Basic Nursing Skills
For CHO/ SN






LEARNING OBJECTIVES

By the end of the session, participants will be able to :

- List key universal precautions to be followed during caring for the patient.
- Describe the method for preparing saline or soda bicarbonate solution and sterile supplies at home.
- Describe the key issues to be addressed while caring for a bed ridden patient.
- Describe the steps for prevention of bed sores.

LEARNING OBJECTIVES

- Describe important steps in caring for a patient with stoma [tracheostomy/ colostomy]
- Describe the important steps in caring for a patient on urinary catheter and nasogastric feeding.
- Describe the management of fungating wound in home care setting.
- Describe the steps in management of lymphedema in upper limb.

NURSING CARE OF BED RIDDEN PATIENTS IS CHALLENGING

In a bedridden patient, the care includes:

- Health education of the family and involving the family in care.
- Demonstrate the care and make a follow up plan.
- Airway clearance. Patient may be conscious or unconscious.
- Adequate fluid intake (oral, nasogastric tube feeding)
- Bowel and bladder care
- Personal hygiene- head to foot care
- Prevention and care of pressure sores
- Exercise and Communication
- Regular home visits for assessment of symptoms, care giving, recording and reporting.

WHAT ARE THE BASIC NEEDS OF PATIENT ?

- Oral care
- Skin care
- Eye care
- Ear & Nose care
- Hair care
- Perineal care
- Nail care

CARE OF HAIR

- Explain the procedure to the patient
- Help the patient move his/her head towards the edge of the bed and remove the pillow
- Protect the bed linen and pillow cover with a towel and mackintosh [rubber/ plastic sheet].
- Insert the cotton balls in to the ears
- Place a mackintosh under the patient’s head and neck. Keep one end of the mackintosh in a bucket to receive the water
- Wash thoroughly with soap or shampoo. Rinse thoroughly and dry the hair. Braid the hair into two on each side of the head.
- Remove the cotton balls from the ear

BED BATH

Bathing is very important in maintaining and promoting hygiene

Objectives:

- To clean the dirt from the body
- To increase elimination of wastes through the skin.
- To stimulate circulation
- To induce sleep
- To provide comfort
- To give the patient a sense of well-being.
- To regulate body temperature.

PROCEDURE

- Maintain privacy.
- Explain the procedure.
- All needed equipment should be at hand and conveniently placed.
- The temperature of the water should be adjusted for the comfort of the patient
- Keep the patient near the edge of the bed to avoid over reaching and straining of the back of the care giver.
- Only small area of the body should be exposed and bathed at a time.

PROCEDURE

- Remove the soap completely from the body to avoid the drying effect.
- Cleaning is done from the cleanest area to the less clean area, e.g. upper parts of the body should be cleaned before the lower parts.
- Wash the hands and feet by immersing them in a basin of water because it promotes thorough cleaning of the finger nails and toe nails
- A thorough inspection of the skin especially at the back of the body should be done to find out the early signs of pressure sore
- Apply moisturizing cream and massage at least 3-5 minutes

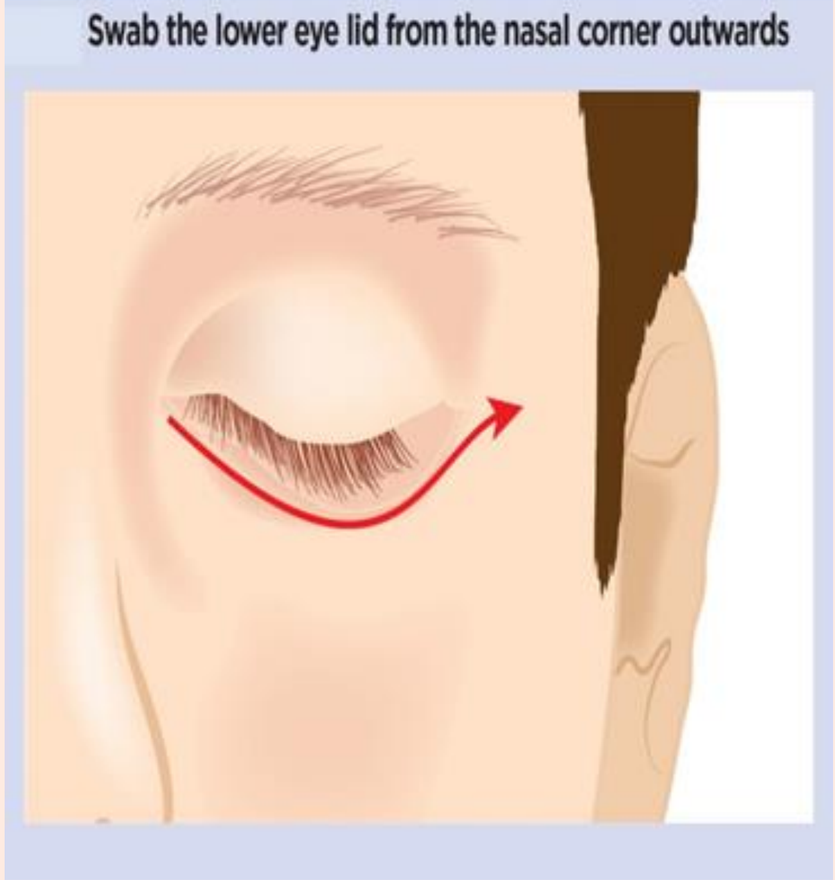
CARE OF EYES

Objectives:

- To relieve pain and discomfort.
- To prevent or treat infection.
- To prevent or treat injury to the eye.
- To detect disease at an early stage.

PROCEDURE

- Explain the procedure to the patient.
- Provide comfortable position
- Wash Hands
- Clean the eyelids and eyelashes with wet swabs
- Wipe the lids from the inner canthus to outer canthus
- Use one swab for one stroke
- Documentation



CARE OF NOSE AND EAR

- Explain the procedure to the patient
- To remove the secretions from the nostrils, wet wash clothes or a cotton applicator moistened with normal saline or water
- Check for any dirt accumulated behind the ears and in the front part of the ear.
- Collection of wax in the ear may cause hearing problem.

ORAL CARE

Mouth is an excellent incubator for growth of bacteria

Objectives:

- To promotes good oral hygiene
- To promotes comfort
- To promotes appetite
- To prevents infection
- To prevent and treat dryness and halitosis

WHO NEEDS MOUTH CARE?

- Terminally ill patients
- Post operative patients
- Patients with infections and disease of mouth
- Patients on Nasogastric tube feeding
- Unconscious Patients
- Patients breathing through mouth

