INTRODUCTION
This chapter is intended to illustrate why maintaining the personal hygiene needs of patients is so important. General principles of assessment will be identified relating to the patient’s normal living routines, safety of the patient and the care environment. More specific assessment and nursing interventions to meet specific hygiene needs, such as ear care or oral hygiene, will be introduced throughout each chapter.

The aim of this chapter is to help the reader understand the role of general comprehensive nursing assessment in meeting personal hygiene needs.

LEARNING OUTCOMES
After reading this chapter, the reader will be able to:

- Discuss the principles of assessment for individualising patient care, including the use of assessment tools.
- Identify infection control measures which require to be assessed.
- Outline the health and safety issues which require assessment before agreeing nursing interventions.
- Discuss the importance of assessing the environment before meeting hygiene needs.
- Describe assessment measures while carrying out prescribed care.
- Discuss the role of evaluating nursing interventions and the role of documentation.
THE IMPORTANCE OF PERSONAL HYGIENE IN GENERAL PATIENT CARE

Any person who is unable to meet their own hygiene needs risks not only feeling psychologically worse but also deteriorating physically.

Historically, good patient hygiene has been seen as important for preventing the spread of disease. The skin is the first defence against disease and there is evidence that keeping the skin clean reduces the number of microorganisms, for example bacteria that can cause the spread of infection (Horton & Parker, 2002).

However, other benefits to the patient should be considered: looking and feeling clean is important for a patient’s feeling of well-being and confidence to interact socially.

When we are no longer able to initiate our own personal hygiene at a time of our choosing and in the manner we prefer, our feeling of social and psychological well-being is reduced (Switzer, 2001). For some people even the motivation to meet their hygiene needs can reduce as the process becomes more difficult. This may be for many reasons: the impact of illness, mobility difficulties, pain, psychological distress or embarrassment at requiring intimate care from a stranger.

The practice of assisting a person to meet their hygiene needs as well as helping the patient can develop the nurse–patient relationship and allows a skilled practitioner to assess how the patient is progressing physically and mentally. Any changes to the patient’s physical condition and ability or their mood can be noted and acted upon. Of equal importance is the role that meeting a person’s hygiene needs in terms of skin, hair and nail care has in promoting individualised care and dignity.

Nursing staff have a duty to meet the fundamental needs of patients under their care; however, according to the Healthcare Commission (2007), around 30% of the complaints received about hospital care relate to nurses not meeting the patients’ basic needs, such as personal hygiene or nutrition. Indeed, the Department of Health (DH; 2000) reached consensus in its document *No Secrets* that ‘acts of neglect or omission’ constitute abuse of vulnerable adults. These include ignoring physical or
medical needs, failing to provide access to appropriate healthcare services and withholding necessities. Personal hygiene, including washing and oral health, is included among these necessities. The *Essence of Care* (Department of Health, 2001) outlines the need for healthcare staff – and nurses in particular – to meet the fundamental needs of patients in care. Personal and oral hygiene are among the areas of care particularly focused on in this document.

Nursing staff, however, are not the sole healthcare professionals involved in assisting patients to maintain their hygiene needs. Box 1.1 illustrates an example of some other healthcare professionals and allied health professionals who may also be involved, as well as the patient’s family should the patient wish.

**A SYSTEMATIC APPROACH TO MEETING PATIENT NEEDS**

At any time the patients in care will be diverse in terms of age, ability, culture and physical and mental abilities; certain patient

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**Box 1.1 Other health professionals who may be involved in meeting patients’ hygiene needs**

- Specialist nurses, e.g. tissue viability nurses/continence nurses/diabetes specialists.
- Liaison nurses, e.g. mental health/child nurses/learning disability nurses.
- General medical staff/general practitioners.
- Specialist medical staff, e.g. dermatologists; orthotics and prosthetics; ear, nose and throat.
- Primary healthcare staff.
- Hospital/community pharmacists.
- Opticians.
- Audiologists.
- Podiatrists.
- Occupational therapists.
- Physiotherapists.
- Dentists.
- Dental hygienists.
- Speech and language therapists.
- Dieticians.
populations are more likely to have particular difficulty in meeting their own hygiene needs (Box 1.2).

However, an individual patient’s ability to self-care may also vary on a daily basis or even more frequently within a period of admission. For example, a patient may be independent before an operation but may take several days post-surgery to reach this level again; a patient may react badly to medication and become too confused to manage independently for some time and a patient who is undergoing a period of rehabilitation after a stroke may take several weeks to reach the level where they can self-care. Therefore, hygiene needs must be evaluated and reassessed whenever a patient’s condition improves or deteriorates (Ashurst, 2003) and the nurse must be responsive to the continual changes in the needs and concerns of each patient.

In order to treat each patient as an individual, the nursing process or systematic approach to nursing is used in the majority of healthcare situations in Britain.

Identified as the core and essence of nursing (Pope et al., 1995), the nursing process ensures that nurses employ a logical, systematic and rational approach towards care delivery. Where possible, the patient should have an active and equal role in the nursing process unless physical or emotional limitations reduce their ability to participate. Therefore, the patient is placed at the centre of the care process and, in conjunction with the patient’s continu-
ous input regarding their condition, the nurse will use a problem-solving approach in order to meet the needs of the patient.

The nursing process comprises five components, or stages, which are followed in order. The process is also cyclical, that is using the process requires the nurse to assess, follow the stages and reassess throughout the patient’s care episode. Table 1.1 illustrates the components and the activities carried out under these headings (Holland, 2008; Kozier et al., 2008).

Using the nursing process ensures patient-centred care of a high quality and that clinically effective care is carried out. The cornerstone of the nursing process is nursing assessment where the patient’s own particular care needs are identified (Hamilton & Price, 2007).

