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EZYAS@HOME

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CLINICAL NOTES



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## Clinical Care Handbook

### Introduction

In 1859 Florence Nightingale suggested that ‘The elements of nursing are all but unknown’. It could be argued that this statement remains true today: some groups maintain that nursing is about keeping clients clean and well nourished; others that it is about making clients feel safe; others focus purely on the psychological needs of clients; and yet others think that it is about carrying out physical tasks delegated by, but remaining under the auspices of, doctors (Hilton 1997).

In looking back down the well-trodden path it can be seen that over the past 150 years or so nursing has slowly evolved from something that was considered essentially women’s work, which could be undertaken by any ‘good woman’, was largely concerned with caring for the sick, and with providing the best environment for nature to take its course, to being something that is very complex, skilled and sometimes highly technical, involving health education and promotion as well as meeting a wide variety of illness related needs of clients. It is now an occupation that attracts both men and women whose pay constitutes more than a bottle of gin (Hilton 1997).

### *Assessment and the nursing process*

Assessment includes collecting all relevant information and then determining the client’s actual or potential problems. From this information care can then be planned in full consultation with the client, their significant others and other members of the multidisciplinary team as appropriate. Care planning should be clearly documented and include the goals of care – that is, what it is we are striving to achieve – making sure, of course, that these are both realistic and achievable, along with precise details of how they are going to be achieved.

# Communicating

## *Introduction*

Communication skills form the basic building bricks of all human interaction, be it a simple greeting or a complex relationship. Our verbal and non-verbal messages create pictures of who we are, how we are feeling and what we like or dislike. As health care professionals the pictures that we paint can reassure people and put them at their ease or, conversely, cause stress and anxiety and make them feel very vulnerable, uncomfortable or even, on occasions, aggressive. The development of sound therapeutic communication skills is therefore vital if we are to put people at their ease and make them feel secure, confident and valued. This means paying attention not only to what we say and do but also to how we say and do it. Written communication skills are equally important. Clear and concise writing skills are essential not just for communicating effectively within a multidisciplinary team and ensuring consistent, quality care, but also to comply with the legal requirement to maintain comprehensive client care records.

Communication is, however, a two-way process. To communicate effectively means developing good skills at a personal level not only as a messenger, but also as a receiver. This requires us to listen attentively, be knowledgeable about the other person(s)'s abilities and perspectives as well as our own, and to develop the skills necessary to facilitate communication for those who are less able than ourselves, whatever the reason. For example, an individual with a specific learning difficulty may find it very difficult to verbalise their care needs and may need to use alternative modes of communication such as sign language to converse with us. A child may not yet have developed an understanding of the double entendres of some of our words. Clients who may be in pain or distress or those who are newly bereaved may find it exceptionally difficult to express their feelings and may ultimately need encouragement and support to do this. Well-developed communication skills are therefore essential tools for nurses and other health care professionals, yet there is a plethora of literature that illustrates that we are notoriously poor at this activity for a variety of reasons, not least a perceived lack of time.

The factors that affect communicating may be:

- physical arising from alteration in the structure, function or process of the organs involved in communicating, such as damage to the tongue or larynx (voice box), or nerves supplying it
- psychological such as fear, anxiety and stress
- sociocultural including language, vocabulary, jargon and gesticulations
- environmental, for example poor lighting, noise or intrusions
- politico-economic, for instance type of occupation, neighbourhood

## *Communicating with clients*

It is important to remember that there is no substitute for face-to-face interaction, particularly on important issues, but only if this is undertaken with thought, using appropriate strategies following a full assessment of the client's ability to communicate. Appropriate and effective communication helps to establish a therapeutic helping relationship, enables us to determine a client's care needs, promotes trust and confidence, and facilitates good multidisciplinary team working. Good practice is outlined below.

Procedure	Rationale
<p>Prepare the environment, creating a climate of warmth and acceptance</p>	<p>To facilitate communication</p>
<p><b>S</b>it squarely in relation to the client, adopt an <b>O</b>pen posture, <b>L</b>ean in towards the client slightly, maintain comfortable <b>E</b>ye contact and <b>R</b>elax</p>	<p>The acronym SOLER, outlining 5 steps to good communication was first coined in the 1980s by Gerard Egan (2002) to help us to remember how using body position can improve our communication and help us to listen more effectively</p>
<p>Ensure that the client is comfortable, relaxed and if possible pain free and, if desirable and appropriate, arrange for a relative or significant other to be present</p>	<p>To promote client participation. To prevent misunderstandings and reduce the potential for collusion</p>
<p>If the content is likely to be of a confidential nature or has the potential to cause embarrassment find a private location acceptable to the client</p>	<p>To maintain confidentiality and self-esteem</p>
<p>Minimize the potential for interruptions</p>	<p>So that you can concentrate fully on the interaction</p>
<p>Review client information already available</p>	<p>To demonstrate good multidisciplinary team working</p>
<p>If possible, prepare what you want to say thoroughly beforehand</p>	<p>To keep the interaction focused</p>
<p>Determine how you are going to get your message across and how the client is going to communicate with you</p>	<p>Not all clients can hear or speak; it is therefore crucial that you establish effective means of communication. This may mean providing writing materials, arranging an interpreter or person to sign, or obtaining picture books, etc.</p>

Procedure	Rationale
Make sure you allocate an adequate amount of time	To prevent you giving off a sense of urgency or rushing the client
Be prepared to adjust the time allowed if necessary	If the client is finding the interaction cathartic, they may open up about other issues. Whilst it may be appropriate to arrange a further meeting to discuss these or to refer the client to another party, sometimes the moment can be lost forever if the issue is not addressed at the time
Introduce yourself and address the client by their preferred name	Common courtesy
Explain the purpose of the interaction and encourage the client to participate freely	Provides clarification and promotes equality
Check whether the client would like anyone else present	To provide support. <b>NB</b> If a non-consenting child, that is, one who is considered in law to be unable to legally give consent to care or treatment, it may be essential that a parent or guardian is present
Or conversely if anyone is present, does the client wish them to stay or leave?	To maintain privacy and confidentiality
Use questioning appropriately; ask one question at a time; give the client time to answer; use both open and closed questions; avoid questions such as 'Why?'	To avoid barriers to communication and to increase the likelihood that you elicit an appropriate response
Engage in active listening, displaying empathy and/or sympathy appropriately, and allow silence	To engender a sense of value, to demonstrate caring and to prevent misunderstanding
Keep your message simple - don't hide behind long words or jargon. Be clear, concise and completely honest	Helps gain the trust and confidence of the individual and ensure understanding
Use the full range of techniques such as:	To enhance the effectiveness of the interaction and ensure understanding
Clarifying observations and statements	If with a child, make sure you are aware of their understanding of different words to avoid anxiety and distress. For example, a child's understanding of 'being put to sleep' by the

## Record keeping

Written communication is as important in the health care arena as both verbal and non-verbal communication. Maintaining clear, concise but comprehensive client care records is absolutely essential both in terms of providing continuity of client care of a high standard and in terms of meeting legislative requirements. Remember, in a court of law it is assumed that *if the care was not documented then it didn't happen*. With the advent of information technology, computerised information systems are being increasingly used to record, store and evaluate information pertaining to clients. These are proving very useful in terms of easier and speedier access to information both within and across care environments, for example department to department, hospital and community. Whatever method is used in your area, however, it is important that you familiarize yourself with the systems and ensure that you do not breach client confidentiality.