ASSESSMENT

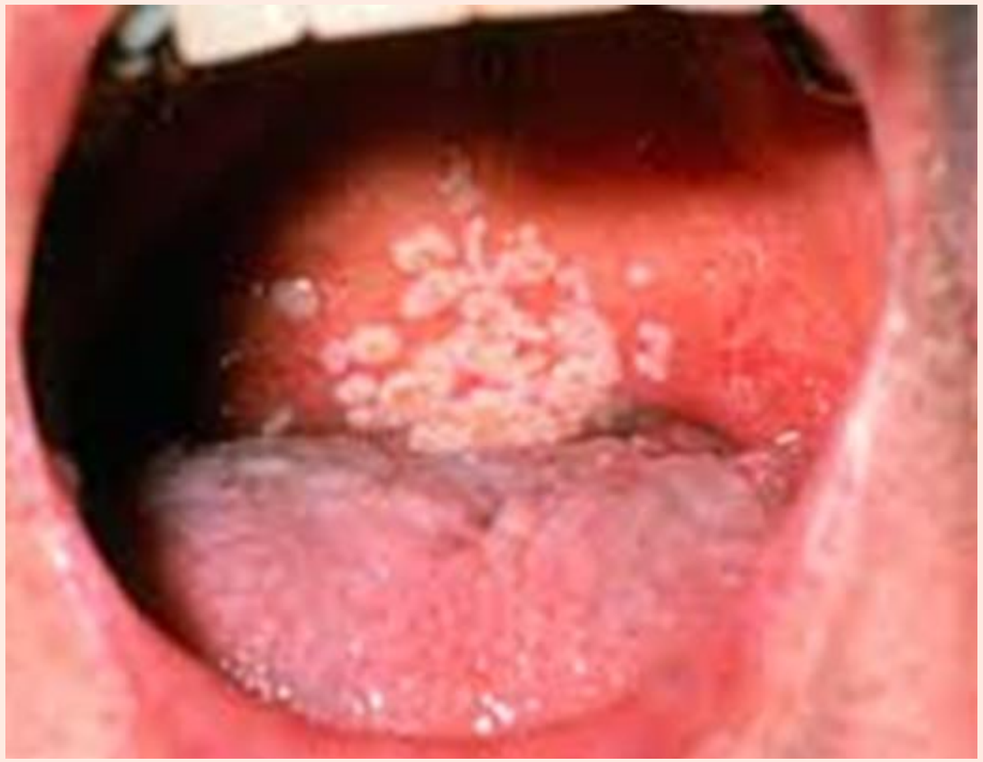
- Cracked lips
- Dry or coated tongue.
- White curd-like patches
- Ulcers in the mouth.
- Any redness or bleeding.
- Medication history
- Any pain in the mouth
- Dysphagia/ change in taste of food
- Any difficulty in chewing
- Anorexia
- Unpleasant smell
- Treatment history

COMMON ORAL PROBLEMS

- Dry mouth
- Painful mouth
- Halitosis
- Candidiasis
- Alteration in taste
- Excessive salivation

