, and urinary meatus; mucous membranes should be pink, moist, and intact.

2. Assess the mouth and oropharynx via inspection.

- Lips.
  - Should be pink or color of the person’s skin, smooth, moist, intact, and free from lesions.
  - Deviations include dryness, fissures, pallor, cyanosis, involuntary movement, and drooping.
- Inner surface of mouth, buccal mucosa, roof of mouth, and floor of mouth.
  - Same assessment results as lips.
  - Deviations include inflammation of the oral mucosa (stomatitis).
- c. Tongue.
  - Should be shiny, pink, and moist, with an even distribution of papillae organized in an inverted “V.”
  - Deviations include dryness, fissures, or inflammation of the tongue (glossitis).
- d. Uvula and tonsils.
  - Uvula should be in midline and rise when client says “ah.”
  - Tonsils should be pink, smooth, with no discharge and should be behind the tonsillar pillars; deviations include inflammation of the tonsils (tonsillitis).
- Teeth and gums.
  - Teeth should be free from tartar, hardened deposits of debris from bacteria, saliva, epithelial cells, and leukocytes (plaque).
  - Gums should be pink, moist, and firm; deviations include receding from teeth and swollen, inflamed gums (gingivitis).

H. Assessment of hair

1. Color of hair.

- Black, brown, blond, red, gray, or white.
- Loss of pigment as one ages results in gray or white hair.

2. Quantity of hair.

- Thick, thin, sparse; none (alopecia); abnormal hairiness (hirsutism).
- Amount of hair may decrease on the lower extremities, pubic and axillary areas, and head as one ages, as the result of chemotherapy, or because of thyroid disease.

3. Distribution of hair.

- Symmetrical; hair in expected or unexpected areas; multiple bald spots; male pattern baldness.
- Male pattern of hair distribution in women is associated with endocrine disorders and steroid
  medications; lack of hair on distal extremities may indicate inadequate peripheral circulation.

4. Texture of hair.

- Coarse or fine; straight, wavy, or curly; oily or dry.
- Dry hair is associated with malnutrition, aging, and hypothyroidism; fine, silky hair is associated with hyperthyroidism; hair return after chemotherapy may have a different color and/or texture.

5. General condition of hair: Clean and combed; dirty, unkempt, and matted.

6. Condition of scalp: Should be shiny, smooth, mobile, and nontender.

7. Presence of infection or infestations.

- Wash hands before and after wearing clean gloves.
- Systematically part hair in multiple sections, particularly behind the ears and at the nape of the neck, to assess for sores, lice eggs (nits), ringworm (tinea capitis),dry flakes (dandruff), or oily scales (seborrhea).

I. Assessment of nails

1. Color of nails.

- Usually pink or light brown.
- Yellow nails are related to cigarette smoking, fungal infections, or psoriasis.
- Blue nails are related to peripheral disease or hypoxia.
- White nails are related to trauma and liver or renal disease.
- Black nails are related to trauma; color due to accumulation of blood under the nail.

2. Shape and nail plate angle.

- Convex curve expected with an angle of 160 degrees between the fingernail and nailbed.
- Angle equal to or greater than 180 degrees (clubbing)is related to long-term lack of oxygen.
- Spoon-shaped nail is related to iron-deficiency anemia.

- Smooth surface expected.
- Excessively thick nails are related to impaired circulation, chronic fungal infection, and aging.
- Excessively thin nails or the presence of grooves or furrows are related to iron-deficiency anemia.
- Brittle nails are related to malnutrition, calcium, and iron deficiency.
- Longitudinal ridges are related to arterial insufficiency.

4. Cuticle and surrounding tissue.

- Smooth intact epidermis expected.
- Edema, erythema, or exudate indicates inflammation or infection; assess for ingrown nails.

5. Capillary refill.

- Compression of the nail produces blanching and color returns in <3 seconds after pressure is released (blanch test).
- Return of circulation >3 seconds (>5 seconds in older adults) indicates cardiopulmonary problems or anemia.

III. Risk Factors for Impaired Tissue Integrity and Related Nursing Care

The integrity of the skin must be maintained to preserve one of the first protective lines of defense of the body. Factors such as moisture, excessive or inadequate hydration of the skin, inadequate nutrition, prolonged pressure, and shearing forces can compromise tissue integrity. Nurses must have a thorough understanding of these factors as they relate to skin breakdown because many of them can be prevented or minimized by nurses when caring for clients.

A. Moisture

1. Incontinence and perspiration because of fever in response to disease or illness can cause prolonged dampness, which softens skin (maceration).

2. Feces and gastric tube drainage that contain digestive enzymes and urine that contains urea can cause loss of superficial layers of the skin (excoriation, denuded skin).

3. Abdominal and perineal skin folds and under the breasts are particularly at risk because these touching skin surfaces confine moisture and are warm, dark, moist places that facilitate growth of bacteria and fungi.

4. Nursing care.

- Keep the client clean and dry, especially skinfolds for a client who is obese, perspiring, incontinent of urine or stool, or has a gastric or urinary tube.
- Assess the skin and mucous membranes of clients who are incontinent regularly.
- Change wet clothing andlinens immediately.
- Provide a skin barrier to the perineal area or around the entry of a gastrostomy or urostomy tube as prescribed; many facilities have standing protocols that permit the nurse to use professional judgment concerning the application of products such as A&D ointment.
- Engage in a bowel or bladder training program if the client is a candidate and it is prescribed.
- Implement a toileting schedule to reduce episodes of incontinence; assist with toileting before and after meals to take advantage of the gastrocolic reflex (food/fluid entering an empty stomach stimulates peristalsis), when awakening in the morning and when going to bed at night, and every 2 hours when awake.

B. Dehydration and edema

1. Fluid loss due to fever, diarrhea, or vomiting or inadequate fluid intake contributes to dry, cracking skin and mucous membranes.

2. Excessive fluid in interstitial tissue (edema)decreases elasticity and flexibility of skin and interferes with oxygenation and clearing of waste from cells, increasing the risk of tissue breakdown.

3. Nursing care.

- Ensure that the client has adequate fluid intake (2 to 3 liters daily) to maintain body function.
    - Administer IV fluids as prescribed.
    - Provide fresh water and preferred fluids and assist a client who is unable to acquire fluid, such as by offering sips of water whenever passing the client’s room.
- Maintain fluid restriction as prescribed.
- Provide pressure relief devices to protect skin surfaces.
- Elevate the legs of a client with dependent edema as long as the client has no acute cardiac insufficiency.

C. Inadequate nutrition

1. Insufficient protein, carbohydrates, and vitamin C contribute to muscle wasting, insufficient subcutaneous tissue, and weight loss.

2. Insufficient protective cushioning of bony prominences by adequate tissue layers increases the risk of skin breakdown due to pressure.

3. Nursing care.

- Assess self-feeding ability; condition of oral cavity, such as lesions, stomatitis, and problems with dentures; current weight; and weight history.
- Ensure that the client receives adequate nutrition; evaluate and document the percentage of each meal ingested; avoid using relative terms such as “good” and “poor” to describe

intake.
- Assist a client with meals as needed and encourage intake of foods high in calories, protein, and vitamin C to maintain weight and facilitate wound healing.
- Conduct a calorie count when prescribed to evaluate the client's nutritional intake.