Table 1.1 Components of the nursing process and associated nursing activities

<table>
<thead>
<tr>
<th>Nursing process components</th>
<th>Nursing process activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment stage</td>
<td>• Collect and organise data (information) from and about the patient</td>
</tr>
<tr>
<td></td>
<td>• Validate (check) data</td>
</tr>
<tr>
<td></td>
<td>• Document data (in care records)</td>
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<tr>
<td>Nursing diagnosis stage</td>
<td>• Analyse data</td>
</tr>
<tr>
<td></td>
<td>• Identify problems</td>
</tr>
<tr>
<td></td>
<td>• Identify patient’s strengths and weaknesses</td>
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<td></td>
<td>• Devise statements which reflect the problem</td>
</tr>
<tr>
<td></td>
<td>• Document problem statements</td>
</tr>
<tr>
<td>Planning stage</td>
<td>• Prioritise patient’s problems</td>
</tr>
<tr>
<td></td>
<td>• Decide goals and expected care outcomes with the patient</td>
</tr>
<tr>
<td></td>
<td>• Identify the interventions required to meet goals</td>
</tr>
<tr>
<td></td>
<td>• Formulate the patient care plan</td>
</tr>
<tr>
<td>Implementation/ intervention stage</td>
<td>• Implement the interventions</td>
</tr>
<tr>
<td></td>
<td>• Assist the patient towards self-care if possible</td>
</tr>
<tr>
<td></td>
<td>• Document nursing/patient activity</td>
</tr>
<tr>
<td>Evaluation/ reassessment stage</td>
<td>• Review the patient’s progress in relation to meeting goals</td>
</tr>
<tr>
<td></td>
<td>• Collect and review data</td>
</tr>
<tr>
<td></td>
<td>• Reassess the patient and modify care plan if needs are not met</td>
</tr>
</tbody>
</table>
Nursing assessment

The purpose of nursing assessment is to collect and process data (information) about the patient in order to develop a clear picture about the patient and his/her needs. Assessment therefore has to be ‘holistic’ in that all aspects of the patient’s life are assessed and not only the physical aspects of their condition (Table 1.2). The components of holistic assessment are discussed in more detail later in this chapter.

Table 1.2 Components and examples of holistic assessment

<table>
<thead>
<tr>
<th>Components of holistic assessment</th>
<th>Examples of assessment questions relating to personal hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical: the patient’s ability to self-care; the effect of the disease process on the body/organs</td>
<td>Is the patient physically able to manage their own hygiene needs? What interventions will be required by the nurse? Does the patient have any allergies, e.g. to soap? Does the patient require any prescribed preparations, e.g. bath additives, medicated shampoo, skin preparations?</td>
</tr>
<tr>
<td>Psychological: the patient’s mental state; the effects of any disease process; the effect of illness/admission on the patient’s mental health.</td>
<td>Does the patient have any mental health condition which will interfere with their understanding of carrying out hygiene needs safely? Does the patient have any anxieties or fears about aspects of personal hygiene? Does the patient recognise the need to maintain personal hygiene?</td>
</tr>
<tr>
<td>Sociological</td>
<td>Are there any factors which may hinder a patient’s ability to meet their hygiene needs? Do the patient’s home circumstances affect their ability to self-care?</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Does the patient have any religious beliefs that must be taken into account when meeting hygiene needs? Are there any factors relating to hygiene which may affect the patient’s well-being and/or relationships?</td>
</tr>
<tr>
<td>Cultural</td>
<td>Does the patient hold specific beliefs about meeting hygiene needs that must be taken account of? Does the patient express a preference for same-sex nursing care?</td>
</tr>
</tbody>
</table>
Data can be objective, that is measured (e.g. temperature or urine output) or seen/felt/smelled (e.g. the nurse may smell that a patient has been unable to meet their own hygiene needs) or subjective, that is what the patient feels (e.g. pain or fear of falling while having a shower).

Assessment on admission or at the beginning of a care episode helps the nurse to establish a baseline of the patient’s condition. Having a clear baseline allows the nurse to measure any subsequent improvement or deterioration in the patient’s condition. For example, assessing a patient’s ability to wash at the first opportunity allows the nurse to decide at a later date whether the patient’s ability is improving.

Assessment at the initial stage of admission to care is also vital to identify any risk to the patient, other patients in the clinical area or healthcare staff. For example, patient allergies can be determined and the level of mobility and mobility aids used can be assessed, as can the risks of infection and pressure sores.

Data can be sourced from many people. The patient is the most direct source of data; however, not all patients will be able to supply the information required to safely proceed with nursing care. The patient may be too young to understand/answer questions or may be too ill to respond. In these types of circumstances, secondary sources of information should be explored. These may be the relatives or carers of the patient, other healthcare professionals known to the patient (e.g. the general practitioner or community nurse) or staff from other hospital departments (e.g. the admissions department). Documentation can be useful in relaying information about a patient (e.g. nursing care plan, doctor’s referral letter or transfer letter from a different care setting). Interaction with the patient also provides a clear opportunity for nursing assessment using a range of nursing skills (Box 1.3).

The data gathered about the patient should be documented in the patient’s care plan as evidence of the decision-making process and to inform other members of the healthcare team.
Box 1.3 Nursing skills required for nursing assessment

- Utilising the five senses: sight, touch, hearing, smell and (to a lesser extent) taste.
- Communication skills: to establish a relationship with the patient and to access as much information as possible and to assist the patient through the nursing process as an active partner.
- Observation skills: to determine aspects of what the patient may not feel able/be able to tell you.
- Measurement skills: to enable the nurse to use screening and risk assessment tools effectively; to evaluate the effects of care.
- Clinical skills: to enable the nurse to be able to carry out the assessment process safely and accurately.
- Critical thinking skills: to enable the nurse to make sense of the data and to be able to prioritise care requirements.
- The skills to apply theory to clinical care. This enables the nurse to use their knowledge in establishing reasons for care needs and to educate the patient.

Scenario 1.1

Mrs Jones, an 82-year-old female patient, has been admitted as an emergency to your clinical area after being found by a neighbour after a fall at home. She has no relatives or other carers accompanying her and there is little written information available. She has told you during the initial assessment interview that she has no problems with mobility, washing and eating. You are unsure as to whether she has been able to provide you with a full picture of how she has been coping. You are walking with her to the area in your ward where the weighing scales are kept.

Think about how you can use the nursing skills required for assessment to establish more information for her baseline assessment during the walk to the weighing scales.

Suggestions for Scenario 1.1

While walking with the patient you can use:

- Observation skills: assess Mrs Jones' mobility
  - Is she steady on her feet?
  - How quickly can she manage to walk?
  - Does she appear to be in pain?
  - Can she use her mobility aid correctly (if used)?
  - Would she benefit from a physiotherapy referral?
• Observation skills: assess Mrs Jones’ teeth and speech
  ◦ Can she speak clearly?
  ◦ Do her teeth appear to be clean?
  ◦ Does she have dentures?
  ◦ Do they appear to be a good fit?
• Observation/sight/touch/smell: assess Mrs Jones’ skin
  ◦ Does her skin appear thin and/or dry?
  ◦ Could she be dehydrated?
  ◦ Does her skin feel dry or papery to the touch?
  ◦ Does her skin look clean?
  ◦ Are there any signs of injury or skin conditions?
• Communication skills
  ◦ Can she maintain a conversation?
  ◦ Does her sight appear to be normal?
  ◦ Is her hearing normal?
  ◦ Does the patient appear to understand your conversation?
• Observations skills: assessing Mrs Jones’ nutrition
  ◦ Do her clothes appear loose?
  ◦ Does she appear to be lighter/smaller than her weight?
• Observation skills/sight/smell: assessing Mrs Jones’ hygiene
  ◦ Are her clothes clean?
  ◦ Does her hair look washed and care for?
  ◦ Are her nails clean?
  ◦ Does she smell fresh?
  ◦ Is there any evidence of elimination problems?