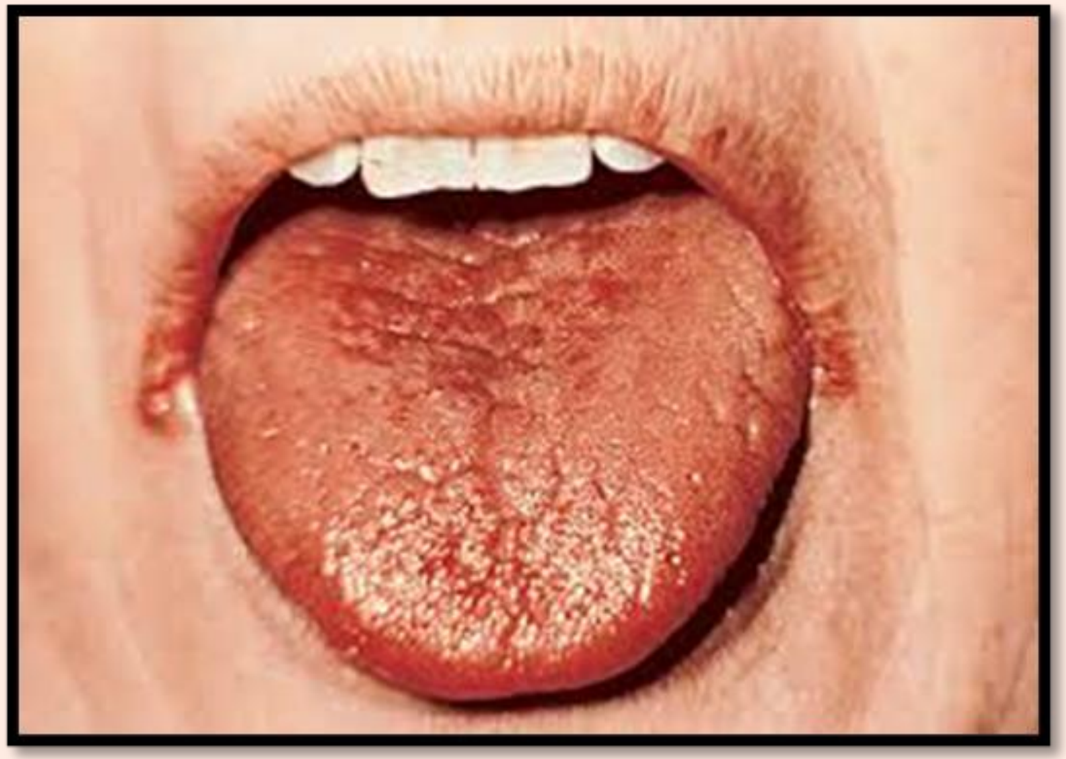
COMMON ORAL PROBLEMS

CANDIDIASIS



COMMON ORAL PROBLEMS

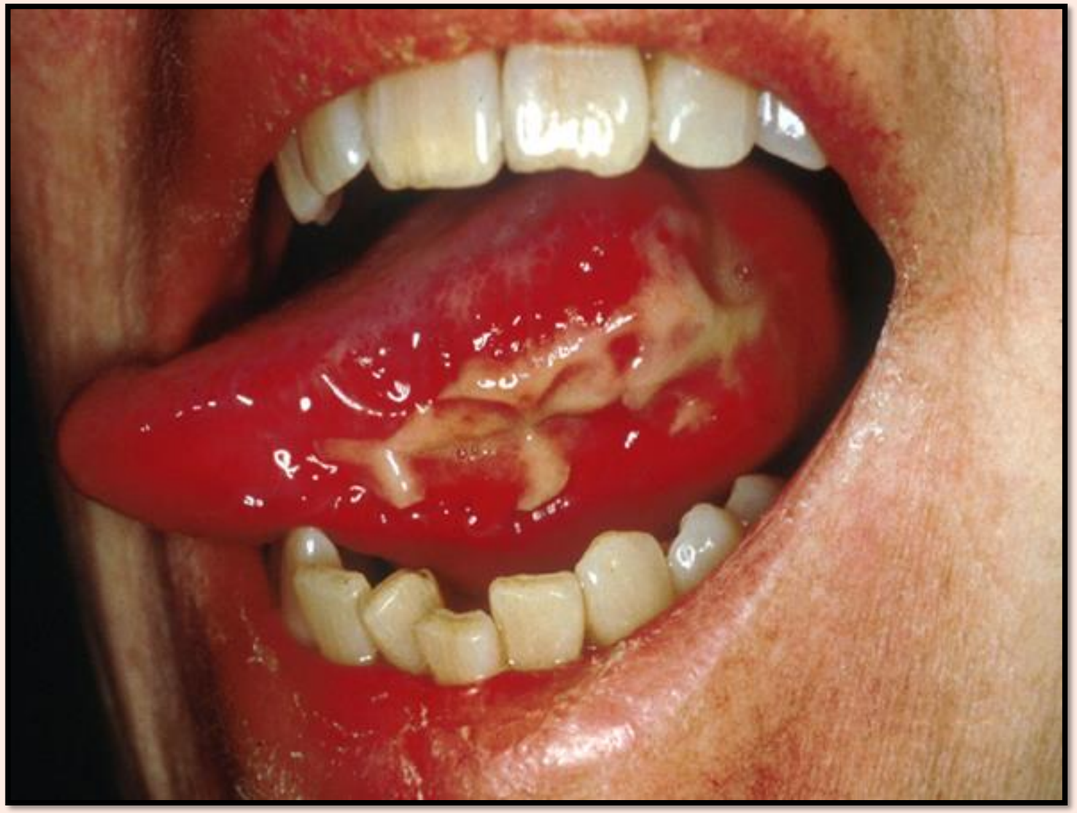
XEROSTOMIA



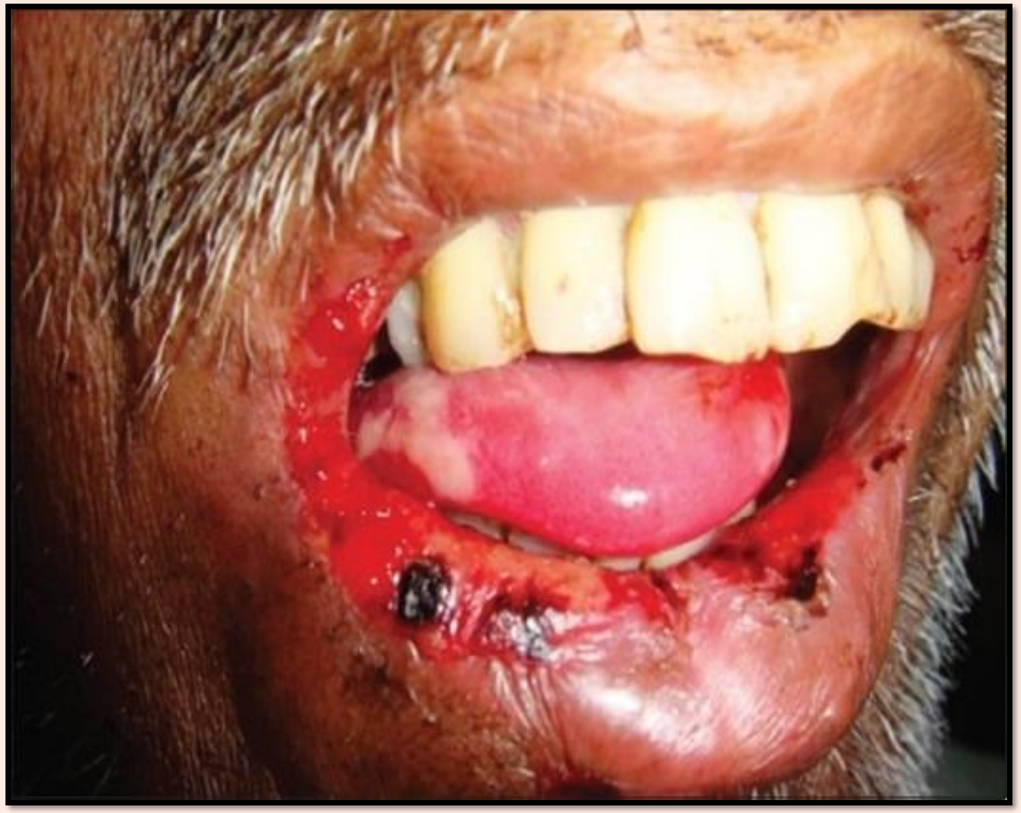
HALITOSIS

COMMON ORAL PROBLEMS

ORAL MUCOSITIS

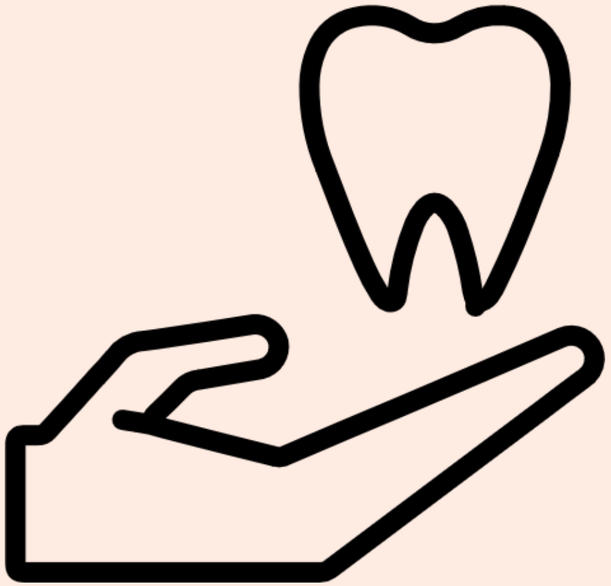


STOMATITIS-ORAL MUCOSITIS



SOLUTION USED FOR MOUTH CARE

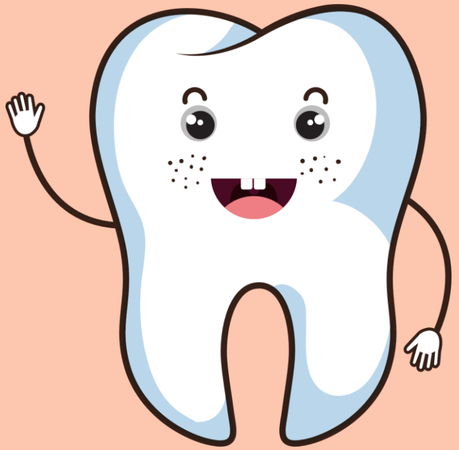
- Water or 0.9% sodium chloride
  - Preparing saline solution: 500 ml water + one teaspoon of common salt (Boil, cool and keep covered until needed)



- Other options: Soda bicarbonate
  - Preparing soda bicarbonate solution: 500 ml of boiled water + ¼ teaspoon of baking soda

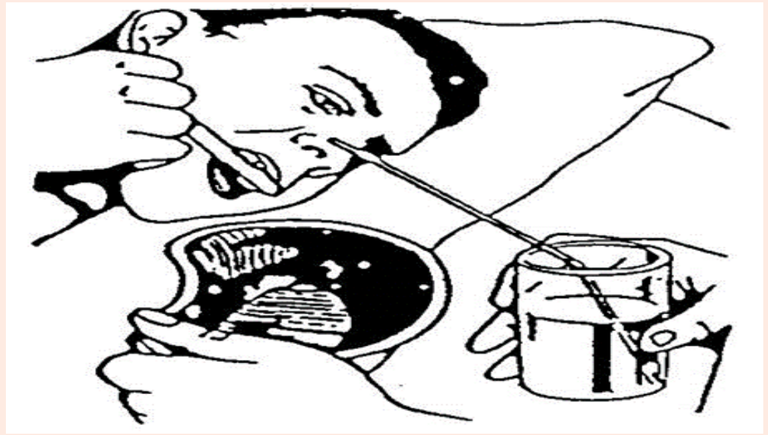
SELF CARE EDUCATION

- Brush the teeth twice a day- with a soft toothbrush
- Toothpaste left in the mouth can cause dryness
- Rinse the mouth – with warm saline or soda bicarb solution
- Tongue – to be brushed with soft toothbrush
- Take plenty of fluids
- Pineapple – contains a mouth cleansing enzyme; also a salivary stimulant; however, it is acidic
- Dentures should be removed at night