D. Prolonged immobility

1. When pressure exceeds 15 to 32 mm Hg (capillary occlusion pressure) due to tissue compression between a bony prominence and a hard surface, such as a bed or chair, tissue ischemia occurs, contributing to cell death.

2. Three factors are a concern:

- Intensity of pressure.
- Duration of pressure.
- Degree of tissue tolerance to the pressure due to a concurrent problem.

3. Concurrent problems that contribute to prolonged pressure and skin breakdown include presence of edema, inadequate nutrition, moisture, dehydration, reduced sensation, and impaired cognition that influences the ability to move.

4. Nursing care.

- Encourage independence but assist with activities that the client cannot complete or care for areas that the client cannot reach.
- Turn and reposition the client every 2 hours and document on a turning and positioning flow sheet; may be done hourly for clients at risk for skin breakdown.
- Teach the client how to shift weight frequently to reduce the duration of pressure.
- Use pressure-relief devices, such as gel cushions, an air mattress, pillows, and elbow and heel pads to distribute weight over a greater area, thereby decreasing the intensity of pressure.
- Provide massage, skin care, and range of motion every time a client's position is changed to increase local circulation and prevent contractures.

E. Shearing force

1. Shearing force occurs when gravity pulls down on deep body structures and frictional resistance occurs between the skin and a firm surface.

2. The epidermal layer slides over the dermis and underlying tissue layers.

3. Shearing and frictional forces damage the vascular bed of skin and superficial tissue.

4. Capillary occlusion pressure is significantly reduced when shearing occurs; the combination of pressure and shearing dramatically increases the risk of skin breakdown.

5. Nursing care.

- Use a pull sheet to move a client up in bed.

- Avoid using a high- or semi-Fowler position or limit the use of this position to alternating 2-hour intervals.
- Use a sliding board when transferring a client from a bed to a stretcher and back.
- Use a mechanical lift to transfer a client from a bed to a chair and back if the client is unable to move independently.

IV. Factors Affecting Hygiene Practices and Related Nursing Care

Personal hygiene consists of activities that maintain body cleanliness, promoting physical and psychological well-being. It is highly individualized and determined by numerous personal, cultural, religious, socioeconomic, environmental, and physical factors. Nurses must have a comprehensive understanding of these factors to aid in the assessment of clients and in the planning of nursing interventions that are specific for each client.

A. Personal preferences

1. Some people prefer to take a shower versus a bath, bathe in the morning versus the evening, and have specific opinions about the type of products they desire.

2. Personal habits develop on the basis of factors such as culture, home environment, family patterns, and economic circumstances.

3. Nursing care.

- Ask about preferences regarding hygiene and grooming activities.
- Accept hygiene practices nonjudgmentally.
- Support hygiene routines whenever possible using products preferred by the client.

B. Culture and religion

1. Maintaining personal cleanliness is not as important in some cultures as in others; North Americans commonly bathe daily, and those in other cultures may bathe only once a week.

2. Some cultures expect a person to use deodorant, and others believe that it is unnecessary.

3. Different cultures have different beliefs about nudity and privacy; North Americans generally bathe in private, and people in other cultures may bathe communally (Box 18.1).

4. Nursing care.

- Identify and meet specific preferences based on cultural and religious customs.
- Provide privacy for hygiene and grooming activities; expose only the area of the body being washed.
- Assign a gender-specific caregiver to a client when touching between unrelated males and females is forbidden in the client's culture.
- Include a family member in meeting hygiene needs if it is the client's preference.
- Support ceremonial washing of a client by family members when requested.

Examples of Cultural and Religious Bathing Practices:

1. Orthodox Jewish women engage in a ritual bath after each menstruation and after childbirth.
2. In some cultures, family members provide hygiene and grooming care for ill relatives.
3. Women who practice the Islam or Hindu religion can receive personal care only from another woman.
4. Muslims use the left hand for cleaning and the right hand for eating and praying.
5. In some cultures, family members may perform religious ceremonial washing when a client dies.

C. Developmental level

1. Common nursing care.

- Encourage clients to provide for their own hygiene needs as independently as possible within developmental, physical, emotional, and mental abilities.
- Provide a bath or assist with bathing activities when a client is unable to reach body parts or when cognitively immature or impaired.
- Use hygiene products that are the client's preference and/or that are designed for a specific developmental age, such as gentle soaps or soap substitutes for infants and older adults.
- Use protective skin barrier ointments in the perineal area when a client is not toilet trained or is incontinent.
- Test the temperature of bath water before use, including water in a shower.

2. Infants and children.

- Have fragile, easily injured skin.
- Are incontinent of urine and feces that promote skin breakdown.
- Have hygiene activities provided for by parents and caregivers.
- Progressively assume more self-care activities as they grow older.
- Eventually provide self-care independently.
- Specific nursing care.
    - Change diaper as soon as soiled.
    - Allow children to engage in self-care as gross and fine motor skills develop.
    - Teach parents to never leave a child unattended in a bath tub.
    - Teach parents to bathe an infant in a plastic tub or bath tub rather than the kitchen sink; accidental turning on of the faucet may cause a thermal injury.

3. Adolescents.

- Have increased sebaceous gland growth and secretion, which makes the skin more oily and susceptible to acne.
- May shower several times a day as they become more concerned about personal appearance. c. Specific nursing care.
    - Support adolescents nonjudgmentally as they engage in meeting hygiene needs to enhance their self-esteem.
    - Support use of prescribed acne medications.

4. Older adults.

- Have many integumentary changes that result in fragile, easily injured skin.
- May need assistance with hygiene because of problems such as physical or physiological limitations and reduced sensation, resulting in an inability to sense pressure, heat, cold, and friction or chemical irritants.
- May be reluctant to seek assistance because of fear that they will be viewed as unable to cope.
- Specific nursing care.
    - Bathe less frequently according to a client's preference to avoid drying the skin.
    - Use mild cleansing products to maintain pH balance of skin and prevent removal of natural moisturizers and lipids that protect the skin.
    - Use a soft cloth and pat skin surfaces dry to avoid damage by abrasion.
    - Allow client to progress at own pace because of developmental decline in mobility; doing so reduces stress, conserves energy, and prevents activity intolerance.
    - Apply a moisturizer/emollient after bathing and at least twice a day to make skin supple and less dry; ensure safety precautions because these products can be slippery.
    - Teach the client to assess all body surfaces, especially bony prominences, daily using a mirror, if needed, to identify tissue trauma.

D. Knowledge, values, beliefs, and motivation

1. Knowledge alone may not precipitate healthful behaviors.

2. An opinion about the worth of something (value) and thoughts that a person considers to be true, which may or may not be based on fact (belief) influence personal hygiene behaviors.

3. Changes in behavior related to health beliefs are based on the client's perception of these factors:

- Seriousness of the illness.
- Personal risk of developing the illness.
- Personal benefit of the actions to be taken.