## Breathing

The process of external respiration (breathing) consists of two stages, namely *inspiration*, inhaling (breathing in) air in order to extract the oxygen from the air, and *expiration*, exhaling (breathing out) in order to expel carbon dioxide. Oxygen is required by the body to release energy at cell level so that the individual can participate in activities. The release of such energy through metabolism produces carbon dioxide as a waste product that must be expelled from the body

Breathing is essential to life. The ability to undertake a swift assessment of the client's ability to breathe and instigate removal of an obstruction and/or rescue breathing if needed is therefore crucial. A full assessment of the person's ability to breathe should be undertaken once adequate respiratory function has been restored.

Factors that may affect breathing may be:

- physical, arising from alteration in the structure, function or processes of the respiratory and associated systems
- psychological, such as anxiety and stress
- sociocultural, for example smoking
- environmental, including pollution and allergies
- politico-economic, for example lack of finances for heating.

### *Assessing an individual's ability to breathe*

Remember that assessment of breathing is only part of a holistic nursing assessment and should not be undertaken in isolation without reference to or consideration of the client's other activities of living.

The specific points to be considered when assessing an individual's breathing include:

- Physical tissues above the sternum and between the clavicles during inspiration, particularly in infants
- Respiratory rate
- depth
- sounds
- pattern/rhythm
- Presence of cough
- productive
- unproductive
- Sputum
- colour
- consistency
- amount
- smell
- Degree of effort, use of accessory muscles (e.g. shoulders/neck)
- Nasal flaring, which is usually a sign of increased effort, particularly in infants
- Sternal recession, the sinking in of sternum during inspiration, particularly in infants
- Tracheal tug, the sinking in of the soft
- Intercostal recession, the sinking in of the soft tissues between the ribs during inspiration
- Facial expressions
- Colour of skin/mucous membranes - mottling, pallor, cyanosis
- Presence of scars
- Shape of thorax, symmetry of movement
- Evidence of external/internal injury
- Position adopted by client and influence of body position on breathing
- Pain related to inspiration/expiration/movement
- Breathes through mouth and/or nose
- Clubbing of finger ends
- Head bobbing, that is, forward movement of head on inspiration in a sleeping or exhausted infant is a sign of breathing difficulty

### *Monitoring respiratory rate*

Monitoring a client's respiration rate is essential to facilitate the evaluation of medical treatment and nursing interventions.

## Equipment

A digital watch or watch with a second hand, together with an appropriate chart for recording, is required. The procedures and rationales are given below.

Procedure	Rationale
Explain procedure and ensure adequate understanding	Promote client co-operation and obtain informed consent, though this step is often omitted where there is a danger that the person may voluntarily control their breathing and thus alter the rate
Count respirations as chest rises and falls for a period of one minute	To monitor rate and compare to norm values New-born: 30-80 rpm Early childhood: 20-40 rpm Late childhood: 15-25 rpm Adult male: 14-18 rpm Adult female: 16-20 rpm Pulse-to-respiration ratio = 5:1
Observe depth of respirations	To monitor depth and compare to norm - usually shallow and effortless
Listen for breath sounds, e.g. stridor, wheeze, rub, rattle	To monitor sounds and compare to norm - usually almost inaudible
Observe pattern of breathing and use of accessory muscles	To monitor pattern and compare to norm - usually effortless
Observe colour of skin/mucous membranes, e.g. pallor, cyanosis	To ensure that adequate oxygen is getting to the tissues (i.e. tissue perfusion)
Record rate on appropriate chart and report any abnormalities	Legal requirement to maintain documentation and safeguard client through good communications

## *Monitoring expectorant*

Monitoring expectorations facilitates thorough assessment and evaluation of the client's condition and response to treatment. Expectorant refers to any secretions coughed out of the lungs and should not be confused with saliva (secretions from the mouth)

## Equipment

The equipment required for monitoring consists of sputum pot, weighing scales (if available), appropriate chart for documenting results, and gloves. The procedures and rationales are given below.



Procedure	Rationale
Glove hands	To protect against infection
Observe colour	To monitor colour and compare to the norm. Yellow to green sputum indicates degree of infection. Putty or grey colour may indicate TB. Blood-streaked sputum may be caused by trauma or lung disease. Haemoptysis (blood in the sputum) is indicative of lung disease. Pink frothy sputum is indicative of heart disease/pulmonary oedema.
Observe consistency	To monitor consistency and compare to the norm

Procedure	Rationale
Observe amount by weighing the sputum pot with the expectorant and subtracting the weight of an empty pot. If scales not available record amount as full pot, half pot, etc.	To measure the amount and compare to the norm. Weighing the expectorant gives an objective measure of the amount and is therefore more accurate and facilitates evaluation
Note any odour from the expectorant without directly inhaling over the pot	Directly inhaling over the pot may lead to inhalation of airborne micro-organisms
Record findings on appropriate chart and report any deviation from the norm	Legal requirement to maintain documentation and safeguard client safety through good communications
Dispose of sputum pot as directed in next section below	To prevent cross-infection
Provide client with a clean sputum pot indicating client's name and ensure an adequate supply of tissues	To maintain client comfort and facilitate evaluation
Advise client on the need to maintain hydration and oral hygiene (see Chapter 3) and offer assistance as necessary	To promote client comfort and reduce the risk of complications

### *Obtaining a sputum specimen*

An analysis of a sputum specimen will identify any abnormalities and provide direction for appropriate treatment.

### **Equipment**

The equipment required consists of specimen pot with lid, clearly labelled with client details; request form signed by a doctor, and labelled with client details; specimen bag; tissues; and mouthwash/oral hygiene equipment.

The procedures and rationales are given below.

Procedure	Rationale
Explain procedure to client	To increase client co-operation and obtain informed consent
Encourage and assist the client to cough into the specimen pot	Coughing expels the sputum from the lung fields
If experiencing difficulty in obtaining the specimen, gently percuss the client's back in collaboration with the physiotherapist	Gentle percussion dislodges sputum, making it easier to expel
Check that expectorant contains sputum	Test will be invalid if saliva is sent in error
Obtain assistance from physiotherapist if you encounter difficulties in obtaining specimen	Physiotherapists are trained specifically in techniques that may help to obtain a specimen
Replace lid on pot ensuring an adequate seal	To prevent leakage
Put form and specimen pot in specimen bag and seal	To ensure request and specimen arrive at laboratory together
Offer mouthwash/oral hygiene equipment	To maintain client comfort
Send specimen promptly to laboratory	To enable analysis of specimen. Delay in sending the specimen will invalidate the test
Document in client's notes that specimen has been obtained	To ensure consistency of care

### *Administration of oxygen*

Oxygen (O<sub>2</sub>) is administered as a corrective treatment for conditions resulting in hypoxia (low level of oxygen in the blood). Oxygen is classed as a medication and must be prescribed by a doctor and administered correctly to prevent over- or under-oxygenation. Remember oxygen is NOT flammable, but it does aid combustion. Patients and visitors should therefore be educated about the increased risk of fire and the precautions necessary to reduce this risk when supplementary oxygen is in use (see 'General considerations' below). Oxygen must only be administered at the rate and percentage prescribed, as over-oxygenation can be dangerous for some individuals, particularly those with chronic lung disease who are retaining carbon dioxide, and infants, where there is also a risk of retinopathy.