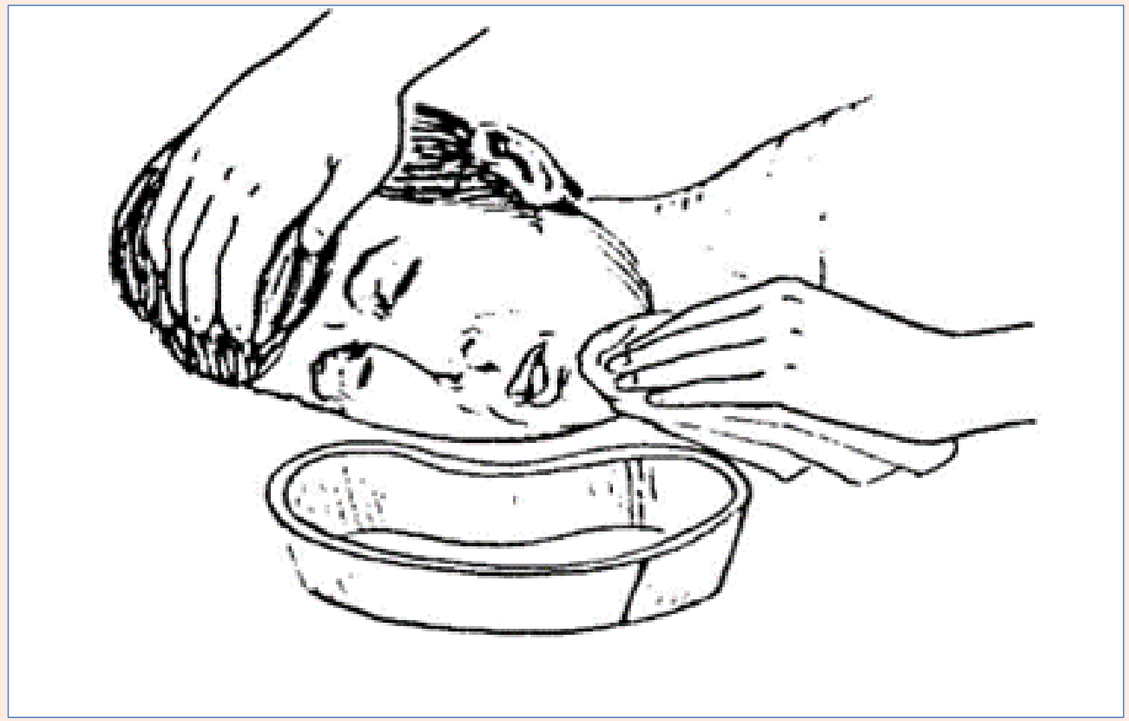


PROCEDURE FOR A PATIENT REQUIRING ASSISTANCE

- Explain the procedure to patient
- Provide privacy
- Bring the patient to the edge of the bed, and preferably in semi-fowler's (raised) position if not contraindicated.
- Position pillow according to the comfort of the patient
- Place a towel under his chin and over the bedding.
- Pour the water over the brush; place dentifrice on it.



- Encourage the patient to rinse his mouth frequently
- Remove the basin; wipe his face and lips with the hand towel.
- Remove and clean the equipment.
- Wash your hands.
- Document time, solution used, condition of the oral cavity








ARTCILES REQUIRED FOR PROCEDURE FOR A TERMINALLY ILL PATIENT

HOSPITAL SETTING

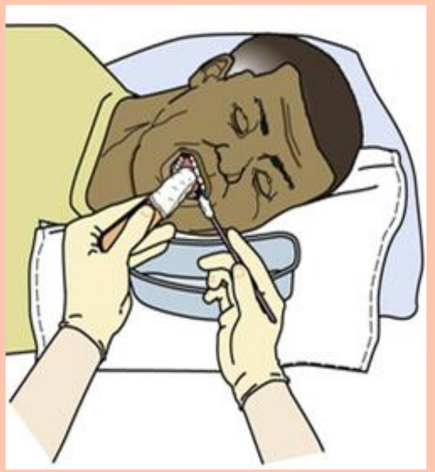
- Artery forceps and bowl
- Tongue depressor
- Gauze piece
- Kidney Tray
- Swab sticks
- Small mackintosh
- Face towel
- Normal saline

HOME CARE SETTING

- Clean cotton cloth/Gauze piece
- Homemade normal saline
- Spoon / ice cream sticks
- Small Mackintosh
- Face towel

PROCEDURE FOR A TERMINALLY ILL PATIENT

- Explain the procedure to the patient
- Provide privacy
- Semi fowler's position (45 degrees raised position) and head turned toward the side
- Place a small mackintosh with a face towel under the head
- Use a padded tongue blade to open the patient mouth and separate the upper and lower teeth
- Soak cotton balls in solution and squeeze out excess by using artery forceps.



- Clean teeth from incisors to molar using up and down movements, from gums to crown.
- Clean oral cavity from proximal to distal (closest to furthest), using one cotton ball for each stroke.
- Lubricate lips using swab stick. Document time, solution used, condition of the oral cavity, any abnormalities noticed, and the patient’s response

COMMON LUBRICANTS FOR LIPS

- Liquid paraffin
- Coconut oil
- Ghee oil
- Vaseline

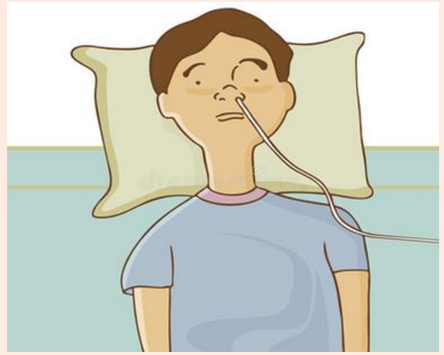
BACK CARE

- Give special attention to the pressure points. If prone to pressure sores – back care every 2 hours
- Lather soap by sponge towel. Wipe with soap and rinse with plain warm water
- Dry the area by patting and not by rubbing.
- Apply moisturizing cream and massage at least 3-5 minutes.
- Massaging helps to increase the blood supply to the area and prevent pressure sore.

NAIL CARE

- Explain the procedure to the patient
- Assemble articles
- Place the rubber sheet under the patients hand or leg
- Soak the fingers in warm water for 5 minutes
- Cut the free edges of the nails
- Encourage the caregiver to provide nail care

CARE OF NASOGASTRIC TUBE



- Perform hand hygiene
- Give fowlers or semi fowlers position before feeding
- Prevent air entry in the tube by pinching it.
- Aspirate and make sure that the tube is in the stomach. If more than 50ml - skip the feed
- Food item is thoroughly grinded and filtered. If not the big particles of food will obstruct the tube.
- Every 2 hourly give 200-250ml (homemade) about 25ml of plain water is given before and after the feed.
- Keep the patient same position at least 30minutes
- Provide oral care and keep the lips moist
- Change the adhesive periodically to prevent ulcer formation

NUTRITION AND HYDRATION

- Well balanced diet and adequate fluid intake
- locally available foods unless if it is restricted.
- Remember force feeding induce vomiting.
- Try to focus on patient preference
- Some food odour can cause nausea and vomiting to the patient, if so avoid it.
- Small frequent diet can be advised.