4. The desire or incentive to learn (motivation) influences whether a behavior is instituted and/or sustained.

5. Nursing care.

- Identify the client's values and beliefs in relation to hygiene.
- Identify the client's understanding of actions and inactions that impact personal hygiene and bodily functions.
- Teach principles associated with hygiene and that are within the client's values and beliefs.
- Help the client to set goals and outcomes and assist clients to meet these goals and outcomes.

E. Socioeconomic status and personal environment

1. Inadequate income influences the environment in which one lives and the ability to afford hygiene products.
2. A person renting a room or living in a rooming house may not have easy access to bathing facilities.
3. Homeless people carry all belongings with them and may bathe in a sink in a public bathroom.
4. Attaining food, clothing, and shelter may be more important than bathing to people who live in poverty.
5. Nursing care.

- Be sensitive to an inability to provide for personal cleanliness due to poverty or homelessness.
- Advocate for the client and initiate contact with an appropriate social service agency that can address the multiple physical and emotional needs of the client.
- Direct the client to a food bank that provides hygiene products or a shelter that provides facilities in which to bathe.
- Direct the client to community agencies that help acquire funding for people living in poverty.

F. Health status and energy level

1. Clients challenged with physical, physiological, emotional, mental, or cognitive problems may not have the physical strength, dexterity, endurance, or psychic energy to provide for their own hygiene needs safely.

2. Common health issues that impact the self-performance of hygiene.

- Pain due to problems such as surgery, trauma, and acute or chronic health problems.
- Impaired mobility due to problems such as Parkinson disease, multiple sclerosis, spinal cord injury, or brain attack.
- Sensory deficits, such as impaired vision or hearing and neuropathies.
- Cognitive deficits, such as delirium, dementia, traumatic brain injury, or lowered level of consciousness.
- Emotional, mental, or cognitive issues, such as an altered reality state, severe anxiety, or depression.

3. Assess the level of client assistance needed to meet hygiene needs.

- Independent: Client is able to provide total self-care without assistance.
- Set-up with partial assistance: Client can physically and mentally bathe most body parts when equipment is positioned in easy reach; caregiver assists with body parts that the client is unable to reach, such as lower legs and feet, back, and buttocks.
- Supervision: Client can physically provide self-care but, because of a mental or emotional impairment, needs coaching to stay focused or complete the steps in a task.
- Complete assistance: Client is physically, emotionally, or mentally incapable of providing self-care; all hygiene and grooming tasks are implemented by the caregiver.

4. Nursing care.

- Complete a nursing history and physical and identify factors that may interfere with a client's ability to provide self-care.
- Identify the client's level of ability to participate in self-care.
- Plan and implement a plan of care that addresses hygiene and grooming needs.
- For nursing care for clients with specific needs associated with an impaired ability to meet personal hygiene and grooming needs.

V. Nursing Care to Support Hygiene

Activities of daily living related to personal care generally include bathing, perineal care, foot care, oral care, hair care, nail care, and shaving. They also include insertion, removal, and storage of hearing aids and dentures. Each of these activities includes specific nursing interventions that incorporate the principles of medical asepsis and client safety. Nurses must understand not only what should be done but also the rationale for each of these interventions.

A. Purposes of hygiene

1. Cleanses the skin by minimizing microorganisms and removing secretions, excretions, and debris from the skin; removes and inhibits unpleasant body odors.
2. Increases circulation by bringing oxygen and nutrients to the cells of the skin and removing cellular waste.
3. Promotes a sense of well-being and fosters relaxation and comfort.

B. Scheduled hygiene

1. Hourly.

- Rounding hourly is also known as "comfort or safety rounds."
- Ensures client's comfort, positioning, and toileting needs are met in a timely manner.

2. Upon awakening.

- Also known as "early morning care."
- Client is toileted upon awakening, hands and face are washed, and oral care and comfort interventions (e.g., positioning, medications) are performed in preparation for breakfast and diagnostic testing.

3. Morning care.

- Also known as "a.m. care."
- After breakfast, clients are assisted with hygiene and grooming activities, such as toileting, bathing, oral care, skin care, shaving if desired, dressing, and positioning in a chair. At this time, linens generally are changed and the room is organized and cleaned.

4. Afternoon care.

- Sometime after lunch, clients may be assisted with toileting and returned to bed for rest.
- Care also may include performing hand hygiene, providing oral care, repositioning, straightening linens, and providing comfort measures, such as medication for pain.

5. Hour of sleep care.

- Also known as “p.m. care.”
- Includes the same care as afternoon care; in addition, a back rub may be performed to promote relaxation.
- The television and lights should be turned off and the door closed, per the client’s preferences.

C. Bathing

1. Commonalities of nursing care for all types of bathing methods.

- Explain what is going to be done and why to meet the client’s right to know and promote motivation and participation.
- Ask the client about his or her usual routine and provide for preferences.
- Complete hand hygiene to minimize cross-contamination, and collect all equipment to avoid interrupting the bath.
- Close the door, pull the curtain, and close all windows to provide privacy and reduce heat loss via convection.
- Offer to toilet the client. Doing so addresses the urge to void that might be stimulated by bathing.
- Position a bath blanket over the client, and remove the top linen from under the bath blanket. Expose only those areas being washed, rinsed, or dried. Doing so provides privacy, comfort, and warmth.
- Encourage independence but assist the client as needed. Self-care supports self-esteem and increases circulation and range of motion.
- Use warm (105°F to 115°F), not hot, water to promote vasodilation and prevent dry skin caused by hot water, which excessively removes sebum.
- Change water when cool, soiled, or soapy. Doing so promotes vasodilation, supports comfort, and minimizes contamination.
- Make a bath mitt with a washcloth by laying a hand on the washcloth, folding one side over the hand then the other, folding the top down across the hand, and tucking it under the folded edge at the wrist. Doing so retains water and heat and prevents the ends from being tossed about, contaminating the environment.
- Wash (softens dirt and debris), rinse (removes debris and soap), and dry (removes moisture that supports microbial growth) each part of the body.
- Reposition the client in functional alignment to support comfort and reduce stress and strain on bones, joints, muscles, ligaments, and tendons.
- Implement safety measures before leaving the client’s bedside.
- Discard soiled towels and washcloths in soiled linen hamper; discard bath water into the toilet; clean the basin and return it to the client’s bedside table. Doing so maintains medical aseptic technique and prepares equipment for future use.
- Evaluate and document the client’s outcomes and tolerance of the activity. Doing so ensures that the client’s status is evaluated and information is communicated to other health-care team members.