These observations allow the nurse to use critical thinking skills and theoretical knowledge to pursue any discrepancies with the patient. Gentle questioning and good communication skills can allow the nurse to explore these with the patient and to find out why the patient may be reluctant to disclose problems to the nurse.

**Screening as part of assessment**
The terms ‘screening’ and ‘assessment’ have become so confused as to be used interchangeably, but in fact they are two discrete nursing approaches (Mousley, 2006). Screening could be defined as a ‘public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by, a disease or its complications, are asked a question or offered a test to identify those individuals who are more likely to be helped than harmed by further tests or
treatment to reduce the risk of disease or its complications’ (National Screening Committee, 2006). Assessment, on the other hand, provides an in-depth approach to establish a diagnosis and to identify management or treatment strategies. For example, a patient may have an oral health screening which may establish the presence of oral disease – perhaps plaque or painful gums – and assessment will establish whether this is a physical, psychological or social problem and nursing care can be established with the patient to treat or alleviate the problem(s).

**Nursing diagnosis**

The nursing diagnosis is made after the assessment stage on considering the patient’s physical, psychological, spiritual or sociocultural reaction to their disease process or medical condition. The nursing process involves dealing with all aspects of a patient’s care, including but beyond their original diagnosis. For example, a doctor may diagnose a patient with a chest infection and it will be up to the nurse to (know to) help the patient wash because the patient is too breathless to wash themselves. This is a new component of the nursing process.

This diagnosis of patient’s problems then allows the nurse and the patient to prioritise the problems, which may be **actual** or **potential**.

Actual problems are those that exist at the time of assessment, for example breathlessness due to a chest infection. Potential problems are those that are at risk of developing if nursing interventions are either not implemented or are ineffective. For example, breathlessness may reduce the patient’s ability to wash or remain continent, which in turn can lead to pressure sores. Therefore, although pressure sores are not present on admission, they may develop if nursing interventions are not put in place, or if the interventions are not effective.

An inability to meet personal hygiene needs may be an actual problem, but this inability can lead to several potential problems for the patient. If, for example, toenails are not cared for, the patient’s mobility may be reduced; if dentures are ill-fitting, the patient may develop abrasions of the gums and reduce their
nutritional intake. Both scenarios will in turn lead to an increased risk of pressure sores.

**Planning stage**
The nursing role is to prevent potential problems occurring and to solve or alleviate patients’ actual problems. Once the patient’s actual and potential problems have been identified, explained and discussed with the patient, the planning stage can commence. Planning involves discussing and identifying with the patient how these problems can be addressed in order to achieve the desired (by both the patient and nursing staff) outcome of nursing care. This involves establishing realistic goals (written statements of outcomes) which nursing interventions can help the patient achieve. Determining timescales for achievement of the goals is also important. For example, a patient may require education and help to achieve independence in meeting oral hygiene needs after a stroke. This may not be achievable in three days but may be achievable in two weeks. Often a series of small/short-term goals are required in order to achieve a longer-term overall goal. The plan of care is written to identify the nursing interventions, patient input and length of time required to achieve these goals. This care plan may be unidisciplinary (i.e. a nursing care plan only) or multi-disciplinary (i.e. whereby all healthcare professionals contribute to the patient’s plan of care).

**Implementation stage**
The implementation stage centres on carrying out the interventions identified in the care plan and monitoring the patient’s reaction to them. This stage should support the medical input as well as the input of other professionals, for example the occupational therapist or the dietician. The core aspect of nursing interventions at this stage is to achieve the agreed goals and outcomes while alleviating illness and promoting health and, where possible, optimum independence.

Part of the nurse’s role during this stage is to act as an educator and teach the patient. This may be about how to learn new ways
of achieving hygiene after illness or trauma or to explain why aspects of maintaining hygiene may be important to the patient’s overall health. For example, the patient may not realise the links between ill-fitting or broken dentures, poor nutritional status and delayed wound healing.

Therefore, for a nurse to be able to carry out interventions effectively with the patient’s knowledge and cooperation, knowledge of theory and clinical procedures is vital.

**Evaluation**

Sometimes described as the final part of the nursing process, evaluation of the effectiveness of the implementation stage (and nursing interventions) allows the nurse and patient to monitor and judge whether the goals and outcomes have been achieved. However, the systematic approach is a continuous process and evaluation is a constant aspect of nursing care. Depending on the care situation and the health status of the patient, some care interventions will need to be evaluated on an hourly, and sometimes daily, weekly or even monthly, basis.

Patients in a high-dependency ward or intensive care may require their condition to be monitored hourly; patients in a residential home specialising in caring for older people may need some aspects of care, for example pain control, continuously monitored and oral health care monitored weekly or monthly.

Methods of evaluation are similar and use the same tools as initial assessment. The new data collection allows the nurse to identify if there are changes in the patient’s condition and to determine whether the nursing care has been effective or whether the assessment phase must be repeated. Non-achievement of goals may be due to a variety of influences; the patient’s overall physical condition may have deteriorated, for example through acquiring an infection; the data collected may not have provided all the information required; the interventions chosen to meet the goals may not have been the correct choice; or the goals may have been too ambitious and therefore unachievable.
The nurse will then have to reassess the patient and, using the data collected, proceed through the nursing process, changing the goals and/or nursing interventions if necessary.

**Care planning**
Nursing care plans are identified as essential in the delivery of modern nursing care (Björvell *et al.*, 2003), their purpose being a reflection of the patient’s needs and wishes and a rationale for nursing interventions. Therefore, patient records should include transparent documentation which is completed in a manner that provides a basis not only for assessment and interventions but also for continuous evaluation and reassessment both of the patient’s condition and the nursing interventions. Björvell *et al.* stress the role of nursing documentation in communication between colleagues and the patient and identify that individualised care plans strengthen the potential for patient participation in the decision-making process.

