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Personal Hygiene and Comfort

Nursing Foundation

Bed bath, oral care, hair care, perineal care, nail care, back care, pressure injury prevention, patient positioning and comfort measures.

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11. PERSONAL HYGIENE AND COMFORT

1. Definition

Personal hygiene refers to practices that maintain cleanliness, promote health, prevent infection and improve physical and psychological comfort.

2. Purposes

- Maintain cleanliness.
- Prevent infection.
- Maintain skin and mucosal integrity.
- Promote comfort.
- Improve self-esteem.
- Encourage independence.
- Identify abnormalities during care.

3. Factors Affecting Personal Hygiene

- Age.
- Physical condition.
- Mobility.
- Consciousness.
- Cultural preferences.
- Cognitive abilities.
- Availability of resources.
- Pain and fatigue.

4. Bed Bath

A bed bath is cleansing the body of a patient who cannot safely bathe independently.

Types

- Complete bed bath.
- Partial bed bath.

- Assisted bath.
- Therapeutic bath.

Articles

Basin, appropriately warm water, washcloths, towels, mild cleanser, gloves when indicated, clean linen and clothing.

Procedure

1. Assess the patient's ability and preferences.
2. Explain the procedure and provide privacy.
3. Perform hand hygiene.
4. Check water temperature for safety.
5. Wash from cleaner to more contaminated areas.
6. Clean and dry skin folds.
7. Provide perineal care separately.
8. Inspect skin for abnormalities.
9. Apply prescribed or suitable skin products.
10. Change linen and position comfortably.
11. Document findings.

5. Oral Care

Purposes

- Maintain oral cleanliness.
- Prevent dental and oral infections.
- Reduce discomfort.
- Maintain moist oral tissues.

Procedure

Assist with toothbrushing, clean the tongue gently, rinse when safe and provide appropriate denture care.

Unconscious or Dependent Patient

Assess airway and aspiration risk. Position appropriately, use suction-assisted oral care when indicated and avoid excessive fluid inside the mouth.

6. Hair Care

- Assess scalp condition.
- Comb hair gently.
- Provide shampooing when appropriate.

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- Maintain privacy and patient preferences.
- Observe for wounds, infestation or irritation.

7. Perineal Care

Cleansing of genital and perineal areas to maintain hygiene and skin integrity.

Principles

- Maintain privacy.
- Wear appropriate gloves.
- Clean from less contaminated to more contaminated areas.
- For females, clean from front to back.
- Return a retracted foreskin to its normal position.
- Dry the skin gently.
- Use routine hygiene for catheterized patients unless otherwise indicated.

8. Nail Care

- Inspect nails and surrounding skin.
- Keep nails clean.
- Trim safely when appropriate.
- Avoid injuring the cuticle.
- Seek specialist foot care for high-risk patients, such as those with neuropathy or impaired circulation.

9. Back Care

Back care includes skin assessment, cleansing, comfortable positioning and appropriate moisturization.

Avoid vigorous massage over bony prominences, reddened areas or suspected tissue injury.

10. Pressure Injury Prevention

Pressure injuries occur due to pressure or pressure combined with shear.

Common Sites

- Sacrum.
- Heels.
- Elbows.
- Occiput.
- Hips.
- Ankles.

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Classification

Stage	Description
1	Intact skin with non-blanchable erythema
2	Partial-thickness skin loss with exposed dermis
3	Full-thickness skin loss
4	Full-thickness skin and tissue loss with exposed or palpable deeper structures
Unstageable	Depth obscured by slough or eschar
Deep tissue pressure injury	Persistent deep red, maroon or purple discoloration or related tissue damage

Prevention

- Assess risk using an appropriate tool.
- Inspect skin regularly.
- Individualize repositioning frequency.
- Offload heels.
- Use pressure-redistributing surfaces.
- Manage moisture and incontinence.
- Support adequate nutrition.
- Reduce friction and shear.

11. Comfort Measures

- Appropriate positioning.
- Pain assessment and relief.
- Clean linen.
- Comfortable room temperature.
- Noise reduction.
- Rest and sleep promotion.
- Emotional support.

Important Examination Questions

1. Define personal hygiene and explain its importance.
2. Describe the bed bath procedure.
3. Explain oral and perineal care.
4. Discuss pressure injury classification and prevention.
5. Explain nursing comfort measures.

Conclusion

Personal hygiene and comfort measures preserve dignity, prevent complications and improve patient well-being.

Quick Revision

- Personal hygiene maintains cleanliness, skin integrity, comfort, self-esteem and independence.

- During a bed bath, check water temperature, provide privacy and clean from cleaner to more contaminated areas.

- Dependent oral care requires airway and aspiration assessment and avoidance of excessive fluid.

- Female perineal cleansing is front to back; return a retracted foreskin to its normal position.

- Stage 1 pressure injury has intact skin with non-blanchable erythema; stage 2 has partial-thickness skin loss.

- Prevent pressure injury through risk assessment, skin inspection, individualized repositioning, heel offloading, moisture control and nutrition.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. Which finding describes a stage 1 pressure injury?

A. Full-thickness tissue loss
B. Exposed dermis
C. Intact skin with non-blanchable erythema
D. Depth obscured by eschar

2. Which direction is appropriate for female perineal cleansing?

A. Back to front
B. Circularly from anus outward
C. From more contaminated to cleaner areas
D. Front to back

3. Which measure helps prevent pressure injury at the heels?

A. Vigorous massage of redness
B. Offloading the heels
C. Keeping all patients supine continuously
D. Increasing friction during repositioning

4. An immobile patient has intact sacral skin with redness that does not blanch. Which action is appropriate?

A. Document the redness and defer pressure relief until the next shift
B. Relieve pressure, assess the skin and implement an individualised prevention plan
C. Massage the bony prominence until the colour returns
D. Keep the current position and add a pad without reassessing pressure

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Answer key and explanations

1. C - Intact skin with non-blanchable erythema

Stage 1 involves intact skin with non-blanchable erythema.

2. D - Front to back

Front-to-back cleansing follows the stated perineal-care principle.

3. B - Offloading the heels

Offloading reduces pressure on the heels.

4. B - Relieve pressure, assess the skin and implement an individualised prevention plan

Non-blanchable redness of intact skin can indicate a stage 1 pressure injury. Pressure relief, assessment and prevention are appropriate; massage may worsen tissue damage.

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