2. Bathing methods and related nursing care.

- Complete bed bath:Involves washing, rinsing, and drying a client’s entire body; may be

performed independently or with some or total assistance from a caregiver (who addresses areas that the client cannot reach, such as the back and feet).
    - Start at the head and work down the body; moves from clean to dirty.
    - Cleanse the far side of the body first, then the near side; prevents contamination of the clean side of the body by a dripping washcloth.
    - Wash the face with plain water, beginning with the eyes from inner to outer canthus; avoid soap, which has a drying effect and can irritate the eyes, and minimizes secretions entering lacrimal duct by moving from inner to outer canthus.
    - Use a different side of the washcloth for each eye to reduce the risk of transferring microorganisms from one eye to the other.
    - Wash, rinse, and dry the face, ears, and neck.
    - Place a towel under one upper extremity and wash, rinse, and dry the arm, axillae, and hand; stroke from distal to proximal. Repeat for the other arm. Use of a towel keeps the bed dry, and stroking from distal to proximal promotes venous blood return.
    - Rest the client's hand in the washbasin if hand or nails are excessively soiled to loosen dirt.
    - Apply deodorant or antiperspirant per client preference to reduce the risk of body odor.
    - Wash, rinse, and dry the chest and then abdomen while exposing only the area being washed.
    - Clean and dry under the breasts of women or men with enlarged breasts due to obesity or gynecomastia to minimize risk of odor and skin irritation.
    - Place a towel under a lower extremity and wash, rinse, and dry, stroking from distal to proximal. Repeat for the other leg and foot.
    - Rest the client's foot in the washbasin if foot or toenails are excessively soiled to loosen dirt.
    - Change the water and provide perineal care.
    - Change the water before moving to the client's back. Doing so ensures clean, warm water and prevents contamination.
    - Turn the client on the side and place a towel on the bed along back and buttocks.
    - Wash, rinse, and dry the back and then the buttocks; moves from clean to dirty.
    - Provide a backrub if not contraindicated. Doing so increases local circulation, promotes relaxation, and supports comfort.
    - Assist the client with grooming (e.g., oral care, shaving, hair care).
    - Put a clean gown on the client, and make the bed with clean linens; remove the bath blanket from under the clean top sheet.
- Partial bed bath: Generally includes body areas that have secretions or excretions, cause an odor, are at risk for skin breakdown and infection, or need to be freshened for the day.
    - Wash the client's face, hands, axillae, back, perineal area, and under the breasts (for women and men with enlarged breasts). Doing so cleanses essential areas of the body while conserving the client's energy.
    - Follow the progression indicated in a complete bed bath to adhere to the principle of clean to dirty.
- Bath-in-a-bag:Includes a package of 8 to 10 disposable washcloths premoistened with a no-rinse surfactant, diluent substance to trap moisture (humectant), and an emollient; proven to reduce overall skin dryness, skin flaking, and scaling; preferred in critical care and long-term care settings because it is less physically stressful for clients.
    - Use a microwave or warming unit to warm washcloths to 105°F, following the

manufacturer directions.
    - Ensure that washcloths are not too hot before use to prevent unintentional burns.
    - Use one washcloth for each area of the body to follow the concept of clean to dirty, which prevents cross-contamination.
    - Do not rinse to prevent removal of the emollient.
    - Allow each area to air dry to ensure that the emollient and skin protectant remain on the skin surface.
- Blanket/towel bath:Involves placing a bath blanket, towel, and washcloth in a plastic bag and saturating them with a commercially prepared solution of disinfectant, nonrinse cleaning agent, moisturizer, and water and then warming according to manufacturer's directions; proven to provide client satisfaction and takes less time than a traditional bath; commonly a method of choice for clients with mild to moderate impaired skin integrity, activity intolerance, or cognitive impairment.
    - Follow agency procedure or manufacturer's directions for the amount of water and products to add to the bag with the bath blanket, towel, and washcloth and warm according to the directions. Doing so ensures that appropriate products and equipment are added, avoids excessive suds, and ensures that the temperature is not too warm.
    - Place a dry bath blanket over the client to provide for privacy and protect the client from drafts.
    - Replace the dry blanket with the fanfolded wet blanket. Starting at the neck, move the dry blanket down while unfolding the fan-folded wet blanket until the client is completely covered from the neck to the feet with the wet blanket.
    - Wash the client with the wet blanket, fanfolding up the wet blanket as you move and replacing it with a fan-folded dry blanket as you work. Doing so ensures that the principle of clean to dirty is maintained because different parts of the wet blanket are used for each body part and the wet blanket is folded and replaced with the dry blanket as the bath progresses.
    - Wash the face with plain water, beginning with the eyes from inner to outer canthus. This avoids soap, which has a drying effect and can irritate the eyes; minimizes secretions from entering lacrimal duct by moving from inner to outer canthus.
    - Use a different side of the washcloth for each eye to reduce the risk of transferring microorganisms from one eye to the other.
    - Wash, rinse, and dry the face, ears, and neck.
    - Don gloves to protect self from the client's blood or body fluids.
    - Turn the client on his or her side, unfold the wet bath towel over the client's back and buttocks, and wash the back and buttocks.
    - Remove gloves, wash hands, don clean gloves, reposition the client, and then provide perineal care.
- Shower and tub baths: Require a prescription because the extent of exposure to warm water causes vasodilation and requires more client effort and energy than other bathing methods; may be prescribed as therapeutic baths, such as oatmeal baths, for clients with skin conditions or hydrotherapy-type baths after a burn injury.
    - Shower: Client stands or sits on a shower chair under a continuous flow of water.
    - Tub bath: Involves immersion in a tub of water; provides more thorough washing and rinsing than other types of baths; generally requires a transfer in a chair lift or bathing stretcher to the tub.
    - Nursing care.
        - Ensure that the shower or tub is clean before and after use to prevent cross-

contamination.
- Ensure a nonskid area around the tub or shower, such as by not using a towel on the floor, to promote safety and prevent a fall.
- Hang an “in-use” sign outside the tub or shower room to support privacy.
- Explain to the client the steps in the transfer procedure to reduce anxiety and support a sense of control.
- Use a shower chair if the client has activity intolerance. Secure the client in a transfer chair or stretcher to ensure a safe transfer.
- Assist the client in entering and exiting the shower or tub. Doing so widens the base of support to help prevent a fall.
- Encourage the use of handrails and grab bars to facilitate movement and help prevent a fall.
- Ensure that the water temperature is no higher than 115°F to avoid unintentional burns.
- Stay with the client or wait on the other side of a curtain throughout the shower or bath, depending on the client’s ability to be independent and safe.
- Limit a bath to 20 minutes to prevent prolonged exposure to warm water, which can cause vasodilation and dizziness, precipitating a fall.

D. Perineal care (female and male)

1. Involves washing the area from the symphysis pubis to the anus.

2. Performed a minimum of once daily, usually as part of a complete or partial bed bath.

3. Performed as often as necessary because of incontinence of urine or feces, profuse diaphoresis, or urethral, vaginal, or rectal discharge.

4. Requires use of a firm but gentle touch to minimize stimulation.

5. Nursing care.

- Gather clean, warm water; a towel; and a washcloth to prevent having to interrupt the procedure later to gather additional equipment.
- Explain what is to be done and close the door and curtain around the client’s bed. Doing so provides information and maintains the client’s privacy.
- Don clean gloves to protect self from the client’s body fluids.
- Position the client for the procedure to access the site that requires hygiene care.
    - Female: Place the client in the supine position with the knees bent and the feet flat on the bed.
    - Male: Place the client in the supine position with the hips and knees extended.
- Drape the client for the procedure to provide for warmth, comfort, and privacy.
    - Female: Arrange a bath blanket over the client in a diamond position with one point at the head, one at the feet, and one point at each side; wrap a side point of the bath blanket around each leg and foot; then drape the point at the feet over the perineal area, where it can be lifted up and folded back (Fig. 18.3).
    - Male: Position the bath blanket above the client’s waist and the bed linens over the legs from the thighs to the feet.