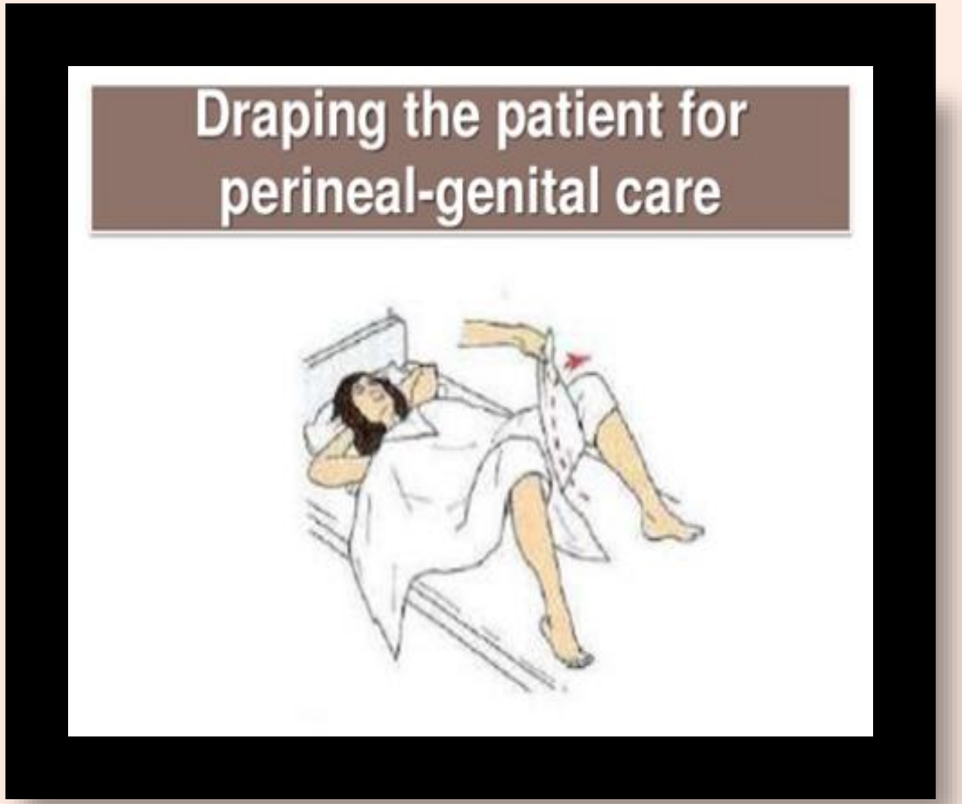
ACTIVE AND PASSIVE EXERCISE

- Exercise must be integrated into the patient's daily life as it prevents contractures, foot drop and wrist drop.
- All the joints need physiotherapy.
- Educate the family the importance of exercise to prevent joint stiffness.

CARE OF PERINEUM

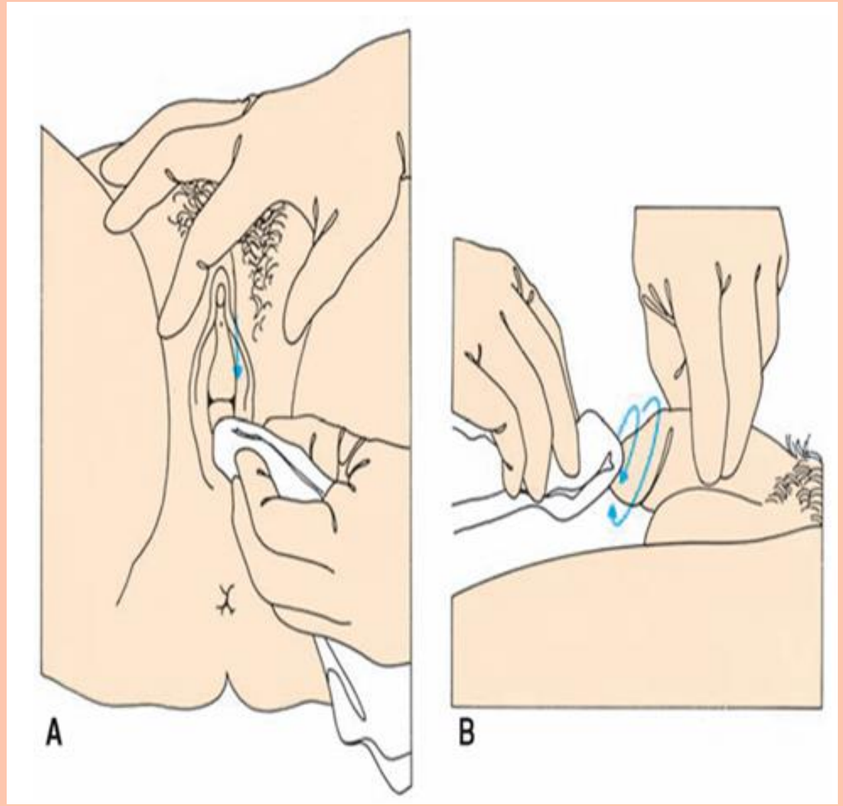
Objectives:

- To maintain perineal hygiene
- To prevent and treat infection



PROCEDURE

- Perineum should be cleaned after each act of urination and defection.
- Clean with soap and water daily 3 to 4 times and keep the area dry.
- Clean from the cleanest to the less clean area.
- The urethral orifice is considered as the cleanest area and the anal orifice is considered as the least clean area.
- Hands should be cleaned after giving Perineal care.



BOWEL CARE

- In a bedridden patient due to lack of exercise, privacy ,reduced food intake, medication etc. causes constipation

- Encourage patients for bowel movement daily. Give time for the bowel movement.

- Patients should be encouraged to take high fiber diet ,adequate fluid intake.

- Encourage regular exercise

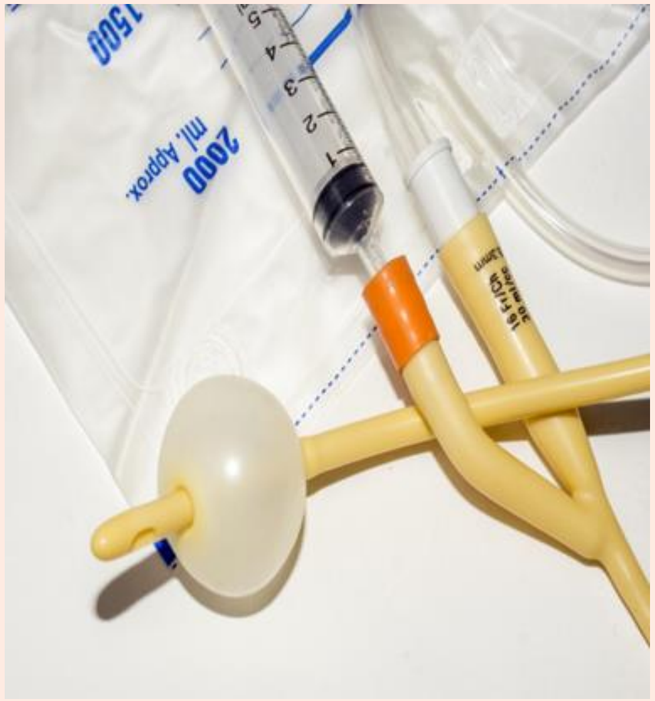
BOWEL CARE

- Use of bedpans: It is mandatory to maintain patients' privacy and use of a commode or lavatory for defecation
- If patient complains of spurious diarrhoea, ask the history when it started and before the onset what was the condition.

Management: Per Rectal Examination, Manual Removal and Enema.