### **Equipment**

The equipment required consists of a mask or nasal cannula that enables the administration of the prescribed dose (percentage) (see Table 1. 1); connection tubing; flow meter; wall or cylinder oxygen supply (oxygen cylinders are black with a white collar); and a humidifier with sterile water if required. The procedures and rationales are given below.

Procedure	Rationale
Explain procedure, addressing health and safety precautions, and ensure adequate understanding	To promote client co-operation and safety
Wash hands following correct procedure	To prevent cross-infection
Assemble equipment - For rates of 40% and over, humidification (moistening of the oxygen prior to it reaching the client) is essential	To prevent dehydration of mucous membranes
Set flow meter to prescribed rate, e.g. 2 litres per minute	To prevent over/under-oxygenation. <b>NB</b> It may be necessary to monitor the client's oxygen saturation rate (O <sub>2</sub> Sat) to ensure this, particularly clients with chronic lung disease, where there is a risk of apnoea, and babies, where the O <sub>2</sub> Sat rate should not be allowed to rise above 99% as there is a significant risk of brain damage
Assist client to position mask (if mouth breathing) or nasal cannula correctly, ensuring a comfortable but not too tight a fit	To facilitate optimum administration, promote patient comfort and reduce the potential for pressure sores
Clients undergoing prolonged oxygen therapy will require monitoring of mucosa and frequent mouth/nasal care (minimum 2 hourly, see Chapter 3)	To reduce the risk of dehydration and promote patient comfort

Procedure	Rationale
Encourage client to relieve the pressure of the mask or cannula from the face, nares and ears hourly as appropriate	To reduce the potential for pressure sores
Continue to monitor the client and promptly report any change in condition	To ensure compliance and to optimize treatment
Update nursing care plan	To ensure consistency in care delivery

### *General considerations of oxygen administration*

- Oxygen is an odour-less, tasteless, colour-less, transparent gas that is slightly heavier than air.
- Oxygen supports combustion, therefore there is always a danger of fire when oxygen is being used.
- The following safety measures should be remembered:
- Oil or grease around oxygen connections should be avoided.
- Alcohol, ether and other inflammatory liquids should be used with caution in the vicinity of oxygen.
- No electrical device must be used in or near an oxygen tent.
- Oxygen cylinders should be kept secure in an upright position and away from heat.
- There must be no smoking in the vicinity of oxygen.
- A fire extinguisher should be readily available and all staff have a responsibility to be competent in its use.

# Mobilising

## Introduction

Motor function and the ability to move involve all parts of the motor nervous system. Injury, malformation or disease to any part of this system will therefore affect the individual's ability to move. The motor nervous system includes:

- The central nervous system (CNS): this is composed of the brain and spinal cord and is responsible for initiating and coordinating movement.
- The peripheral nervous system: this consists of nerve pairings, which radiate to the various parts of the body from the CNS. These pairs of nerves send messages to and from the brain.
- Muscles, ligaments and tendons: these are located throughout the body and respond to sensory information. Muscles use the pulling forces of contraction and work in antagonistic pairs, that is, they oppose each other.
- The skeleton: this provides a system of support with a variety of joints that enable a wide range of movements.
- The spine and discs: these form a significant part of the skeleton and have particular notable functions:

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Functions of the spine	Functions of the discs
Protects the spinal cord	Act as shock absorbers
Provides central support and stability	Vertebral spacers
Enables a range of movement	Reduction of friction
Ligament and muscle attachment	Limit over-extension/movement

It is therefore clear that the skills of movement are complex and involve both conscious decision-making and other subconscious changes such as reflex actions; together these enable us to move and complete everyday tasks such as cleansing, dressing and eliminating, as well as walking.

As individuals, the ability to move and the range of movements we can undertake are learnt and developed from those basic functions present at birth. The degree of movement, and thus ability to function in all aspects of life, are unique to the individual. This ability can be affected by many factors – not just by injury, malformation and disease.

### The factors that may affect mobility may be:

- Physical arising from altered structures, function or processes of movement, for instance weakness arising from conditions such as anaemia, neurological or muscular impairment, or fractures.
- Psychological including depression, fear and anxiety (particularly in older people) and altered body image, for example stroke or amputation.
- Pain including that affecting general joint/muscle movement.
- Environmental/social such as poor housing, obstructions and other hazards, and social isolation.
- Politico-economic for example lack of finances for aids, adaptations and employed help.

These are just some of the many possible consequences of prolonged immobility. Optimising clients' mobility is therefore an essential nursing skill and should be undertaken in collaboration with other members of the multidisciplinary team (MDT), which includes physiotherapists, social workers, occupational therapists, remedial gymnasts, appliance officers, as well as the client, carer and medical staff.

**Figure 2.2** Example of Pressure Risk Assessment Tool

## **NURSING MANAGEMENT**

### **Waterlow Assessment Score**

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#### **< 10 (Low Risk)**

- Assess patient's skin condition weekly or if condition changes
  - Record score in care records
  - Educate patient to relieve own pressure
  - Complete movement plan
- 

#### **10+ (Low-Medium Risk)**

- Assess patient's skin condition daily
  - Record score in care records daily
  - Educate patient to relieve own pressure
  - Complete movement plan
  - Ensure pressure-reducing foam mattress or pressure-reducing mattress overlay in situ at all times
- 

#### **15+ (Medium-High Risk)**

- Assess patient's skin condition every shift
  - Record score in care records daily unless score changes; if so document accordingly
  - Educate patient to relieve own pressure areas
  - Discuss, with patient, moving and handling techniques
  - Ensure dynamic pressure-relieving mattress in situ at all times when in bed as per local policy and pressure-relieving cushion in situ when using chair
- 

#### **20+ (High-Very High Risk)**

- Turn or tilt patient on a 2-4 hourly basis and assess patient's skin condition on each occasion
  - Record score in care records daily unless score changes; if so document accordingly
  - Educate patient to relieve own pressure areas
  - Discuss, with patient, moving and handling techniques
  - Ensure dynamic pressure-relieving mattress in situ at all times when in bed as per local policy and pressure-relieving cushion in situ when using chair
  - Refer to Tissue Viability Nurse for further advice and guidance
  - Refer to other agencies as necessary, e.g. dietetics, physiotherapy, medics
- 

Adapted from Waterlow (1985)

# Personal cleansing and dressing

## *Introduction*

The ability to cleanse and dress is a fundamental need and involves far more than the physical act of cleansing the skin to reduce the potential for infection and injury. Personal cleansing and dressing is also important in promoting the psychological, social, cultural and overall well-being of the individual. In acknowledging the importance of this aspect of care, best practice, which include: individual assessment of personal and oral hygiene needs; planning negotiated care based on a sound assessment; providing a conducive environment; ensuring that clients have toiletries for their personal use; providing adequate levels of assistance; providing any necessary information and education to enable clients to maintain their individual personal hygiene needs; and finally, continuous evaluation and reassessment of care needs.