Owing to the diversity of patients and their conditions, it is unlikely that hygiene needs remain static. The patient may be recovering from illness and so becoming more independent or a crisis in health can result in dependency increasing, and so required interventions will naturally change. Ongoing reassessment of the patient’s ability and needs is vital at least on a daily basis. Evaluation of care delivered in terms of the relationship of hygiene measures to other areas of care is also imperative, for example poor hygiene care may exacerbate skin problems and untreated urinary incontinence may increase the need for hygiene care.

**ROPER, LOGAN AND TIERNEY MODEL FOR NURSING**
The cyclical nature of the nursing process is demonstrated through the above descriptions of the stages. Using a framework for the nursing process guides the nurse. Using the Roper, Logan and Tierney (RLT) model for nursing contributes towards individualising patient care.
The current RLT model revised in 1996 (Roper et al., 1996) is based on a model for living (Tomey, 1998). The main concepts of the model are that people are engaged in a process of living from conception until death and that, in order to live, ‘activities of living’ (ALs) must be carried out. The ability to manage these activities changes – possibly several times and to different degrees – throughout the lifespan. The model incorporates five concepts (Roper et al., 1996; Holland, 2008). The five concepts are:

1. The 12 activities of living
2. The influence of lifespan (age)
3. The influence of the dependence–independence continuum
4. Factors influencing ALs
5. Individuality in nursing (normal living).

**The 12 activities of living** (Box 1.4)

- Represent the activities engaged in by all individuals whether sick or well.
- Are often seen as the main focus of the model but self-care abilities are influenced by the other four factors.
- The choice of ALs is influenced by Maslow’s (1987) Hierarchy of Needs.

**Box 1.4 Roper, Logan and Tierney’s activities of living (ALs)**

1. Maintaining a safe environment.
2. Breathing.
3. Communicating.
4. Mobilising.
5. Eating and drinking.
7. Personal cleansing and dressing.
8. Maintaining body temperature.
10. Sleeping.
11. Expressing sexuality.
12. Dying.
The influence of lifespan (age)

- Described by the stages of prenatal, infancy (0–23 months), childhood (2–12 years), adolescence (13–19 years), adulthood (20–64 years), older age (65+ years).
- Each stage is characterised by physical, intellectual, emotional and social developments.

The influence of the dependence–independence continuum

- Represented by a straight line.
- People move in either direction, depending on their circumstances.
- The goal of nursing is to enable the patient to acquire optimal (best) functioning in each activity (not necessarily independence, as this may not be a realistic goal).
- Assessment is needed to identify what the patient could/could not do before and what were their previous coping strategies.

Factors influencing ALs

- Physical.
- Psychological.
- Sociocultural.
- Environmental.
- Politico-economic.

Individuality in nursing (normal living)

- How the person carries out the AL.
- How often is the AL carried out?
- Where is the AL carried out?
- Why is the AL required?
- What is known about the AL?
- What are the patient’s beliefs about and attitudes towards the AL?
The RLT model has been criticised on the grounds that the concept of holistic nursing is not clearly defined in comparison to other nursing models. Nurses in particular are accused of not properly integrating the influencing factors but focusing instead on the care of the physical factors affecting these activities. Roper et al. (1996) argue that each AL is not as simple and straightforward as it looks; although some ALs have a biological basis to them, for example maintaining body temperature, others, such as those relating to personal dress, cleanliness, sexuality and the nature of work and play, have clear sociocultural influences.

**Scenario 1.2**

Ali is a 52-year-old gentleman who was admitted to the ward after being diagnosed as having had a stroke.

He has a right-sided weakness (hemiparesis) and has some problems with speaking, although he can understand what is being said. His wife visits daily, but they are both having difficulty coming to terms with what has happened to Ali.

On admission, Ali was assessed as having difficulty with balance, eating, washing and continence.

Using what you know about the nursing process and RLT model for nursing, think about how you would go about helping Ali and his wife to identify short-term goals to improve his condition. Consider whether you could involve other allied health professionals.

**Suggestions for Scenario 1.2**

You could carry out assessments of how dependent/independent Ali is in managing the skills. You may also decide to refer to allied health professionals – the physiotherapist, the speech and language therapist, the dietician and the occupational therapist – for specialist assessments. You may decide to use a nutrition screening tool for Ali and explain how it can monitor his progress.

You could discuss with Ali and his wife if he prefers what he thinks are the most important priorities to be addressed. You could use your theoretical knowledge to help Ali and his wife to understand why he has these problems and you could explain to Ali and his wife the potential problems that may occur if his current problems are not addressed.

You could explain the options for short-term goals, the skills involved and how Ali can contribute to his own care.
None of the ALs is independent. Problems in managing one AL will almost certainly affect at least one other AL. Nursing assessment requires the nurse to have the theoretical knowledge to be aware of the interlinking of each AL. Areas for general assessment of ALs relating to personal cleansing and dressing are noted below. Later chapters will identify any specific assessments that should be carried out in addition to the general assessment.

**Maintaining a safe environment**

- Is the patient able to understand risks and dangers?
- Does the patient pose any risks to other patients (e.g. the presence of infection)?
- Is the patient immunosuppressed?
- Is the patient pain free?
- Does the patient need a pain assessment?
- Is the patient’s skin intact?
- What is the patient’s pressure sore risk?
- What environmental factors in the clinical area or the home pose a risk to the patient?
- Does the patient have any allergies to prescribed treatments or medications?

**Breathing**

- Does the patient have an illness that affects breathing?
- What is the patient’s rate of respiration?
- Is the patient breathless on exertion?
- Is the patient receiving oxygen therapy?
- Does the patient’s breathing adversely affect their ability to self-care?
- Do breathing difficulties render the patient too anxious to meet hygiene needs?

**Communicating**

- Is the patient physically able to communicate their needs?
- Is the patient cognitively able to communicate their needs?
• What other influences may be preventing the patient from communicating their needs?
• Does the patient have problems with vision?
• Does the patient have problems with hearing?
• Can the patient understand what is being communicated?
• If not, what problems are influencing the patient’s ability to communicate?

**Mobilising**

• Is the patient fully mobile?
• What physical problems does the patient have with mobility?
• Has admission to care affected mobility?
• What may be the cause of these problems?
• Does the patient have any psychological problems that may affect their mobility?
• Does the patient need a falls risk assessment?
• Are there any environmental problems that may contribute to mobility problems for the patient?