BLADDER CARE

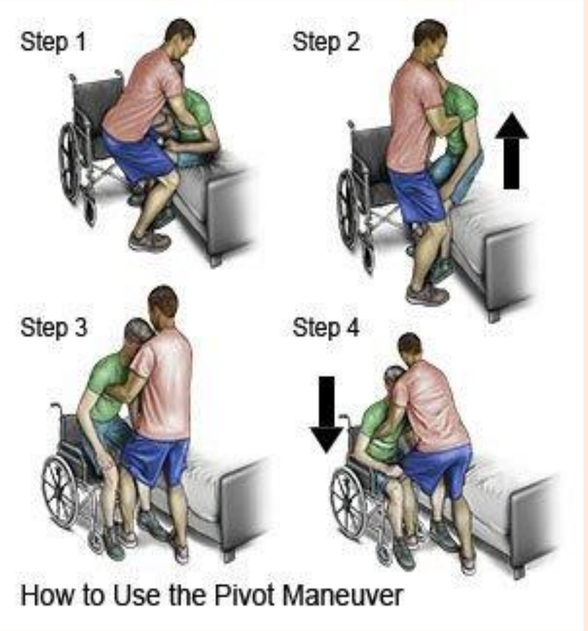
- The catheter should be changed from 3 weeks to 1 month
- Provide perineal care (clean below the umbilicus to the mid thigh with soap and water)
- Keep the urobag cap always closed and below the waist level
- Empty bag when it is ¾ th full.
- Intake of fluid –at least 2.5 to 3litres in 24hours



- Observe urine is draining freely. Any colour change in the urine should be reported
- Encourage the patient for daily bowel movement.

LIFTING, SHIFTING AND TRANSFERRING THE PATIENT

- Before starting to lift a patient, always explain the procedure to him.
- Consider the weight of the patient.
- Identify the need for help before lifting.
- If the patient is obese, do not attempt to lift the patient by yourself. Get one partner.
- Use your legs to lift.
- Have the feet positioned properly.
- Keep the weight close to the body.
- Lift without twisting



How to Use the Pivot Maneuver

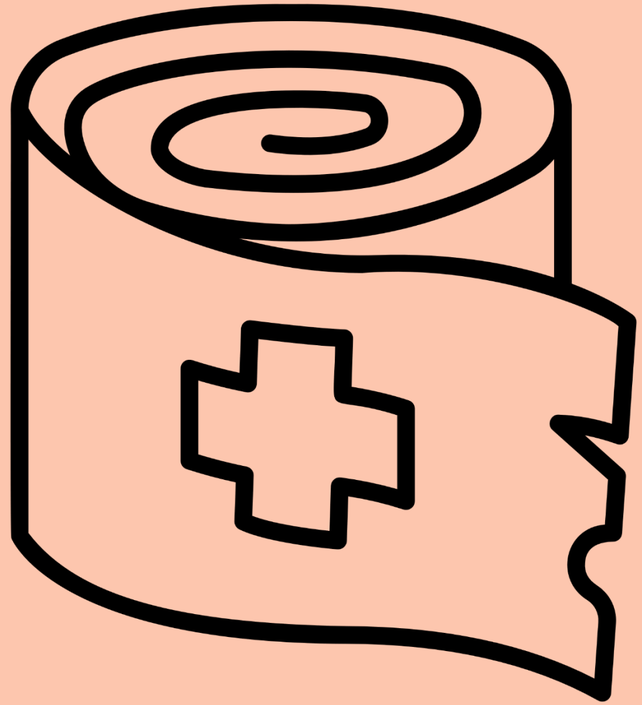
BED MAKING

- To provide comfort
- To change wet/soiled linen for the bed ridden patients
- To maintain neat appearance and clean environment
- To provide a smooth wrinkle free bed

Pressure Ulcer

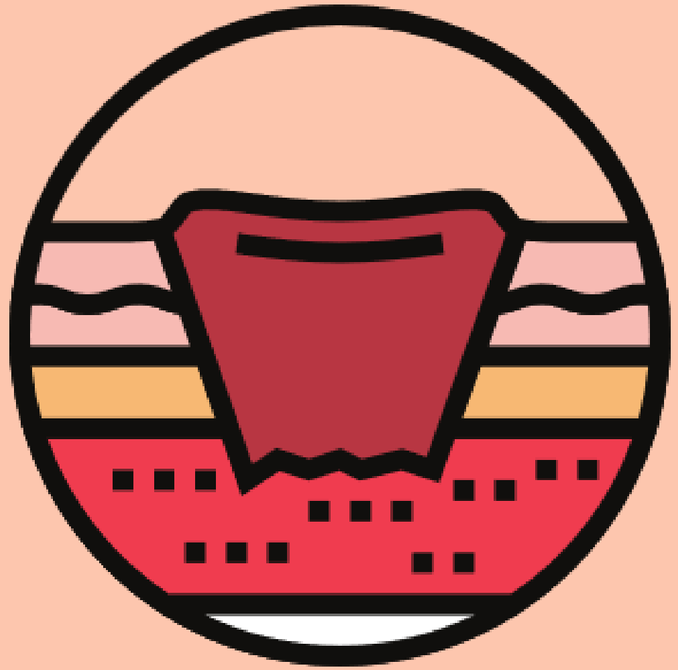
Fungating wound

Lymphoedema

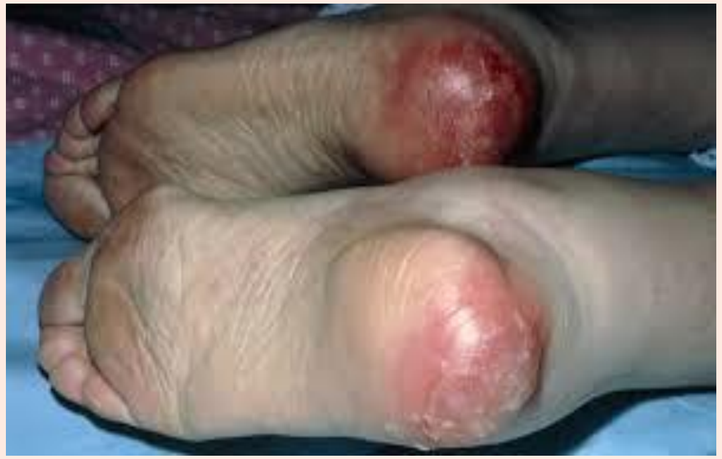


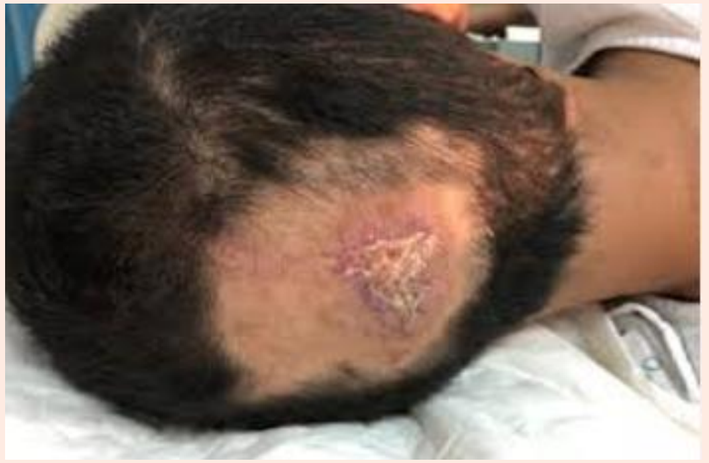
PRESSURE ULCER

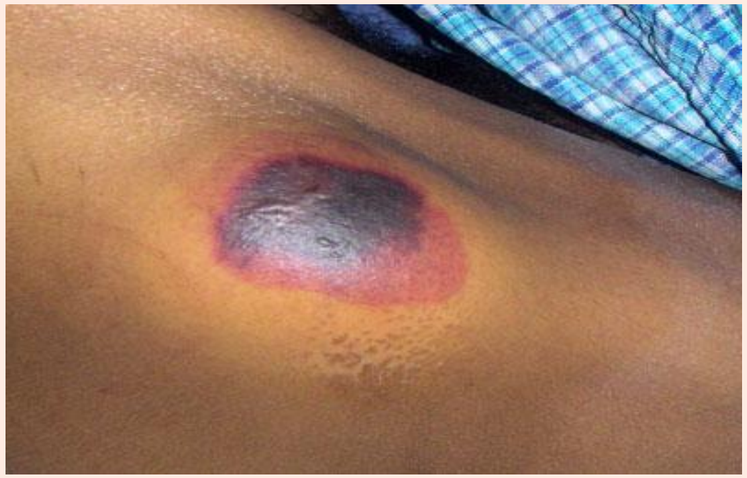
Pressure ulcer is localized injury to the skin and other underlying tissue, usually over a body prominence, as a result of prolonged unrelieved pressure.