## *Assisting individuals with bathing*

Maintaining personal hygiene is essential for the preservation of health and the prevention of infection, and removal of body odour. Individuals, whenever possible, should be encouraged to perform their own personal hygiene so that their independence is promoted. Bathing may involve assisted washes in or out of bed, bed bathing, showering or immersion in a general bath. Care must be taken throughout to keep wounds or dressings dry, and such considerations may influence the mode of choice.

## Equipment

The equipment required will vary according to individual client needs but may include soap, face cloth, two towels (one face and one bath), disposable wipes, clinical waste disposable bags, toiletries (for example, deodorant, perfume, aftershave), client's comb/brush, bowl of hot water (35-40°C), gloves and apron, lotion thermometer, suitable bath/shower, chair/shower stool, disposable floor mat, appropriate aids if bathing/ shaving, clean nightdress/pyjamas or clothing as required, clean bed linen/linen skip and a trolley/adequate surface.

## Bathing/showering in the bathroom

The client's preference may be for a general bath (sometimes referred to as an 'up bath' or shower. An assessment of the individual client's preference along with an assessment of their strength, mobility and mental capacity is essential prior to the carrying out of this activity. The nurse must ensure the client's safety at all times. The procedures and rationales of bathing/showering in the bathroom are given below;



Procedure	Rationale
Plan the activity with the client and explain the procedure	To gain consent and co-operation
Prepare a warm environment, and ensure that all equipment is in the bathroom/shower room prior to taking the client	Prevents cooling. Ensures privacy and client safety. Saves time and is therefore a more effective use of resources
Assist the client in gathering towels, clean clothing/nightwear and toiletries. Walk with the client to the bathing area (if appropriate). If the client has difficulty mobilizing, it may be necessary to use a mechanical hoist or wheelchair	Promotes independence and ensures client safety
Apply apron, wash hands and apply gloves as appropriate	Personal protection and prevention of cross-infection
Line the bath with a plastic liner and prepare the water for the bath/shower, monitoring the temperature using a lotion thermometer, and adjust to meet client's preferences. <b>NB</b> Always run cold water first and adjust to warm (approx. 30°C).	Reduces potential for cross-infection. Promotes client safety and comfort
Assist client in undressing, but keep covered until immersed in water	To prevent scalding To promote and maintain client independence and to maintain body temperature, client dignity and privacy
Assist client into bath or under the shower. Two nurses may be required for this activity (client may need to sit on hoist seat in the bath, or shower chair in the shower)	Client safety/comfort
Assist the client in washing, ensuring face, neck and upper body are washed first	To reduce risk of cross-contamination
If required, assist client in washing hair	To promote a sense of well-being and a positive body image

### *Assisting individuals with oral hygiene*

Oral hygiene may involve the use of a toothbrush and paste, a mouthwash or other mouth cleaning preparations, such as interdental sticks and floss, to achieve and maintain the cleanliness of the teeth or dentures, the gums, hard and soft palates and lips. It is considered an essential nursing procedure as an unkempt mouth can prove to be a serious health hazard over time for some individuals.

Assessment and care of the oral cavity should therefore form part of a client's daily hygiene routine, and efficacy of interventions should be continuously evaluated.

### Care of dentures

An important aspect of oral hygiene is the care of prostheses, which include dentures, plates and braces. These are the client's personal property and need to be handled carefully to avoid damage and breakage.

## Assisting individuals with eye care

Eye care is part of maintaining a client's personal hygiene and is usually performed as part of bathing/showering. Generally the normal physiological processes of blinking and tear production maintain the cleanliness of the eyes, along with daily washing. When a client has difficulty in meeting their eye care needs then the nurse may need to assist, particularly if discharges or crusts appear around the eyes. This can usually be removed by gentle eye swabbing, as outlined below.

Procedure	Rationale
Explain procedure to client	To gain consent and co-operation
Apply apron and wash hands	To reduce risk of cross-infection
Gather all equipment	Ease of access
Ensure privacy for the client	Maintains dignity
Ensure good light source	To facilitate the procedure
Assist the client into a comfortable position	Client comfort, co-operation and ease of access for the nurse to perform the procedure
Prepare equipment, wash hands	To prevent cross-infection
Cover the client's chest using the towel from dressing pack	To protect client's clothing
Instruct client to close their eyes	To reduce the risk of damaging the conjunctiva or cornea
Moisten swab in the solution and gently swab from the inner canthus outwards, using one wipe. Repeat in the same direction until the eye is free from crusts/discharge. Repeat on the other eye, all the time observing the general condition of the eyes	To restore hygiene
Procedure	Rationale
If the client has an infection, wash hands before moving from one eye to the other and always swab the non-infected eye first	To decrease the risk of infecting the other eye
If the eye is to be touched to remove a foreign body, a cotton bud should be used	To prevent further injury or abrasion
Gently dry the client's eyelids	To remove any excess moisture
Remove and dispose of equipment safely	Infection control
Leave the client comfortable. Remove apron and wash hands	To reduce the risk of cross-infection
Evaluate care delivery, document and report any change in client's condition	Legal requirement
Update care plan as necessary	Promotes continuity of care



## Facial shaving

Facial shaving is often a significant aspect of a man's personal hygiene routine and can improve both his comfort and self-esteem. It can be performed during or following washing.

Procedure	Rationale
Hold razor in dominant hand and at a 45° angle to the skin, use short, firm strokes in the direction of hair growth, keeping the skin taut with the other hand (if client has tendency to bleed, nurse should wear disposable gloves or better still discourage wet shaving)	Prevents razor cuts and discomfort during shaving
Allow client to look in the mirror to monitor progress. While performing shave suggest that the client raise a hand if it becomes uncomfortable at any time or if they wish to cough	Promotes client participation and involvement. To prevent injury
Rinse razor in bowl of warm water at frequent intervals. The nurse may need to change the razor and/or apply more lather	Maintains a clean-cutting razor blade
Repeat the above until all facial hair is removed and the client is satisfied. Rinse the face thoroughly, ensuring all soap and hair has been removed	Prevents accumulation of shaving cream, which can cause drying
Gently pat the skin dry using the face towel	Moisture may cause sore skin
Apply aftershave lotion/skin conditioner if required. Allow client to look in mirror to see if they are satisfied with their personal appearance	Stimulates/lubricates the skin. Promotes self-image/esteem
Remove all equipment. Leave client comfortable and the environment dry. Return client's toiletries. Discard disposable razor in sharps box	Safety
Remove gloves and apron, and wash hands	To prevent cross-infection
Record in nursing records as part of maintaining personal hygiene and report any anomalies	Legal requirement

**Note** that if the client is using an electric shaver, the skin should be kept dry and the shaver should be cleaned immediately following use.