**Eating and drinking**

• What is the patient’s nutritional risk?
• Are there any patient problems with eating and drinking that are affected by poor oral health?
• Are there any eating and drinking problems that will adversely affect the patient’s personal cleansing/oral hygiene, e.g. is the patient nil by mouth?

**Eliminating**

• Does the patient have elimination problems, e.g. infection?
• Is the patient continent of urine?
• Is the patient continent of faeces?
• Does the patient use urinary continence aids?
• Does the patient use aids to faecal continence?
• What elimination problems will affect the patient’s personal cleansing?

**Maintaining body temperature**

• What is the patient’s temperature?
• Is the patient prone to feeling the cold?
• Is the patient pyrexial (have a high temperature)?
• Is the room a comfortable temperature?
• Is the patient able to adjust their clothing if they become too warm or too cold?

**Working and playing**

• Does any aspect of the patient’s occupation pose a risk to maintaining personal hygiene, e.g. skin conditions?
• Do any of the patient’s lifestyle choices impact on the patient’s personal hygiene?

**Sleeping**

• Does the patient require any hygiene interventions overnight, which may disrupt sleep?
• Are there any personal hygiene problems which currently or may disrupt sleep?
• Does the patient require a special bed/mattress/linen?
• Does the process of carrying out personal hygiene interventions independently exhaust the patient?

**Expressing sexuality**

• What hygiene activities does the patient view as important in expressing their gender?
• What problems relating to personal hygiene may be causing difficulty with intimacy?
• What personal hygiene factors may impinge on the patient’s ability to form relationships?
• Are there any hygiene problems that the patient perceives as preventing them from having an active sex life?
Dying

- What hygiene interventions are needed to improve the patient’s comfort?
- What hygiene interventions may cause the patient discomfort?
- Does the patient require additional pain relief before any hygiene interventions?
- Do the relatives wish to participate in hygiene care?
- Are there any cultural/religious requirements relating to dying and personal hygiene?

THE CARE ENVIRONMENT IN RELATION TO PERSONAL CLEANSING

Maintaining a safe environment

In a follow-up to *Essence of Care* (Department of Health, 2001), the DH (2007) developed a further set of benchmarks to encourage best practice in achieving an optimum environment for care to be carried out in any care setting. The entire document has two main focuses. One area of attention relates to personalising the environment to suit patients’ ages, culture, gender and allowing best access to individuals with varying abilities. The other main focus is on the safety of the care environment, with three factors against which local practice can be benchmarked (Table 1.3).

Aside from these benchmarking statements, to ensure the care environment is safe there are other general areas of assessment which are common to all patients, these are:

- Infection control.
- Moving and handling.
- Health and safety.
- Prescribed care.

Assessing infection control risks (patient)

One in 10 patients will develop a hospital-acquired infection (HAI). The costs of HAI are high to the patient through increased length of stay, increased fear and increased risk of death for some
Table 1.3 *Essence of Care* factors for the care environment

<table>
<thead>
<tr>
<th>Factor No.</th>
<th>Factor title</th>
<th>Benchmark of best practice</th>
<th>Examples provided (relating to personal hygiene)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Well-maintained environment</td>
<td>People experience care in a tidy and well-maintained environment</td>
<td>There is no litter and bins are readily available</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The area is the appropriate temperature</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Toilet, bathroom and shower areas are free from clutter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There is sufficient storage for patients’ belongings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Linen and laundry segregation; storage and disposal are well managed and appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Repairs are carried out promptly</td>
</tr>
<tr>
<td>4</td>
<td>Clean environment</td>
<td>People experience care in a consistently clean environment</td>
<td>Cleaning arrangements are flexible to meet the needs of the patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Regular routines for cleaning and managing of waste are in place that meet the national standard</td>
</tr>
<tr>
<td>5</td>
<td>Infection control precautions</td>
<td></td>
<td>Patients are informed why specific infection control measures are taken</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Staff wear personal protective equipment (PPE) as appropriate, changing between dirty and clean tasks and each episode of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Systems are in place to replace mattresses, mattress covers, baby changing mats, exercise mats, exercise mattresses, cushions, commodes and curtains, as appropriate</td>
</tr>
</tbody>
</table>

(Source: Department of Health, 2007)
patients and to the NHS through longer admissions, longer waiting lists, increased care costs and resource use.

Any general assessment of infection control risks for every aspect of personal hygiene includes the patient’s current infection control status: does the patient have a current infection? Has the patient got a history of contracting infection(s)? Is the patient at particular risk of contracting infection? If the patient has an HAI, it is expected that healthcare staff follow a structured process in order to identify the root cause of how the infection was passed on to the patient and to learn from the process in order to prevent further spread (National Patient Safety Agency, 2007). Particular illnesses and infections which require monitoring and action to prevent the risk of spreading include (NHS Scotland, 2005):

- *Clostridium difficile*.
- Diarrhoea and vomiting or gastro-enteric infections.
- Influenza.
- MRSA (methicillin-resistant *Staphylococcus aureus*).
- Scabies and lice.
- Shingles (varicella zoster virus).
- Tuberculosis.

Poor infection control measures while carrying out hygiene procedures – in particular bathing, showering and oral hygiene – increase the risk of cross infection. Patients who will require particular assessment for both the presence of infection and the risk of infection include:

- Infants and people over 65 years.
- Patients with wounds of any kind, e.g. pressure sores or trauma.
- Patients admitted for surgery, i.e. pre- and post-operative patients.
- Patients who are immunosuppressed (have a lowered resistance to disease) through illness or medical treatment.
- Patients who undergo radiotherapy or chemotherapy.
- Patients who undergo invasive treatment (treatment that involves inserting medical equipment into the body which
may instigate an inflammatory response), e.g. intravenous infusions, urinary catheters, parenteral feeding tubes, wound drains.

Nursing staff will be required to assess what PPE is appropriate and when it must be used. It is important throughout this book to take note of whether procedures are clean or sterile/aseptic, as how and when gloves are worn will vary. Wearing a plastic apron means that the contact surface of the nurse’s uniform is non-penetrable by water, blood or body fluids. This reduces the risk of transferring infection from patient to patient, patient to nurse or within different areas of the clinical environment (Dougherty & Lister, 2008).

The assessment of the patient will determine whether a patient is suitable for a bath or shower, or whether bed bathing would be the best option from a risk assessment perspective.

Assessing infection control risks (environment)
The thorough cleaning of bathrooms, shower rooms, toilets and all equipment used is vital to prevent cross-infection. Local policy should be used for general hygiene measures with specialist interventions used for patients who have known infections such as MRSA or Clostridium difficile.