- Cleanse the perineal area with soap and water using a different side of the wash cloth for each stroke and cleaning the area of the urinary meatus first and then progressing to more soiled perineal areas. Doing so prevents contamination of clean areas with a soiled part of the washcloth and adheres to the principle of clean to dirty. Soap and water removes thick, cheesy odoriferous secretion of sebaceous glands, desquamated epithelial cells, and mucus (smegma),under the loose skin at the end of the penis (foreskin, prepuce)of a male or under the labia minora and around the clitoris of the female and minimizes bacterial growth.
    - Female.
        - Spread the labia with one hand and wash the far side, near side, and then down the middle of the vulva from the urinary meatus to the anus, using a separate part of the wash cloth for each stroke (Fig. 18.4); repeat until clean.
        - Rinse the vulva using the same principles of clean to dirty.
        - Pat dry with a clean towel.
    - Male.
        - Begin with the penile head; retract the foreskin (if uncircumcised) and wash in a circular motion around the tip of the penis and glans and then working down the shaft toward the suprapubic area (Fig. 18.5); repeat until clean.
        - Rinse the penis using the same principles of clean to dirty.
        - Pat dry with a clean towel.
        - Return the foreskin to its natural position over the glans penis if the client is uncircumcised to prevent constriction of blood flow that may precipitate edema, pain, and even necrosis of the glans penis.
        - Spread the client’s legs and gently wash, rinse, and pat dry the scrotum.

- Turn the client on the side and wash, rinse, and dry the buttocks and then the anus; work from the urinary meatus toward the anus; this follows the principle of clean to dirty.
- Assess the area for skin breakdown due to contact with urine and feces.
- Clean a urinary retention catheter if present.
    - Hold the catheter with one hand close to the urinary meatus and wash with soap and water down the tubing in a circular motion away from the meatus toward the distal end of the catheter; repeat with a different area of the washcloth until clean. Doing so avoids traction on the catheter, preventing trauma to the urethra, and follows the principle of clean to dirty.
    - Rinse and dry tubing to remove moisture minimizes the growth of microorganisms.
    - Continue with the rest of the bath if perineal care is part of a complete bed bath.

E. Foot care

1. Involves cleaning the feet from the ankles to the toes.

2. Performed as part of a complete bed bath.

3. The feet should be assessed before and reassessed after care; compare assessments for symmetry.

- Bilateral dorsalis pedis pulses.
- Temperature and color of skin and toenails.

- Capillary refill.
- Movement and sensation.

4. Nursing care.

- Maintain standard precautions because of the potential to be exposed to impaired skin, particularly if the client has health problems such as peripheral vascular disease or diabetes.
- Position the client in a sitting position in bed or a chair; soak each foot for 5 to 10 minutes at a time in a basin of warm water (105°F to 115°F) that is positioned on a waterproof pad. Do not soak the feet of a client with peripheral vascular disease or diabetes. Warm water softens dirt and promotes circulation and relaxation. However, it also removes natural oils, promoting drying and cracking of the skin.
- Wash, rinse, and dry each foot gently and thoroughly, especially between the toes, and then place feet on a clean pad or towel. Doing so cleanses the skin, removes irritating soap, and prevents skin maceration. A clean surface provides a safe place on which to provide additional foot care.
- Apply lotion to the feet but avoid areas between the toes and excessive amounts of lotion. Doing so lubricates the skin, but excessive amounts can cause skin maceration, especially if applied between the toes.
- Provide a bed cradle if the client has a foot problem to raise linens off the legs and feet, relieving pressure and supporting comfort.
- Teach the client precautions to protect the feet.
    - Assess the feet daily using a mirror, visit a podiatrist routinely, and notify a primary health-care provider if a problem is identified.
    - Wear well-supporting shoes when out of bed, and ensure that linings and surfaces of shoes are smooth and intact.
    - Wear socks without seams.
    - Avoid excessively soaking the feet and dry between the toes well.
    - Have toenails cut by a podiatrist to ensure professional assessment and care.
    - Avoid self-treatment of corns, calluses, and other problems with over-the-counter remedies.

F. Oral care

1. Involves maintaining the integrity of a client’s oral mucous membranes, teeth, gums, tongue, and lips. Includes caring for dentures if present.

2. Performed as part of a partial or complete bed bath, before and after meals, and in the morning and evening.

3. Provided more frequently for clients who are on nothing-by-mouth (NPO) status, mouth breathing, receiving oxygen, or have a nasogastric tube because these situations contribute to dry mucous membranes and collection of bacteria and thick, sticky secretions on the tongue, teeth, and lips (sordes).

4. The oral mucosa, teeth, gums, and lips should be assessed for color, extent of tissue hydration (moist), and presence of lesions (absence of lesions).

5. Products based on the client's preference should be used (e.g., toothbrush, toothpaste, mouthwash, and floss).

6. Oral care for a conscious client.

- Wash hands, and then don clean gloves. Doing so minimizes microorganisms on the hands and protects the caregiver from the client's body fluids.
- Place the client in the Fowler's position to minimize the risk of aspiration.
- Place a towel under the chin and across the client's chest.
- Apply a small amount of toothpaste on a moistened toothbrush to avoid excessive foaming, and have the client brush his or her own teeth if able; if unable, complete the procedure for the client.
- Instruct the client to hold the brush at a 45-degree angle and brush the base of the teeth at the gum line with short, vibrating, circular motions; repeat for all surfaces where teeth contact gums. This dislodges plaque that adheres at the base of the tooth.
- Instruct the client to brush back and forth over biting surfaces as well as the tongue to dislodge food debris, plaque, and sordes from crevices of teeth and on the tongue.
- Instruct the client to rinse the mouth with water or mouthwash and spit (expectorate)it into an emesis basin.
- Floss the teeth by stretching the floss between the fingers and sliding the floss between two teeth down to the gum line; then move the floss with an up and down motion several times. Use a systematic progression to include all teeth. Doing so loosens and removes debris between teeth.
- Wipe the client's mouth with a towel; clean the equipment and return it to the client's bedside table.
- Remove gloves and dispose in an appropriate trash container; wash hands.

7. Oral care for an unconscious client.

- Position the client in the side-lying position with the head turned to the side to facilitate drainage of secretions and fluids used in oral care via gravity, which minimizes the risk of aspiration.
- Place a towel under the client's chin and across the pillow and mattress; position an emesis basin slightly under the client's chin.
- Wear gloves and a gown and face shield if splashing is likely to protect self from contact with the client's body fluids.
- Dip a gauze-covered tongue blade or sponge swab in half water and half mouthwash; swab the tongue, teeth, hard palate, and inside of the cheeks and the lips.Gentle friction helps to loosen debris.
- Avoid swabbing the last third of the back of the tongue to prevent stimulation of the gag reflex.
- Rinse the oral cavity using a clean, wet gauze covered tongue blade or sponge swab.
- Do not leave the client until all cleaning solution has drained from the client's mouth to prevent aspiration.
- Stop the procedure and suction the client if the client coughs or demonstrates signs of choking; do not leave the client until the client's respirations return to the client's normal rate and rhythm. Doing so minimizes aspiration of solution into breathing passages and provides for client safety.