## Hair care

Hair care is again a significant part of the grooming process and the attention given to this activity often reflects how a client feels. The condition of the hair and scalp can also be a good indicator of a client's general health; therefore regular attention to this aspect of care is important. The client's gender, cultural and racial preferences need to be taken into account when assisting in grooming of the hair, and under no circumstances should a client's hair be cut without their express permission.

The client's level of independence needs to be considered when undertaking your initial and subsequent assessments, along with any contra-indications to this procedure, such as arthritis or head and neck injuries, which may affect their ability to become involved.

### *Assisting individuals to dress*

Dressing allows the client to maintain their individuality, self-image and self-esteem besides providing protection. It is an important vehicle for communicating one's personality, values, beliefs and culture in society, as well as one's gender. Nurses can assist clients in this activity by encouraging them to make choices and decisions about their personal dress and assisting them in this activity when they are unable to self-care.

Dressing best takes place following washing or bathing though clothes should always be changed when soiled, to promote the client's dignity. Clothes worn during waking hours should not be worn for sleeping as one can lose up to one litre of sweat during the night and this can increase significantly in illness. When dressing the client in clothing of their choosing bear in mind that the clothes should be in keeping with the environment, the general condition of the client and the time of day. Also consider their ease of removal and application and the need for access, for example catheters and drains.

## Maintaining body temperature

Most of the time adults are unaware of their body temperature because it usually remains at a constant, comfortable level. A special regulating centre in the brain, the hypothalamus, carefully balances the amount of heat produced and the amount lost by the body by, for example, making us sweat or shiver. Control of temperature in this way is part of maintaining homeostasis of the body. Adults are therefore referred to as being 'homoeothermic', that is, able to maintain their core body temperature at a constant level regardless of the external temperature.

In infants and children, however, the control centre is not fully developed. This therefore means that there is a potential for wide variations in body temperature; this is why it is crucial that parents or carers monitor constantly the temperature of infants and children and make adjustments to their clothing and environment on their behalf.

### The factors that may affect body temperature include:

- physical, for example illness, infection, gender, age, metabolic rate
- psychological such as emotion, stress and anxiety
- sociocultural including exercise, activity, recreational drugs
- environmental, for example time of day, severe heat or cold
- politico-economic, for instance lack of finances for heating or occupation.

## Normal body temperature

The following levels may vary slightly in different textbooks, but the following is intended to offer a simple, useful guide.

Normal range	= 36-37oC
Pyrexia	= 38-40oC
Hyperpyrexia	= 40.1oC and above
Heat stroke	= usually occurs around 41-42oC
Death	= 43oC and above
Hypothermia	= 35oC and below
Death	= 20oC

**Figure 9.2 Range of body temperatures**

°C	Celsius measurement
43	Client does not usually survive
42	] <b>Hyperpyrexia</b>
41	
40	] <b>Pyrexia</b>
39	
38	
37	Range of normal temperatures
36	
35	] <b>Hypothermia</b>
34	
33	
32	
31	
30	
29	
28	
27	Client does not usually survive
26	
25	

The sites that can be used to monitor temperature are:

- the axilla (axillary)
- the mouth (orally)
- the tympanic membrane (inner ear, aural)
- the rectum (rectally)
- the skin.

Great care should be taken when selecting the site. Whilst the rectal route is considered the most accurate because of its proximity to the core of the body it is obviously the least convenient, the most invasive and carries a number of risks not least the potential to perforate the rectum. It is therefore the least-used site but the best option when a very accurate measurement is required, for example in cases of hypothermia.

For many years the mouth has been the most commonly used site in adults, but care must be taken to ensure that the thermometer is placed firmly in the pocket to the side of the frenulum below the tongue and that the client is fully orientated and co-operative; confused or disorientated clients may bite or try to swallow it.

This site is therefore not recommended in children unless they are fully compliant, nor should it be used for measuring the temperature of breathless patients or patients who suffer from epilepsy. When using this site it is also important to check that the client has not just had a hot or cold drink as this can significantly affect the measurement. The axilla and groin are useful and less dangerous but are less efficient, particularly in clients who are obese or very thin, as good skin contact is essential for accurate measurement.

## Methods of temperature measurement

Traditional mercury thermometers have been used for many years in clinical settings and may be used in the mouth, the axilla or the rectum. Although they are familiar to nurses and clients, their use has declined in recent years due to the potential hazards of mercury spillage and broken glass. There is also controversy surrounding accuracy of measurement and the length of time a mercury thermometer needs to be left in place. Types available include oral, rectal and subnormal (those that record below 35°C), and disposable covers are readily available to reduce the risk of cross-infection.

### **Electronic thermometers**

These have become more popular in recent years and are often purchased for use in the home. An internal probe is connected to a power supply that has a display unit and beeps when the maximum temperature is reached. They can be used in the mouth, the axilla or the rectum and should be covered with a clean disposable probe cover for each patient. They take significantly less time to register an accurate temperature than traditional thermometers and have therefore become increasingly popular. Though incurring a more significant cost they are considered a much safer product.

### **Tympanic thermometers**

These are placed in the ear canal and heat is detected as infra-red energy from the tympanic membrane. It is a rapid way of measuring temperature, only taking a few seconds, but there is some controversy over the accuracy of measurement. They are probably the most widely used devices used in hospitals today.

### **Chemical disposable thermometers**

These may be used in the mouth or the axilla. They are usually plastic strips which are impregnated with thermo-sensitive chemicals that change colour with increasing temperature. As these are disposable there is no risk of cross-infection.

### **Disposable strips**

These are widely available from retail pharmacies and consist of individually wrapped strips for single use only. The strip is applied to the forehead until a reading can be visualized on the strip. Whilst they can give a broad indication of whether the individual is hot or cold they are the least accurate and only really serve as a very basic guide as to whether more professional attention is needed.

## *Monitoring temperature*

Monitoring a client's body temperature is essential to establish current health status, identify actual or potential problems, facilitate medical and nursing intervention, and monitor client progress.