To prevent cross-infection items such as toiletries, towel bales and specialist equipment (e.g. moving and handling equipment) should not be stored in bathrooms or toilet areas. Equally, all patients’ personal toiletries and equipment should be used exclusively by the patient; disposable equipment should be used where possible, for example wipes. Single-use equipment should indeed only be used once before being sent for sterilisation.

Cleaning and effective decontamination and sterilisation (Table 1.4) of all reusable equipment such as dental examination equipment, hoists, baths and showers is integral to protecting the patient (NHS Executive, 2000). Each item should be cleaned on the basis of risk assessment for each patient who has used or will use the equipment.
Table 1.4 Cleaning, decontamination and sterilisation assessment of reusable equipment

<table>
<thead>
<tr>
<th>Patient situation</th>
<th>Infection control measure</th>
<th>Level of infection risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment used for non-infected people with healthy, intact skin</td>
<td>Cleaning as per local policy</td>
<td>Low</td>
</tr>
<tr>
<td>Equipment which has had contact with bodily fluids</td>
<td>Decontamination as per local policy</td>
<td>Medium</td>
</tr>
<tr>
<td>After use with infected patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before use with patients vulnerable to infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment to be used with mucous membranes</td>
<td>Sterilisation</td>
<td>High</td>
</tr>
<tr>
<td>Items to be introduced with broken skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Damani, 1997)

Assessing moving and handling risks
Possibly up to 120 million days are lost from work through back injury (Health and Safety Executive, 2000). Many nurses in the past have admitted not using moving and handling equipment, even when it has been available (McGuire et al., 1997) and nearly as many nurses have complained that what equipment is available is either not suitable or not in good working order (Moody et al., 1996).

The bath/shower room is an area where patient and nurse safety may be compromised in many ways. Before planning how to best meet a person’s hygiene needs a comprehensive moving and handling assessment must be carried out.

Often bath/shower rooms are small, restricting movement particularly if moving and handling equipment is required. In these circumstances healthcare staff, just as much as patients, are at risk of injury. Bath/shower rooms must be equipped with grab rails and handles that have been placed strategically where the patient can use them to facilitate safe standing/transferring. These may be wall-mounted, fixed to the floor or may be integral to the bath or shower. Occasionally, these aids can actually make mobility
more difficult, for example floor-to-ceiling poles can stop equipment being taken right up to the bath or shower. It should be remembered that not all aids will be suitable for all people in all circumstances and that individual assessment remains vital (Swann, 2005).

Bath and shower seats are available for assisting patients to balance while washing. There are several variations; some may be discrete units which can be used for either the bath or the shower, some attach to the bath when needed and are equipped with harnesses for safety; others have inbuilt transfer systems. It should be remembered that people may have just as much difficulty getting out of the bath as getting in and this process can put severe strain on carers’ musculoskeletal systems.

Assessment involves considering risks relating to equipment, processes and activities (e.g. using a patient hoist) that may cause harm (Rinds, 2007).

Core equipment identified for moving and handling should be available in every clinical setting (Table 1.5). Community-based patients should have had an assessment that identifies which equipment can be made available for use to assist the patient, carers and healthcare staff in the home. Equipment to assist moving and handling usually falls under one of three categories (Nazarko, 2005):

- Equipment to aid independence: for patients who have slightly reduced mobility but can weight bear and have both upper- and lower-body strength, e.g. grab rails.
- Equipment to assist with moving: requires nursing/carer intervention but patient retains some upper- and/or lower-body strength, e.g. standing hoist, turntable.
- Equipment to move the full weight of the person: requires at least two nurses as patient has very little or no upper/lower-body strength, e.g. tracking hoist.

Patients with special needs, for example those who are very overweight, may need specially ordered equipment (Rush, 2004). Specific assessment should also be carried out relating to any equipment used with the patient:
### Table 1.5 Core moving and handling equipment required to carry out personal hygiene interventions

<table>
<thead>
<tr>
<th>Type</th>
<th>Intervention</th>
<th>Rationale for use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electric profiling beds</td>
<td>Bed bathing</td>
<td>Increases independence: patient can rise and change position using electronic buttons</td>
</tr>
<tr>
<td></td>
<td>Transferring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ear, eye, nail and hair care; oral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hygiene practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increases independence: patient can rise and change position using electronic buttons</td>
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<tr>
<td></td>
<td>Reduces the load on the patient’s sacrum</td>
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<tr>
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<tr>
<td></td>
<td>The patient can vary the bed height independently; ease of transfer</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Reduces the risk of back injury for carers</td>
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<tr>
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<tr>
<td></td>
<td>Modern beds can turn the patient in bed</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>NB:</strong> Mattresses may not always be compatible with standard moving and handling equipment</td>
<td></td>
</tr>
<tr>
<td>Glide sheets/slide sheets</td>
<td>Bed bathing</td>
<td>Made of low-friction, lightweight materials which allows multidirectional glide</td>
</tr>
<tr>
<td></td>
<td>Transferring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sitting up in bed</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td>Reduces shearing force</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduces friction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>NB:</strong> Cannot be used on a dynamic mattress unless the mattress is static</td>
<td></td>
</tr>
<tr>
<td>Manual transferring turntable</td>
<td>Transfers only – patient <strong>must</strong> be able to weight bear</td>
<td>Allows transfer from seating or lying equipment</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Can be used for patients who can stand but have difficulty walking/moving their lower limbs</td>
<td></td>
</tr>
<tr>
<td>Shower chair</td>
<td>Showering</td>
<td>Allows dignified transfer of patients</td>
</tr>
<tr>
<td>Transfer chair</td>
<td>Accessing bath/shower room</td>
<td>(unlike wheelchairs the plastic is easily cleaned to prevent cross-infection)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NB:</strong> These chairs should always be used instead of transferring using a commode (preserves dignity and privacy)</td>
</tr>
<tr>
<td>Mechanical standing hoists</td>
<td>Transferring from:</td>
<td>Allows patient to achieve a standing position while the upper body is supported by a sling</td>
</tr>
<tr>
<td></td>
<td>• bed to chair (and back)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• bed to commode or shower chair (and back)</td>
<td>Used for sit-to-stand and stand-to-sit transfers</td>
</tr>
<tr>
<td></td>
<td>• chair to toilet (and back)</td>
<td>Allows the patient to have genitals and buttocks washed after using the toilet</td>
</tr>
<tr>
<td></td>
<td>• chair to seating (and back)</td>
<td><strong>NB:</strong> The patient must be able and willing to cooperate or they may fall through the sling onto the floor.</td>
</tr>
</tbody>
</table>
### Table 1.5 Continued