8. Care of a client with dentures.

- Dentures should be removed and cleaned according to the client's usual routine; usually removed, cleaned, and stored when sleeping and reinserted in the beginning of the day.
- Dentures should be inspected for integrity and not be used if cracks or rough edges are present.
- The mouth, especially the gums under dentures, should be assessed for redness, irritation, lesions, or signs of infection. Ensure that dentures are not loose or tight. Seek a referral for a dental consult if there is a concern.
- Removal of dentures.
    - Encourage the client to remove the dentures or remove the dentures for the client if necessary.
    - Remove the top denture before the bottom denture to ease removal of the larger top denture.
    - With a gauze pad, grasp the upper denture with a thumb and forefinger and move the denture up and down to release suction.
    - Use your thumbs to push up gently on the bottom denture at the gum line to release suction.
    - Tilt the dentures vertically slightly when removing them from the mouth to avoid stretching the client's lips.
- e. Cleaning of dentures.
    - Transport dentures in an emesis basin or denture cup and wash them in a sink padded with a towel. Doing so minimizes risk of breaking the dentures if dropped.
    - Use denture cleaner, a soft toothbrush, and warm, not hot, water to clean dentures. Regular toothpaste and a firm toothbrush may be too abrasive. Denture material can warp or become sticky when exposed to hot water.
    - Brush gums and tongue with a soft toothbrush; assist to rinse mouth with water or dilute mouthwash.
- Storage of dentures.
    - Soak dentures overnight in a labeled (client's name and other identifying information) denture cup with dental cleanser and cool water per the client's preference. This keeps dentures clean and white and prevents warping when stored in cool water.
    - Place the denture cup in the bedside table to help prevent loss.
- Insertion of dentures.
    - Apply denture adhesive to the underside of the top denture if preferred by the client to securely seal the denture to the hard palate and upper gum.
    - Tilt the top denture at a slight angle to ease insertion and press into place with a thumb on the palate to promote adherence.
    - Repeat with the bottom denture; press gently downward into place. This securely seals the bottom denture to the bottom gum.

G. Hair care

1. Condition of hair can be a measure of physical and emotional health. See "Assessment of Hair" in this chapter.

2. The scalp perspires and secretes oils, and hair is a perfect environment for the collection of secretions and dirt.

3. Hair care should include brushing/combing daily and shampooing weekly.

Video:

4. Nursing care.

- Brushing or combing hair.
    - Place a towel over the client's shoulders.
    - Position the client in the sitting position if able or, if not, the side-lying position.
    - Brush or comb hair beginning from distal ends in small sections moving up toward the scalp every 2 to 3 inches as tangles are removed. This removes tangles and stimulates scalp circulation. Attending to small sections and lengths at a time avoids scalp trauma and pain.
    - Style hair according to client's preference; use hair clips or braid long hair per the client's preference. Avoid inappropriate styles, such as pigtails for older adults. Hair clips or braiding helps prevent matting and facilitates movement in bed when a client has long hair. Instituting client preferences supports self-esteem, dignity, and a sense of control.
    - Provide additional interventions for hair that is dry, coarse, curly, or kinky in texture.
        - Apply mineral oil or a moisturizing hair cream before combing to lubricate hair and scalp, which limits tangles and matting.
        - Use a wide-tooth comb when combing hair to minimize breakage of hair.
    - Clean the brush or comb and store it in the bedside table; fold the towel into itself and place it in a linen hamper.
- Shampooing hair.
    - Comb or brush the hair to remove tangles before shampooing.
    - Place the client in the supine position.
    - Place a waterproof pad or plastic garbage bag on the bed, position a shampoo cradle under the client's head, and place a towel around the client's neck.
    - Position a trough over the side of the bed to a collection receptacle to direct water off the bed and contain it in a collection receptacle.
    - Have the client protect the eyes by holding a towel over the eyes if able and wet the hair with warm water using a water pitcher.
    - Apply shampoo and then wash the hair, using products per the client's preference.
    - Cover hair styled in cornrows or braids with a stocking cap and shampoo through the cap. This technique cleans the hair while preserving the hair style.
    - Massage the scalp with the fingertips to stimulate scalp circulation and promote relaxation.
    - Double-rinse with warm water, and then apply a cream rinse per the client's preference. Doing so removes shampoo, which may irritate and dry the scalp, causing itching.
    - Dry hair well using a hairdryer if available.
    - Comb hair and style according to the client's preference to support self-esteem, a sense of control, and dignity.
    - Replace soiled linens with clean linens; dispose of soiled linens in a soiled linen hamper.
    - Clean equipment and return to storage areas.

H. Shaving

1. Total or partial removal of hair from the face of a man is a personal preference.

- Some men consider it an important daily grooming measure.
- Some men do not shave because it is forbidden in their culture.

2. Grooming the hair on the face involves its removal or washing, combing, and trimming a beard or mustache.

3. The face and neck should be assessed for skin lesions, eczema, or ingrown hairs because these areas should be avoided during shaving or may be a contraindication for shaving.

4. Nursing care.

- Identify the type of razor to use; when possible, defer to the client's preference.
- Use an electric shaver if the client is receiving an anticoagulant or has a low platelet count. Doing so prevents breaks in the skin that can result in excessive bleeding.
- Don gloves to protect self from the client's blood if shaving breaks the client's skin.
- Use a disposable safety razor.
    - Position a warm washcloth on the beard for a few minutes to soften and lift whiskers.
    - Spread shaving cream over the beard and mustache area liberally to reduce skin irritation.
    - Hold the skin taut and shave in the direction that hair grows (Fig. 18.7). Doing so helps maintain the 45-degree angle of a safety razor blade to the skin, thereby preventing the blade from irritating the skin or causing ingrown hairs.
        - Shave cheeks down toward the ridge of the chin.
        - Instruct the client to position the upper lip over the teeth to increase access to the skin under the nose.
        - Shave down from nose to upper lip.
        - Shave down from lower lip to chin.
        - Shave neck upward to chin.
    - Shave the ridge of the chin carefully to minimize the potential for a cut because of its contour.
    - Place the disposable razor in a sharps container to reduce the risk of injury.
    - Wash the face with a wet washcloth to remove shaving cream and debris, and then pat dry.
    - Apply aftershave lotion per the client's preference to soothe irritated skin.
- Use an electric razor.
    - Apply preshave lotion to the beard and mustache area to soften and raise whiskers.
    - Hold skin taut and shave in the direction that hair grows to prevent ingrown hairs and skin irritation. (a) Use a circular motion to shave the cheeks. (b) Shave the mustache area in a downward motion. (c) Shave the neck in an upward circular motion.
    - Apply aftershave lotion per the client's preference to soothe irritated skin.
    - Clean the razor: Remove the head, brush out debris with the small brush provided with the razor, replace the head, and return it to its storage container in the middle draw of the bedside table. Doing so minimizes growth of microorganisms and protects the razor from damage or loss.
- Care of a mustache and/or beard.