### **Equipment**

Appropriate thermometer (digital, tympanic, rectal, or mercury) paying due regard to the age of the client, their level of ability to co-operate, local clinical guidelines and contemporary evidence

- Designated chart for recording
- Protective covers/probe covers
- Equipment for disposal, cleansing and disinfection

### **Auxiliary measurement**

<b>Procedure</b>	<b>Rationale</b>
Wash hands using effective techniques	To prevent cross-infection
Collect appropriate equipment	Remember that only electronic or mercury thermometers are suitable for axillary measurement

Procedure	Rationale
Hold mercury thermometer at eye level, rotating slightly to ensure mercury line is visible. Check mercury is low enough to record the temperature. If not, shake it down in a downward direction, taking care not to hit any nearby objects	For accuracy of measurement  To prevent breakage
Explain procedure and ensure client has understood	Promotes client co-operation and informed consent
Screen the bed or close door. Assist client to comfortable position and move clothing away from shoulder	Promotes comfort, maintains client's privacy, prevents embarrassment, exposes axillary area
Place the thermometer in the centre of the client's axilla	To ensure good contact with the skin when the arm is lowered
Rest the client's arm across the chest, advising them to remain as still as possible	To avoid thermometer moving out of position
Leave in position until electronic thermometer signals, or 7-8 minutes for mercury thermometers	To ensure accuracy of measurement
Remove thermometer, read and record result, noting any significant changes	To ensure continuity of care and meet legislative requirements
Remove disposable cover and clean thermometer, adhering to local policy	To prevent cross-infection
Report any abnormal findings	To ensure client receives appropriate care

## Oral measurement

Procedure	Rationale
Assist client into a comfortable position, explain procedure, and gain consent	For information-giving and client comfort
Hold mercury thermometer at eye level, rotating slightly to ensure mercury line is visible. Check mercury is low enough to record the temperature. If not, shake it down in a downward direction, taking care not to hit any nearby objects	For accuracy of measurement.  To prevent breakage
Cover thermometer with a disposable cover	To reduce infection risk
Place thermometer under the client's tongue beside the frenulum	To ensure correct reading

Procedure	Rationale
Advise client not to talk, to keep lips closed to form a seal and, if fully co-operative, ask them to hold the thermometer in situ. Leave in place for a minimum of seven minutes	To keep thermometer in place. If the client is unable to hold the thermometer in situ consider using another route. To allow adequate time for the thermometer to register
Remove thermometer, remove cover, read at eye level, record results and report any significant change	To ensure continuity of care and prompt attention if necessary
Clean thermometer according to local policy	To minimize cross-infection

## Using a digital thermometer

Follow the procedure outlined above but wait for the signal that signifies that the highest temperature has been reached.

## Tympanic measurement

### Equipment

- Electronic tympanic thermometer (check for patency)
- Speculum covers (disposable - one for each client)
- Appropriate chart for recording

Identify factors that may affect the reading, for example the presence of cerumen (ear wax), recent facial/aural surgery (potential for injury and should therefore be avoided), hearing aid, or ear infection (the area will be very sensitive and therefore should be avoided; the risk of cross-infection would also be significant were this site to be used).

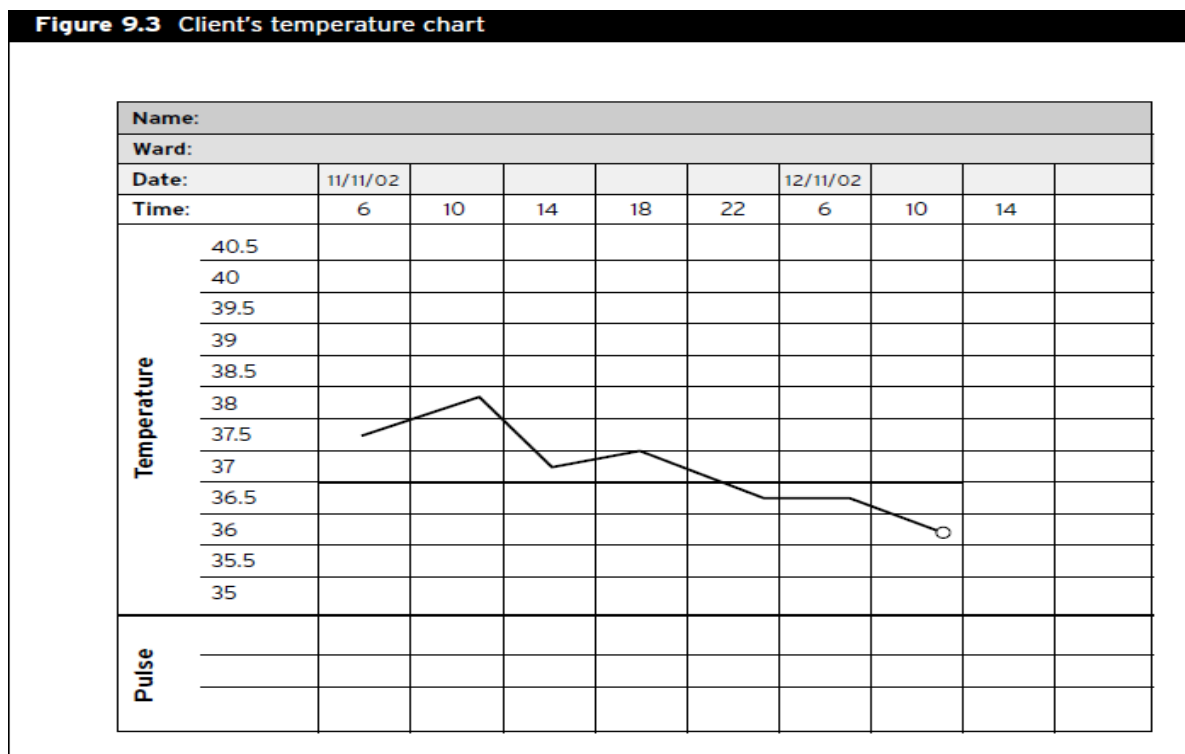
Procedure	Rationale
Assist client into comfortable position, with head turned towards one side, making sure client has not recently been laid on that side	Client comfort; ear canal easily viewed. If client has been laid on that side, reading may be higher
Remove tympanic thermometer from charging base. Place disposable speculum cover over the probe until it locks in place	For safety; prevents cross-infection between clients

Procedure	Rationale
Gently pull ear pinna backwards, upwards and outwards. Insert speculum into ear canal snugly to make a seal, pointing towards the nose	Straightens the external auditory canal; allows maximum exposure of the tympanic membrane
Depress the scan button on the handheld unit. Leave thermometer in place until a signal (usually a bleep) is heard and the temperature reading can be seen on the digital display	Causes infra-red energy to be detected from the tympanic membrane
Remove speculum carefully from ear. Discard speculum cover into appropriate disposal bag/receptacle by pressing ejection button	Client comfort; safety; prevents cross-infection
Return handheld unit to charging base	Automatically causes digital reading to disappear and prevents damage to sensor. Some units also have a built-in security device in that the unit will cease to function after a given amount of time if not replaced on the base station
Record result noting any significant change and report accordingly	To ensure continuity of care and prompt attention if necessary

### Recording and documenting body temperature

Care should be taken to ensure that temperature measurement is recorded accurately to provide a clear picture of the client's condition over time. If done correctly it enables us to see at a glance any change in the client's condition and helps us determine whether or not interventions are being effective, as can be seen in Figure 9.3. If you use an alternative route to the one commonly used in the environment of care it is important that this is recorded on the chart as this may account for any apparent variation, as can be seen on 12/11/02 at 10.00 hrs.