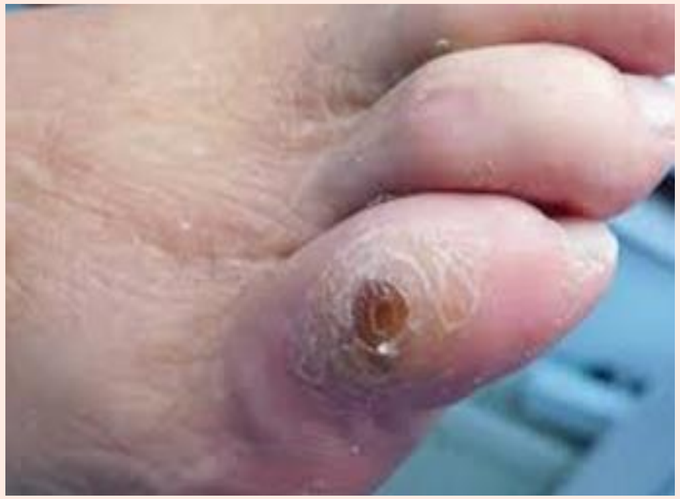


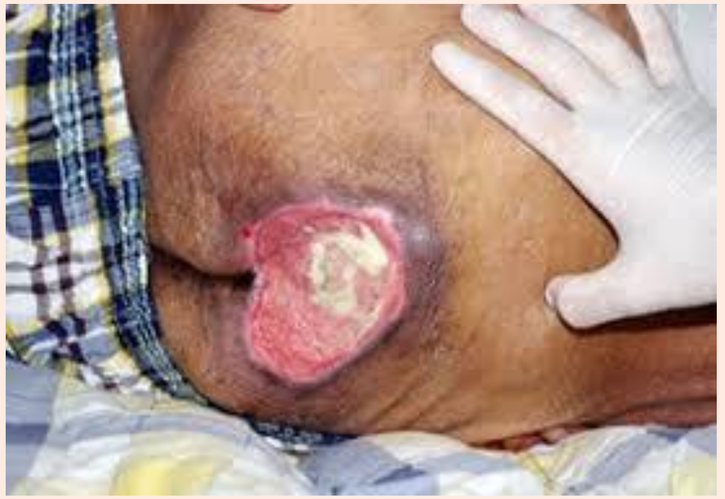
PRESSURE SORE IMAGES – DIFFERENT PARTS

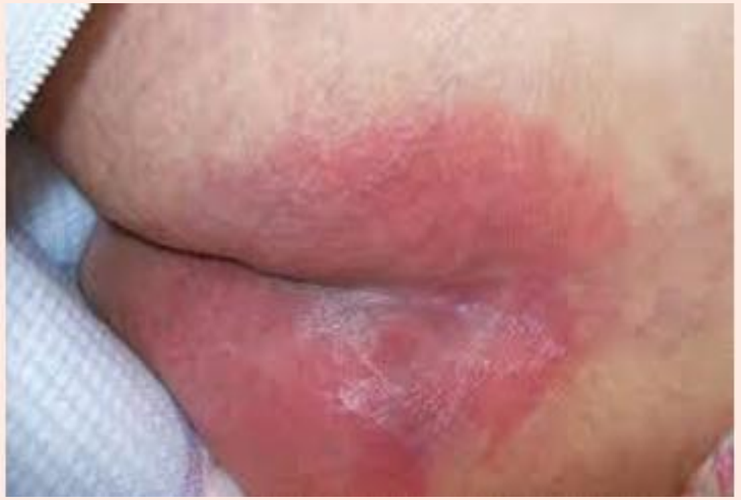












PATHOPHYSIOLOGY

Pressure for a long time

↓

Collapse of blood vessels

↓

Nutrition ,Oxygen & tissue perfusion

↓

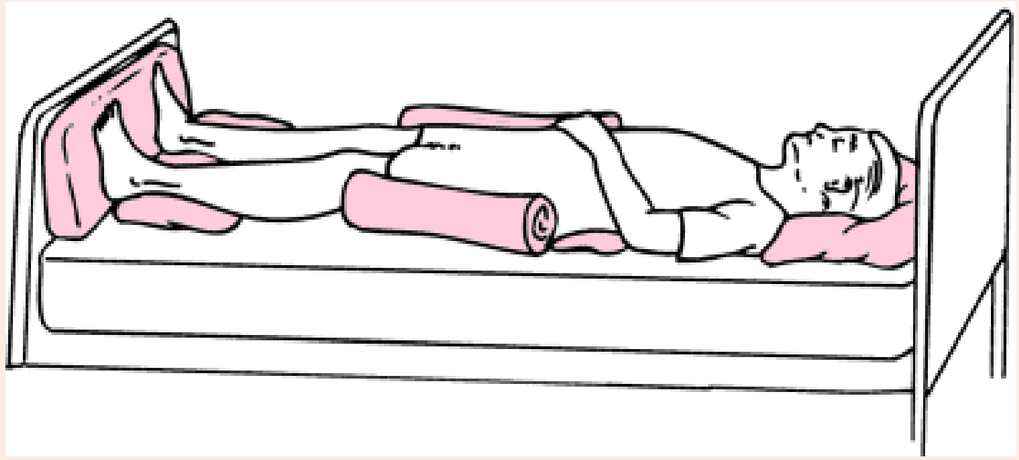
Tissue ischemia & hypoxia & cell death

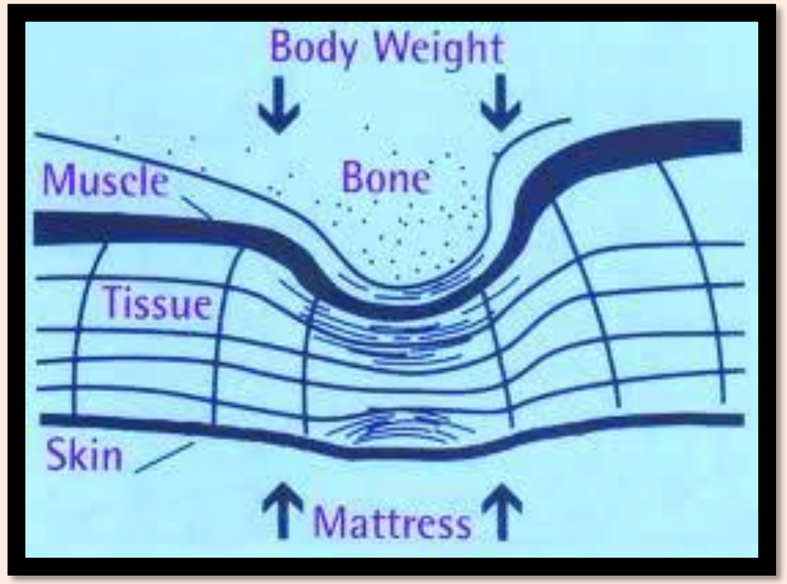