- Ask the client's permission to trim a beard or mustache and identify the extent of trimming according to the client's preference. Doing so supports the client's preference and avoids removing too much of the mustache or beard.
- Secure signed consent if the client wants a mustache or beard removed. This protects the caregiver if the client should regret the change and blame the caregiver.
- Use a scissor or razor (disposable or electric) to trim a beard.
  - Comb a mustache straight down, and trim the length just above the upper lip.
  - Trim the line of a beard so that it is clearly defined.

I. Nail care

1. Nails grow continuously and should be groomed during a complete bed bath.

2. Seek a referral for a podiatrist for care of toenails, especially for people who have diabetes or vascular occlusive disease. Doing so avoids causing a break in the skin or an ingrown toenail if toenails are clipped too short, which could precipitate an injury or foot ulcer.

3. Nursing care.

- Soak the client's hands or feet in a basin of warm water for 5 minutes to soften nails and cuticles.
- Dry hands and feet well, especially between digits to prevent skin maceration and infection.
- Use a washcloth or the flat end of an orange stick to gently push back the cuticle; use the pointed end to gently clean under the nails.
- Use an emery board to gently file nail edges if permitted by agency policy and procedure. Doing so removes sharp edges, which prevents scratches.
- Apply moisturizing lotion to the hands and feet but not between toes. Lotion makes skin soft and supple and avoiding between toes prevents skin maceration and infection.

VI. Providing Hygiene for Clients With Special Need

Nurses should provide hygiene to or assist all clients with hygiene-related activities every day and whenever needed. The challenges of these activities increase when clients have issues that interfere with understanding what is being done, are unable to participate with the activities, or have unique physical or physiological needs.

A. Clients with impaired cognition

1. May be unaware of the need for hygiene care, unable to remember how to bathe and groom oneself, or unable able to follow directions.

2. Includes unconscious clients.

3. Nursing care.

- Assess the client's ability to comprehend what is to be done and the ability to participate in care.

- Teach the benefits and risks of hygiene and grooming activities if the client is receptive to teaching.
- Administer prescribed analgesic or anxiolytics to promote relaxation.
- Postpone bathing if the client is agitated to prevent escalation of the agitation.
- Use a bath-in-bag product if available. Doing so limits the perception that interventions are threatening and is quicker to implement than a traditional bath.
- Use simple commands in short phrases, and avoid multiple or complicated directions to support understanding.
- Avoid using mouthwash to prevent it from being swallowed.
- Avoid putting hands in the client's mouth to reduce the risk of caregiver injury.
- Apply an eye lubricant and tape the eyes closed or apply an humidified eye shield as prescribed for an unconscious client or for a client who has an absent blink reflex when preparing for sleep. Eye care should be provided every 2 to 4 hours and when necessary. Doing so protects the cornea and delicate mucous membranes of the eye from becoming dry.

B. Clients with physiological impairments

1. Causes of impairments:

- Physiological problems that affect the neuromusculoskeletal system, such as immobility due to a brain attack or multiple sclerosis.
- Lack of energy due to anemia or a chronic debilitating disease, such as chronic obstructive pulmonary disease.
- Pain from surgery or disease processes that impairs ability to move.

2. Nursing care.

- Assess the client's overall strength, hand grasp strength, balance, flexibility, coordination, ability to sit unsupported, range of motion, dexterity, and activity tolerance. This assessment helps to determine which aspects of care can be implemented independently and which require assistance.
- Encourage independence but provide assistance to complete tasks the client is unable to complete; provide assistive devices, such as a padded handle on a brush, as indicated to promote independence and support self-esteem.
- Provide prescribed pain medication if indicated to reduce pain, which will enable the client to participate in the activities.
- Pace care and provide rest periods to conserve energy and prevent activity intolerance.

C. Clients with physical limitations

1. Physical limitations, such as casts; traction; nasogastric, gastrostomy, or urinary retention catheters; surgical drains; and restraints may interfere with a client's ability to provide self-care.

2. Nursing care.

- Identify the presence of equipment and how it interferes with independence. This assessment determines what activities may require adjustments to meet the client's hygiene needs without interrupting a therapeutic modality.

- Identify the number of caregivers necessary to provide required care to ensure that the safety of the client and caregivers is maintained.
- Provide specific interventions depending on the physical limitation.
    - Casts: Protect cast edges with plastic wrap to keep it from getting wet during a bath.
    - Traction.
        - Do not release weights because weights maintain the pull of traction and therefore alignment of the bone.
        - Instruct the client to sit forward to provide access to the client's back for administering care.
        - Instruct the client to use the trapeze to lift the body off the mattress to provide access to the client's buttocks for administering care.
    - Restraints: Remove only one wrist or mitt restraint at a time while providing care to prevent the client from injuring self or caregiver.

D. Clients with impaired vision

1. A visually impaired client may be challenged when managing the environment and providing for self-care safely.

2. Nursing care.

- Determine the extent of the client's visual impairment and how it impacts self-care. Assessment allows for appropriate planning of care.
- Describe the location of items in the environment, especially the bedside call bell and nurse alert cord in the bathroom, to reduce anxiety and support safety.
- Describe the location of items on the overbed table using the numbers on a clock to support independence, which promotes self-esteem.
- Remain nearby when the client is providing self-care to support safety.
- Assist with activities that the client is unable to complete.

E. Clients with impaired mental health

1. Clients with mental illness may be unaware of the need for hygiene; lack the energy to engage in hygiene activities (e.g., with depression); or not take the time to engage in hygiene activities (e.g., with bipolar disorder, manic episode).

2. A person with a mental illness may experience an altered state of reality, such as delusions or hallucinations, paranoia, inability to make decisions, or moderate or severe anxiety that interferes with the ability to provide for one's own hygiene and grooming.

3. Nursing care. a. Assess the client's feelings, mood, and behavior and how they may impact on the performance of hygiene activities. b. Administer prescribed anxiolytics before starting care to minimize the client's anxiety when indicated. c. Speak calmly using a soft tone; use unhurried, slow motions to limit the perception that actions are threatening. d. Provide a bath-in-a-bag or towel bath. Doing so minimizes stress of the procedure, is less threatening, and is quicker to use than a traditional bath. e. Postpone activities if the client is agitated to prevent escalation of the agitation. f. Avoid touching an angry, hostile, or paranoid client to provide hygiene care. Doing so prevents an escalation of the client's feelings or behavior because touching the client may be perceived as a threat.

F. Clients with body piercings

1. Body piercing is the insertion of barbells, rings, or precious stones in a setting into skin or mucous membranes.

2. Piercings can be found in such areas as around the eyebrow, external ear, nose, lip, umbilicus, tongue, and genitalia.

3. Nursing care.

- Assess the sites of piercings for clinical manifestations of inflammation or infection, such as redness, discomfort, swelling, and drainage. Assessment provides for early identification of a problem.
- Identify the way in which the client usually provides self-care; refer to the agency's procedure manual for details (generally, soap and water or alcohol is used to cleanse sites). Doing so limits microorganisms at the site of piercing, preventing infection.