**Figure 9.3** Client's temperature chart





## Strategies to raise and lower body temperature

Raising body temperature	Lowering body temperature
<p>Add extra layers of thin clothing or bedding. Multiple layers of thin clothing are more effective than one or two thick layers, as they trap the warm air. Some man-made fibres can encourage sweating and thus may decrease temperature. Cotton is therefore preferable</p> <p>Encourage the client to wear a hat or cover the head, as most heat is lost through the scalp</p> <p>If possible close any open windows and doors</p>	<p>Remove layers of clothing/bedding. Do not remove all at once or you may cause the client to shiver, which will have the overall effect of increasing rather than decreasing body temperature</p> <p>Encourage the client to wear natural cotton fibres as these absorb heat</p> <p>Use a fan positioned on the client's back as this forms a larger surface area</p>
Raising body temperature	Lowering body temperature
<p>Give the client warm drinks if allowed</p> <p>If possible increase the room temperature</p> <p>Adults and older children can be helped or encouraged to wash their hands and face in warm water provided that they have full sensation. Otherwise there is a risk of burn injury. For this reason hot-water bottles and high-temperature heat pads are not recommended and are indeed banned in most institutions</p> <p>Monitor the client's temperature when actively intervening and ensure that it does not rise more rapidly than 1°C per hour as this can lead to shock. If the client requires their temperature restoring more quickly, this should be undertaken in a critical-care area where the client can be closely monitored</p> <p>If the client is seriously hypothermic (i.e. a temperature of 32.5°C or below) and continuously monitored a foil blanket may be used with caution, but again care should be taken to ensure that the body temperature does not increase too rapidly. Warmed intravenous fluids may also sometimes be prescribed for this client group but again great care is needed</p>	<p>Give the client cold drinks if allowed or ice to suck</p> <p>If possible reduce the room temperature or place the client near an open window but not in a draught</p> <p>Adults and older children can be helped or encouraged to wash their hands and face in tepid water. Tepid sponging of the whole body where the client is allowed to dry by the process of evaporation is not generally recommended as this can reduce the temperature too rapidly (see below)</p> <p>Monitor the client's temperature when actively intervening and ensure in the case of adults that it does not fall more rapidly than 1°C per hour as this can lead to shock. In the case of infants high temperatures can cause febrile convulsions; it is therefore appropriate to reduce their temperature more rapidly. This can be achieved by immersing them fully in a cool water bath</p> <p>An antipyretic such as paracetamol may be prescribed if other methods of temperature reduction have failed, though this should not be the action of first resort as it can interfere with the body's natural defence mechanisms</p>



# Blood Pressure Measurement

## *Sphygmomanometers*

- There are three types of **sphygmomanometers** used to measure blood pressure: mercury, aneroid, and digital.
- Reading blood pressure by auscultation is considered the gold standard by the Heart, Lung and Blood Institute of the NIH.



### *Subject*

- Position: supine, seated, standing.
- In seated position, the subject's arm should be flexed.
- The flexed elbow should be at the level of the heart.
- If the subject is anxious, wait a few minutes before taking the pressure.

### *Procedures*



- To begin *blood pressure measurement*, use a properly sized blood pressure cuff. The length of the cuff's bladder should be at least equal to 80% of the circumference of the upper arm.
- Wrap the cuff around the upper arm with the cuff's lower edge one inch above the antecubital fossa.
- Lightly press the stethoscope's bell over the brachial artery just below the cuff's edge. Some health care workers have difficulty using the bell in the antecubital fossa, so we suggest using the bell or the diaphragm to measure the blood pressure.
- Rapidly inflate the cuff to 180mmHg. Release air from the cuff at a moderate rate (3mm/sec).
- Listen with the stethoscope and simultaneously observe the sphygmomanometer. The first knocking sound (Korotkoff) is the subject's systolic pressure. When the knocking sound disappears, that is the diastolic pressure (such as 120/80).
- Record the pressure in both arms and note the difference; also record the subject's position (supine), which arm was used, and the cuff size (small, standard or large adult cuff).
- If the subject's pressure is elevated, **measure blood pressure** two additional times, waiting a few minutes between measurements.
- A BLOOD PRESSURE OF 180/120mmHg OR MORE REQUIRES IMMEDIATE ATTENTION!



### *Precautions*

- Aneroid and digital manometers may require periodic calibration.
- Use a larger cuff on obese or heavily muscled subjects.
- Use a smaller cuff for paediatric patients.
- For pediatric patients a lower blood pressure may indicate the presence of hypertension.
- Don't place the cuff over clothing.
- Flex and support the subject's arm.
- In some patients the Korotkoff sounds disappear as the systolic pressure is bled down. After an interval, the Korotkoff sounds reappear. This interval is referred to as the "auscultatory



gap." This pathophysiologic occurrence can lead to a marked under-estimation of systolic pressure if the cuff pressure is not elevated enough. It is for this reason that the rapid inflation of the blood pressure cuff to 180mmHg was recommended above. The "auscultatory gap" is felt to be associated with carotid atherosclerosis and a decrease in arterial compliance in patients with increased blood pressure.

### ***Practice***

- Use our aneroid and mercury sphygmomanometers simulators to practice your blood pressure measurement skills.
- Then take one of our courses that feature blood pressure, auscultation, and other physical examination skills.
- For paediatric patients, the NIH provides tables which use age, sex and height to interpret blood pressure findings. View our pediatric blood pressure drills for more information.

## **Blood Sugar Levels (BSL)**

### ***Definition***

Diabetes mellitus refers to a group of diseases that affect how your body uses blood sugar (glucose). Glucose is vital to your health because it's an important source of energy for the cells that make up your muscles and tissues. It's also your brain's main source of fuel.

If you have diabetes, no matter what type, it means you have too much glucose in your blood, although the causes may differ. Too much glucose can lead to serious health problems.

Chronic diabetes conditions include type 1 diabetes and type 2 diabetes. Potentially reversible diabetes conditions include prediabetes — when your blood sugar levels are higher than normal, but not high enough to be classified as diabetes— and gestational diabetes, which occurs during pregnancy but may resolve after the baby, is delivered.

### ***What is a glucose test for?***

A glucose tolerance test is done if a glucose screening test result is higher than normal. It is used to diagnose gestational diabetes. Gestational diabetes is high blood sugar (diabetes) that starts or is found during pregnancy.

### ***How many hours fasting is required for a BSL?***

Do not eat or drink anything except water for 8 to 10 hours before a fasting blood glucose test. These are used to diagnose diabetes, a condition caused by too much glucose (sugar) in the blood. Iron blood test. Iron blood tests are usually taken in the morning before you eat anything.

### ***What is fasting blood sugar?***

Fasting blood sugar (FBS) measures blood glucose after you have not eaten for at least 8 hours. It is often the first test done to check for prediabetes and diabetes. 2-hour postprandial blood sugar measures blood glucose exactly 2 hours after you start eating a meal. This is not a test used to diagnose diabetes.