<table>
<thead>
<tr>
<th>Type</th>
<th>Intervention</th>
<th>Rationale for use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient hoists</strong>&lt;br&gt;(full body sling hoists)</td>
<td>Facilitates any type of movement (raises patient from the bed; transfers patient)&lt;br&gt;Bed making&lt;br&gt;Transfer to shower chair&lt;br&gt;Transfer to patient transfer chair</td>
<td>Used for patients who have little or no independent mobility&lt;br&gt;Some are designed for use with immersion baths&lt;br&gt;Some have weighing scales attached for monitoring the patient’s weight&lt;br&gt;<strong>NB:</strong> Patient must be able cooperate and understand the procedure; otherwise, their limbs may slip through the slings</td>
</tr>
<tr>
<td><strong>Bath hoists</strong></td>
<td>Allows patients to be transferred from transfer chair; raised on the hoist and lowered into an immersion bath</td>
<td>Movable arms allows the patient to access the hoist easily, e.g. using standing aid or turntable&lt;br&gt;Used for patients who have sitting balance but poor lower-body strength&lt;br&gt;<strong>NB:</strong> Does not have a smooth turning circle and cannot be used outwith the bathroom area&lt;br&gt;Slings can be damaged by repeated water submersion and must be checked frequently for damage and weakness of the structure</td>
</tr>
<tr>
<td><strong>Reclining/rising chairs</strong></td>
<td>Helps a patient with limited mobility from a sitting to standing position</td>
<td>Assists with transfer to shower chair or bath hoist.</td>
</tr>
<tr>
<td><strong>Adjustable-height baths</strong></td>
<td>Raises the bath to a height suitable for nursing staff</td>
<td></td>
</tr>
</tbody>
</table>

- Is the equipment in good working order?
- Is there a transparent checking and maintenance plan for the equipment?
- Have staff been trained in how to use and maintain the equipment?
• What is the impact of the equipment on the patient’s dependence/independence?
• Is this the best equipment for the patient’s situation and ability?
• How many nurses are required to carry out the procedure?
• Is the environment suitable for equipment use, e.g. is there enough room to manoeuvre the equipment?
• Is there a need to refer for specialist assessment, e.g. physiotherapy/occupational therapy?

One vital aspect of general assessment is to ensure that risk assessment forms trigger assessment of all aspects of the care processes (Rinds, 2007).

**General health and safety**
The risk of falls and injury can increase through hard surfaces becoming slippery if allowed to remain wet. Non-slip flooring is recommended but not always available; therefore, the use of non-slip mats and extra attention to keeping floors dry and free from spills such as water, soap or talcum powder is important. After each and every use, non-slip mats should be washed and dried according to local infection control policy and replaced frequently.

Obstacles in bathrooms and shower rooms can also pose difficulties for patients in terms of risk of falling (Hall, 2003).

Water temperature presents another potential hazard, particularly for some patient groups (Box 1.5). Patients have been scalded

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**Box 1.5 Patients who risk scalds and burns from hot water**

- People aged 65+ years.
- Infants and young children, particularly newborn babies.
- People with learning disabilities.
- People who have epilepsy.
- People with poor mobility.
- People with circulatory or neurological disease.
- People with mental health problems.
- People with reduced cognitive ability.
and have even died after healthcare workers have failed to monitor the temperature of bathwater (Hill et al., 2002). The DH (2002) recommends a water temperature of no more than 43°C for adults. Children under 18 months should not be exposed to water higher than 38°C (or lower than 36°C) (NHS Scotland, 2003), and until adulthood water temperature should not exceed 40°C (NHS Estates, 1998).

Bidets should be regulated to no more than 38°C and any water outlet that is not restricted to 43°C should be clearly labelled ‘Very Hot Water’. Many baths and showers are currently available with inbuilt thermostatic control; however, the responsibility for patients’ safety remains with healthcare staff, and water temperature should still be checked manually using a bath thermometer before being used by the patient. Nurses should be aware when patients use bathrooms and toilets that they may be at risk of burns or scalds from hot-water pipes, heated towel rails and radiators. Care must be taken to keep these covered safely (NHS Estates, 2007) and patients should be discouraged from leaning on these for balance.

Traditionally tepid (lukewarm) sponging has been recommended to lower temperatures of patients. The Royal College of Nursing (2008) cautions that using lukewarm sponging or baths with children risks actually raising their temperature as the practice may cause the blood vessels to constrict (become narrower), which will raise a temperature even further. The child may become so cold they shiver, which raises the metabolic rate and so raises their temperature. This is likely to be true of older people, who find it harder to maintain their temperature than younger adults do.

Patients who have cognitive problems, patients with learning disability and young children are at risk of accidentally ingesting personal toiletries such as brightly coloured shampoos or bath preparations. Cleaning fluids for infection control can also pose risks to these patients. Policies for the control of substances harmful to health (COSHH) should be followed (Health and Safety Executive, 2002) and patients should be advised about storing their personal toiletries safely.
Privacy and dignity are paramount to carrying out hygiene interventions, and intimate care must be carried out with sensitivity. Patients may feel the need to bath alone and lock doors, putting themselves at risk of help being delayed should they have an accident. A detailed and extensive risk assessment must be carried out which incorporates the expertise of the multidisciplinary team and the wishes of the patient.

The decision as to whether patients can be supervised discreetly rather than accompanied in the bath or shower room depends on whether:

- The patient can get in/out of the bath/shower independently.
- The patient can sit up unaided and wash independently.
- The patient can make a safe decision regarding acceptable/comfortable water temperature.
- The patient’s sensitivity to extremes of water temperature is not impaired.
- The patient has the mental ability to recognise dangerously hot water and take action.
- The patient is capable of calling for assistance if needed.
- The patient is able to exit from hot water independently.

Personal privacy may not be possible and patients will need to be encouraged to accept help with personal hygiene. This may be particularly relevant for children and teenagers who are self-conscious about their changing body and older patients who were raised during an era that was naturally more modest than current society.

PRESCRIBED CARE

What is prescribed care?

While many patients are able to meet their own hygiene needs or require minimal help to achieve the level of hygiene which satisfies their personal and social requirements, others will require hygiene interventions from a medical perspective. Nursing assessment contributes to this decision in that the patient may have identified problems with skin health, oral health, hearing or
other deficits relating to personal hygiene which have occurred through a disease process.