NCLEX!!! Piercings have to be removed because they can interfere with magnetic resonance imaging (MRI) and surgery (e.g., a tongue barbell may interfere with the insertion of an endotracheal tube). Most piercings have at least one end that can be unscrewed to allow removal. These sites close in a few days; therefore, piercings must be reinserted as soon as possible.

G. Clients with a hearing aid

1. A hearing aid is a device that is placed in the external auditory canal; it magnifies sound to improve hearing.

2. Nursing care.

- Identify the type of hearing aid used by a client.
- Inspect for cracks, broken cords, or torn ear molds; a device should not be inserted if it is not intact.
- Remove a hearing aid.
    - Turn off the hearing aid and remove it from the client's ear.
    - Wipe the hearing aid and ear mold with a damp cloth and dry well.
    - Remove earwax that may be in the small opening in the ear piece using the cleaning instrument provided by the manufacturer. If the device has a screen or filter to block earwax, gently tap the aid against a clean cloth on a table to remove earwax.
    - Clean the external auditory canal with a washcloth wrapped around a finger; rinse and dry well.
    - Inspect the ear for any signs or symptoms of irritation, infection, sores, or drainage; notify the primary health-care provider if any are present and do not reinsert the ear mold or hearing aid until the client is assessed by the primary health-care provider.
- Store a hearing aid.
    - Remove the battery and store the hearing aid in its case, which generally is a labeled, moisture-control container. This prolongs battery life.
    - Place the case in the client's bedside drawer to protect it from moisture, damage, or loss.

- Insert a hearing aid.
    - Identify whether the hearing aid or mold is labeled right or left to ensure that the correct hearing aid or ear mold is inserted into the correct ear.
    - Check the battery by turning on the device, turning the volume to its highest capacity, and listening for a whistle. If no whistle occurs, check the battery and replace it if necessary.
    - Turn down the volume and turn off the hearing aid.
    - Insert the hearing aid into the correct ear; turn it on, and adjust the volume according to the client's preference.

VII. Bedmaking

A bed is the client's most immediate environment. The linens on the bed usually are changed daily as part of morning care or as needed if they become wet or soiled. The pillow and draw sheet should be changed daily, even if the other linens are not because they are a reservoir for microorganisms. Linens include flat sheets or fitted sheets. Flat sheets require specific techniques to secure them to the mattress and limit wrinkles and are discussed in this section.

A. Making an unoccupied bed

1. Wear gloves if the risk of exposure to blood or body fluids is present.

2. Loosen tucked-in linen and fold it into itself; carry it positioned away from the body, and place it in a soiled linen hamper. These actions contain soiled linen while avoiding contaminating the caregiver's uniform.

3. Place a clean bottom sheet on the bed and unfold it lengthwise so the center crease is along the center of the bed to ensure that enough clean linen will be available to cover the sides of the bed.

4. Avoid shaking or fluffing linens to avoid raising microorganisms into air currents unnecessarily.

5. Secure a flat sheet to the mattress.

- Line up the edge of the bottom sheet at the edge of the mattress at the foot of the bed to allow more linen to be tucked in at the head of the bed.
- Tuck the bottom sheet at the top of the bed under the mattress. This secures the sheet, making it less likely to be displaced when the head of the bed is raised.
- Make mitered corners on the bottom sheet at the head of the bed. Securing the bottom sheet helps to eliminate wrinkles, which can cause pressure injuring skin and be uncomfortable.
    - Pick up the top edge of the sheet or spread about 12 to 18 inches from the end of the bed; lift it on top of the mattress.
    - Tuck the sheet hanging below the mattress under the mattress.
    - Lift the sheet off the top of the mattress and let it hang free on the side of the bed if it is a top sheet or spread; tuck in under the mattress along the entire side of the bed if it is a bottom sheet.

6. Secure a fitted sheet to the mattress.

- Tuck the edge of the top corner of the sheet under the mattress followed by the bottom corner.
- Move to the other side of the bed and tuck the edge of the top corner of the sheet under the mattress followed by the bottom corner.

7. Spread a draw sheet across the center of the bed and secure it tightly under the mattress on both sides of the bed. A draw sheet helps secure the bottom sheet in place, protects the bottom sheet from minor soiling, and can be used to lift and turn a client. Often times a draw sheet is no longer used, particularly with fitted sheets, because it increases the risk of wrinkles that promote pressure against the client's skin.

8. Unfold the top sheet 4 inches down from the head of the bed with the center fold in the center of the bed; open up the sheet and let it hang free over the sides and bottom of the bed. This ensures that there is enough linen on each side and bottom of the bed.

9. Unfold a spread with the center fold in the center of the bed; position it 8 inches from the top of the top sheet; open up the spread and let it hang free over the sides and bottom of the bed; fold the top sheet over the top edge of the spread.

10. Tuck both the top sheet and spread under the mattress at the foot of the bed on each side of the bed. Make a mitered corner with the top sheet and blanket or spread on both sides at the bottom of the bed; do not tuck it in as with the bottom sheet, but let it hang free.

11. Make a toe pleat by raising the top linen and making a 2-inch fold down by the feet. Doing so allows for movement of the client's feet and prevents tight fitting linens from causing footdrop or pressure sores on the toes or heels.

12. Put on a pillowcase.

- Grasp the closed end of the pillowcase and turn the pillowcase inside out over the same hand holding it; with the same hand gasp the pillow in the middle of one end and slide the pillowcase down over the pillow with the other hand.
- Change the pillowcase daily or more frequently if necessary; pillowcases generally harbor the most microorganisms because of the secretions of the nose and mouth.
- Position the pillow at the head of the bed.

B. Making an occupied bed

1. Raise the side rail on the nonworking side of the bed to prevent the client from rolling off the bed.

2. Turn the client toward the nonworking side of the bed.

3. Position the pillow under the client's head to support functional alignment and prevent unnecessary strain on neck muscles.

4. Unfold a bath blanket over the client and remove the top linens from under the bath blanket. Doing so provides for privacy and supports comfort and warmth.

5. Loosen the soiled bottom linen and fanfold it toward the client, tucking it just under the legs, buttocks, back, and shoulders (Fig. 18.11).

6. Fanfold the clean linen up to just short of the edge of the soiled linen; it may be necessary to position a towel or pad between the soiled linen and clean linen (Fig. 18.12).

7. Raise the side rail and assist the client to turn to the other side of the bed; explain that it may feel like rolling over a “hump”; position the pillow under the client’s head. This informs the client about what to expect and maintains the client’s head in functional alignment.

8. Go to the other side of the bed, lower the rail and remove the soiled linen by rolling it up into itself, hold it away from the body, and dispose of it in a soiled linen hamper or laundry bag; doing so contains soiled linen and avoids contaminating the caregiver or the environment. Do not put it on the floor or a chair.

9. Pull through the clean linen from under the client and finish making the bed.

10. Assist the client to the supine position in the middle of the bed and then reposition the pillow under the client’s head.

11. Position the top sheet and spread over the bath blanket and remove the bath blanket from underneath.

12. Make the top of the bed and change the pillowcase as indicated in the procedure for an unoccupied bed.