### ***What should be the fasting blood sugar levels?***

Normal fasting blood glucose is below 100 mg/dl. A person with pre-diabetes has a fasting blood glucose level between 110 and 125. If the level rises to 126 or above, a person has full-blown diabetes.

# Dying

## *Introduction*

From the moment we are born the only predictable event in life is that one day we will die. Dying is thus an inevitable part of life, yet it remains surrounded in mystery to a large extent, provoking fear and anxiety in most individuals, particularly in Western society. However, when explored, it is not usually the thought of death that creates anxiety but the where, the when, the why and the how. Other issues of concern often include: what will happen to my body; how will those left behind manage, financially and emotionally; and who will help them through this difficult time? It is also not unusual for dying clients to feel guilty about the distress they perceive they are causing to their loved ones.

## Factors affecting dying may be:

- physical arising from the nature of the terminal illness or cause of death such as pain, nausea, breathlessness
- psychological such as fear and anxiety about death itself or the effects on those left to grieve
- sociocultural including personal beliefs about death and attitude towards death and dying
- environmental, for example preferred place of death, quiet/noisy, private/open
- Politico-economic such as lack of finances for funeral, outstanding debts.

## *Signs of approaching death*

It is not uncommon for health care professionals to be anxious about their first encounters with death. The following points may help to allay some of the anxieties you might have arising from a limited knowledge base, and reduce some of the fear stemming from the 'unknown'.

- As the client's bodily systems begin to shut down, motion and sensation are gradually lost.
- Whilst the client's temperature may be elevated they often feel cold and clammy to touch. This can be disconcerting for both relatives and staff and can be eased by regular cleansing with moist wipes.
- Respirations may be noisy due to the build-up of secretions in the lungs. This can be distressing for relatives and inexperienced staff. Administering an antimuscarine such as hyoscine butyl bromide sublingually, if prescribed, can sometimes reduce this.
- Cheyne-Stokes respirations are common and again can be disconcerting if not expected or understood.
- Circulation fails and the blood pressure falls. It is therefore best to remove any monitoring devices, which tend to alarm when pulse, blood pressure and/or respirations fall outside the parameters set.
- Pain, if it has been present, may subside. Unfortunately this can sometimes lure relatives into a false sense of security.
- The client's mental condition usually deteriorates though it is thought by many that hearing remains acute and indeed may be accentuated immediately prior to death.

**If death occurs** inform the client's doctor as soon as possible that the death has occurred. He/she may write out the medical certificate of death when he/she visits the house, or may request you attend the surgery for this purpose.

## *Informing relatives*

If relatives are not present the identified next of kin should be informed of the client's deteriorating condition. Only in exceptional circumstances should relatives be informed of a death over the telephone. Those receiving notification of a sudden unexpected death may show severe emotional reactions. Encouraging survivors to view the deceased can seem quite brutal; however, this can help to reinforce the reality of the event and assist subsequent grieving. Consider the likely effect of showing personal emotion. It may or may not be appropriate depending upon the circumstances surrounding the actual/impending death.

## Accounting for valuables

- All valuables should be identified, accounted for and sent for safe-keeping as soon as is reasonably practical, in keeping with local policy.
- Any jewellery left on the deceased should be taped, and details noted on the appropriate documentation.
- A second responsible person should always be called on as witness when accounting for client property whether the client is deceased or otherwise.
- No valuables or other client property should be given to relatives prior to full documentation and a signature of receipt should be obtained.

## Last Offices

Specific needs in relation to Last Offices can vary according to the client's cultural and religious practices (see Table 7.1). It is therefore important to elicit the wishes of the client and of the relatives prior to death if at all possible, and to make sure that these wishes are clearly documented in the client's records and adhered to.

Some relatives may explicitly express a wish to undertake the Last Offices themselves, whilst others may wish to participate but are not aware of the possibility. Every effort should be made to elicit relatives' wishes in a tactful manner without creating a feeling of pressure. When relatives express such a desire this should, if at all possible, be facilitated, with both parties having a clear understanding of the desired degree of involvement. It is essential that client advocacy continues in death and every effort should be made to ensure continued privacy and dignity.

**Table 7.1 Last Offices: special considerations for different cultural and religious practices**

Religion	Special considerations
<b>Islam (Muslim)</b>	Family members will wish to be present at death to perform last rites and will request that the client's head be pointed towards Mecca (south-east in the UK). Relatives or religious leaders usually perform Last Offices as soon as possible after death either at home or in the mosque. If there is no family present, staff wearing gloves should straighten the body, remove tubes, catheters, cannulae, etc., turn the head towards the right shoulder, facing Mecca, and cover the body with a clean white sheet. Under no circumstances should nails or hair be cut. Organ donation is only permitted with the express permission of the imam (religious leader) and post-mortem only agreed if required by law. Islam requires that the deceased be buried, preferably within 24 hours.
<b>Jehovah's Witness</b>	Relatives sometimes wish to stay during Last Offices to read prayers and will inform staff of any particular requests. The church does not object to post-mortem or organ donation; this is therefore a matter of individual choice. Both burial and cremation are acceptable.
<b>Judaism</b>	If at all possible a Jewish person or Holy Assembly should be present at death, and they will perform ritual prayer and washing. The body must be left for eight minutes immediately following death before it is touched, and the funeral must take place within 24 hours, though it cannot take place during the Sabbath (Friday sunset until Saturday sunset). If strict orthodox the body should be handled as little as possible. If handling by non-Jews is necessary, gloves must be worn. If relatives are not present staff should straighten the body with hands open and arms parallel and close to the body, close the mouth and eyes, and remove cannulae, drains, etc. The body should be dressed in a shroud and covered with a clean sheet. Relatives may request that the body be laid on the floor with the feet projecting towards the door. It is customary for someone to stay with the deceased from death until burial and prayers will be recited during this time. Progressive Jews may be laid out as described in the text, while wearing gloves, but it is always advisable to check with the relatives or rabbi first if you are unsure. Post-mortem is only permitted if required by law.
<b>Mormon (Church of Jesus Christ of the Latter Day Saints)</b>	Last Offices as outlined in the text are usually acceptable. Relatives may wish to remain present to recite prayers and to dress the deceased in sacred underwear. There are no religious objections to organ donation or post-mortem.
<b>Rastafarian</b>	Last Offices as outlined in the text are usually acceptable. Relatives may wish to remain present to recite prayers. Both post-mortem and organ donation are generally considered to be distasteful.
<b>Sikhism</b>	The family will wish to be present at death, particularly the eldest son, and will normally perform Last Offices. They may, however, ask staff to straighten the body, close the eyes and mouth, and cover the deceased with a clean sheet. Under no circumstances should the turban, shorts, wrist bracelet or sword be removed. Hair (including beard) and nails should not be cut, nor the 'Kanga' (comb) removed. Post-mortem is only permitted if required by law, and organ donation is not allowed.