**Nurse prescribers**
Resolving or alleviating these problems may require medical or specialist interventions. The patient is then likely to require medication or treatment under the category of prescription-only medicines (POM), which may only be prescribed by a qualified healthcare practitioner (e.g. doctor, dentist or qualified nurse prescriber). Nurse prescribers are registered nurses with an additional prescribing qualification recorded with the Nursing and Midwifery Council (2005). Like all registered nurses, independent/supplementary prescribers must work within their area of competence and will not be able to prescribe for children or people with mental health problems unless they are qualified to do so. Professional accountability demands that they prescribe only after a full assessment of the patient and only prescribe from the range of POM relating to their experience (Nursing and Midwifery Council, 2005).

**Administering prescribed treatments**
There are a range of POMs that could be prescribed for patients, but this book will mainly consider the range of topical prescriptions available. Oral medication (e.g. tablets, capsules) and injections are outwith the remit of this book. However, it must be emphasised that patients are likely to be prescribed medication under these categories. The registered nurse has an accountability to follow the standards for medication (Nursing and Midwifery Council, 2008) and to ensure that all staff are aware of possible side effects of medications which are being administered.

**Unregistered nurses and prescribed care**
Nursing students should not participate in medicine administration unless under supervision of a registered nurse and having been assessed as being competent to do so. The accountability rests with the registered nurse for deciding competence, but the responsibility lies with the nursing student to indicate if they feel any administration procedure is outwith their competence for
stage of programme (Nursing and Midwifery Council, 2008). Unregistered nurses may have these duties delegated to them but, again, accountability remains with the registered nurse.

Patients who self-administer their medication
Many patients who are in care settings will be perfectly capable of administering their own medications. However, the responsibility for assessing capacity for self-administered medication (SAM) still lies with the registered nurse, and it must not be forgotten that a patient’s condition can change dramatically and quickly.

Patients can be assessed for suitability to SAM at one of three levels:

Level 1

- The patient understands the POM being administered.
- The registered nurse must prompt the timing of the administration.
- The registered nurse must supervise the patient self-administering the medication.
- The registered nurse is responsible for the secure storage of the medicines.

Level 2

- The patient understands the POM being administered.
- The patient must prompt the timing of the administration and ask for the medication.
- The registered nurse must supervise the patient self-administering the medication.
- The registered nurse is responsible for the secure storage of the medicines.

Level 3

- The patient assumes responsibility for the full process including safe storage.
The registered nurse has responsibility for continual assessment to ensure competence.

All levels must be recorded in the patients’ documentation (Nursing and Midwifery Council, 2008). Parents and guardians of children in care can administer medication to their children under the same conditions. The British National Formulary (BNF) identifies a number of labels to be adhered to with different medications. It is important that all who may be administering prescribed care are made aware of any advisory labels (e.g. Label No. 28, ‘To be spread thinly’) and cautionary labels (e.g. Label No. 15, ‘Caution flammable: keep away from fire or flames’) issued with the medication (British National Formulary, 2008).

THE EFFECT OF AGE ON PRESCRIBED CARE

Infancy (0–23 months)
Newborn babies may be at risk of a reaction to any medication in the mother’s breast milk. The amount of drug transferred in breast milk is rarely thought sufficient to obviously affect the infant. This applies particularly to drugs that are given parenterally (not using the digestive system). However, there is a theoretical possibility that the small amount of drug present in breast milk can induce a hypersensitivity reaction in the baby and so, if possible, medication should be avoided where possible (British National Formulary, 2008).

The risks to babies aged over 1 month is the same as for children. Babies less than 30 days old need particular care when prescribing and administering treatments. Babies of this age find it harder to clear drugs from their systems and risk toxicity (poisoning) from medication. This is particularly true of babies who are premature or jaundiced in the first few days/weeks of life (British National Formulary, 2008).

Childhood (2–12 years)
For safety reasons, children (like older adults and babies) are rarely included in drug trials, and so the presence of a licence
does not necessarily indicate that a drug is suitable for a child or older person. Children therefore should always be prescribed medication with caution, and their age – and weight – should be taken into account and noted on any prescription documentation. It must be remembered that, although older children may have a weight similar to that of an adult, their organs do not have the same maturity and they may not be able to excrete the drugs from their bodies at adult doses. Dosages must be clearly prescribed in full to avoid accidental overdose.

A further consideration for children on long-term medication is the potential effect of medication, particularly liquids, on oral health. Sugar-free medication is preferable, or the child may be able to swallow solid doses and may prefer to do so (British National Formulary, 2008).

**Adolescence (13–19 years)**

There are few considerations for teenagers that are not also considerations for adults, although again teenagers are rarely included in drug trials.

**Adulthood (20–64 years)**

Adults and older adults have the greatest proportion of annual prescriptions. Many preparations may cause oral health problems even with short-term use. Antibiotics, for example, may cause oral thrush – a candidiasis-related fungal infection. Mouth ulcers can form as side effects from drugs, for example cytotoxic drugs (chemotherapy) and even non-steroidal analgesics; teeth can become stained even from some oral health preparations, for example some mouthwashes; the flow of saliva can be disrupted as a side effect of medicines such as antidepressants and analgesics (British National Formulary, 2008).

Pregnancy: medications can harm the embryo or foetus at any stage of the pregnancy not just the first trimester. When prescribing for a woman of childbearing age, and for men, assessment would include asking whether she was trying to conceive (British National Formulary, 2008). Many medications must be prescribed with caution and some topical preparations are included, for
example steroid and antifungal preparations. Eye drops also require cautious prescribing as the medication (e.g. a steroid preparation) may be absorbed systemically.

**Older people (65+ years)**
Older people often have more than one disease occurring at the same time (multiple pathology), which may affect the number of medications they are prescribed. The more medications prescribed increases the risk of adverse drug interactions or reactions. The symptoms of these adverse incidents are sometimes confused by nurses as being part of normal ageing (e.g. reduced appetite, weakness, tiredness, confusion) and are not picked up on. However, normal ageing processes such as reduced liver and kidney function also mean that older people may have increased sensitivity to prescribed treatments (i.e. any allergies or reactions will appear faster and more severely than adults) and will not be able to secrete the waste from the drugs as efficiently as younger adults.

**CONCLUSION**
This chapter should have illustrated to the reader the importance of meeting personal hygiene needs for each patient. Assessment of every aspect of the patient’s condition and the care environment is vital before, during and after carrying out nursing interventions. Nurses should refer to this chapter throughout the book for core assessment strategies.

**REFERENCES**