↓

Stress

↓

Breakdown of skin



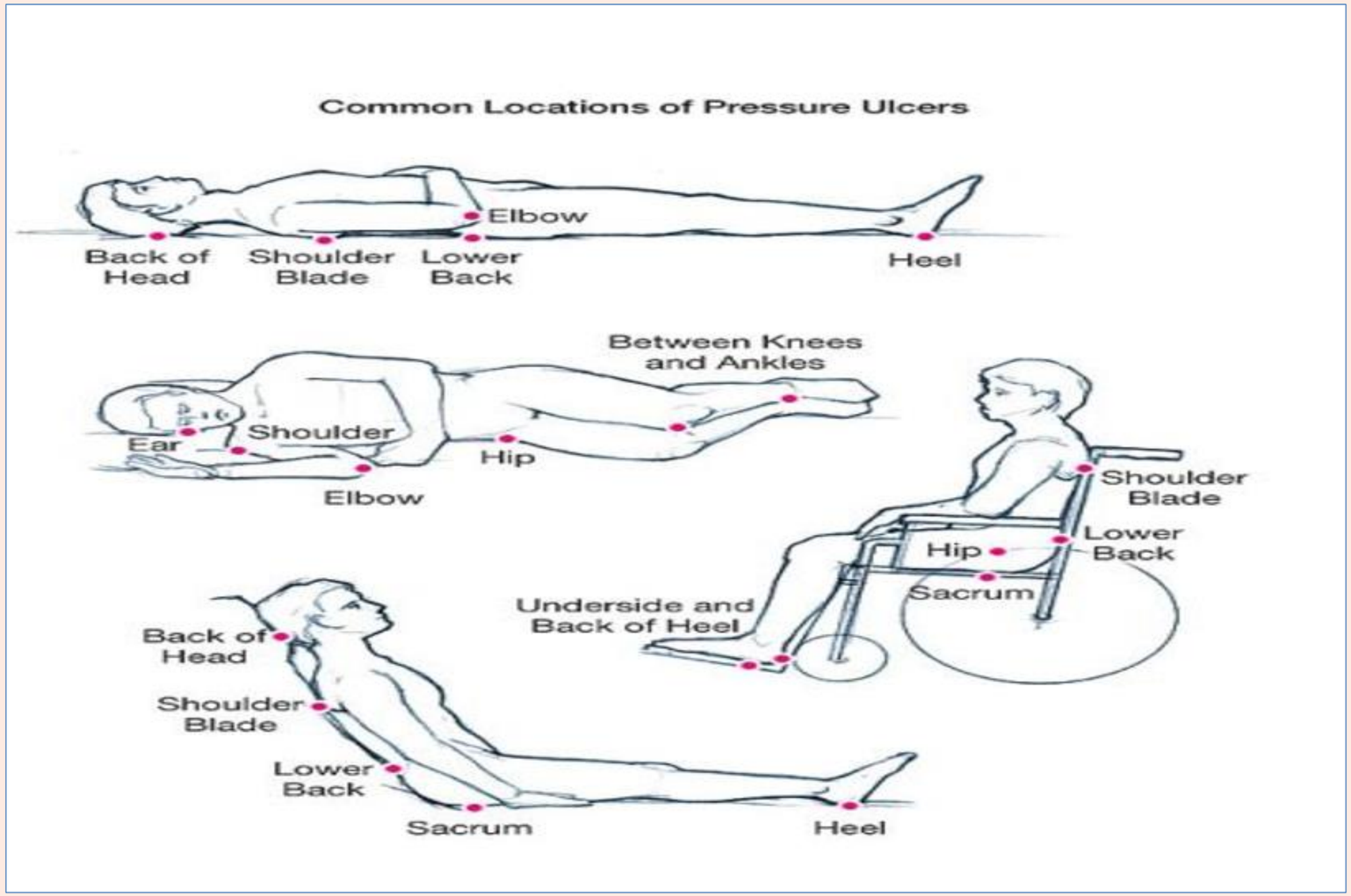


RISK FACTORS

- Friction
- Shear
- Impaired sensory perception
- Impaired physical mobility
- Altered level of consciousness

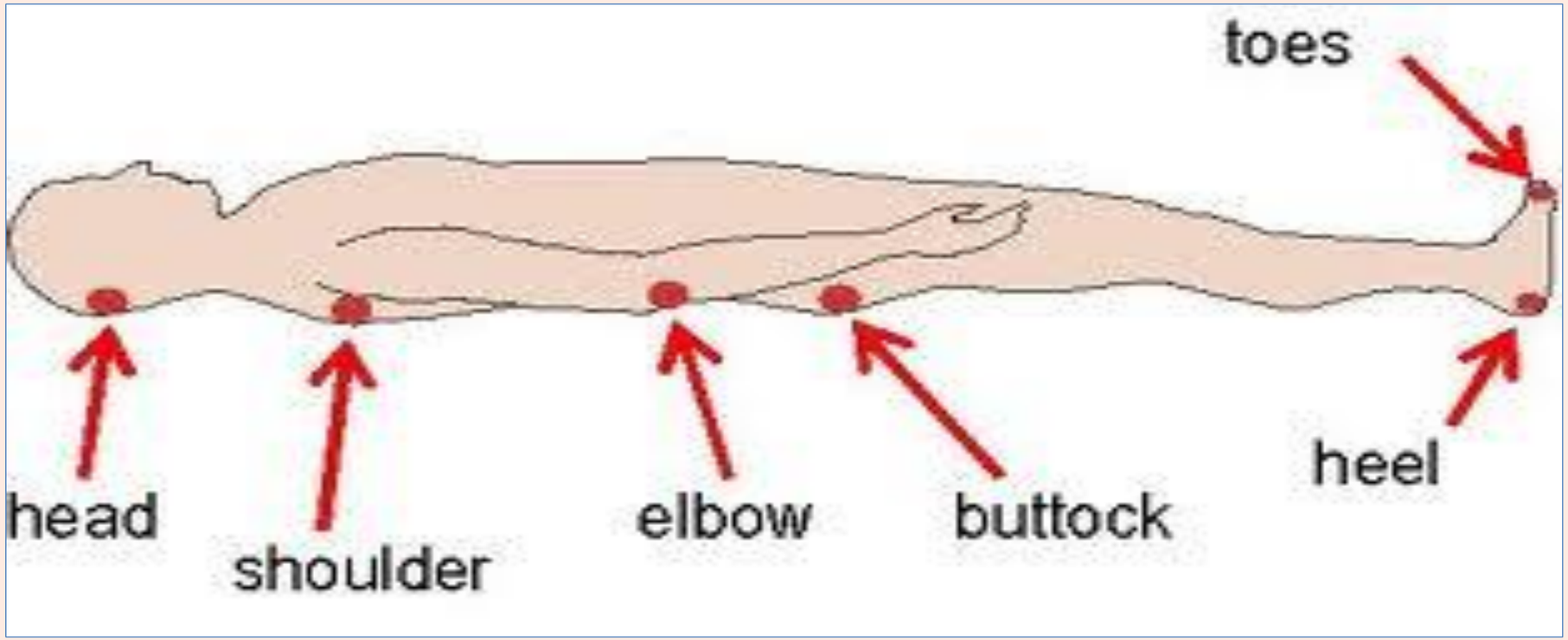
- Fecal and urinary incontinence
- Malnutrition
- Dehydration
- Excessive body heat
- Advanced age

COMMON SITES OF PRESSURE ULCERS



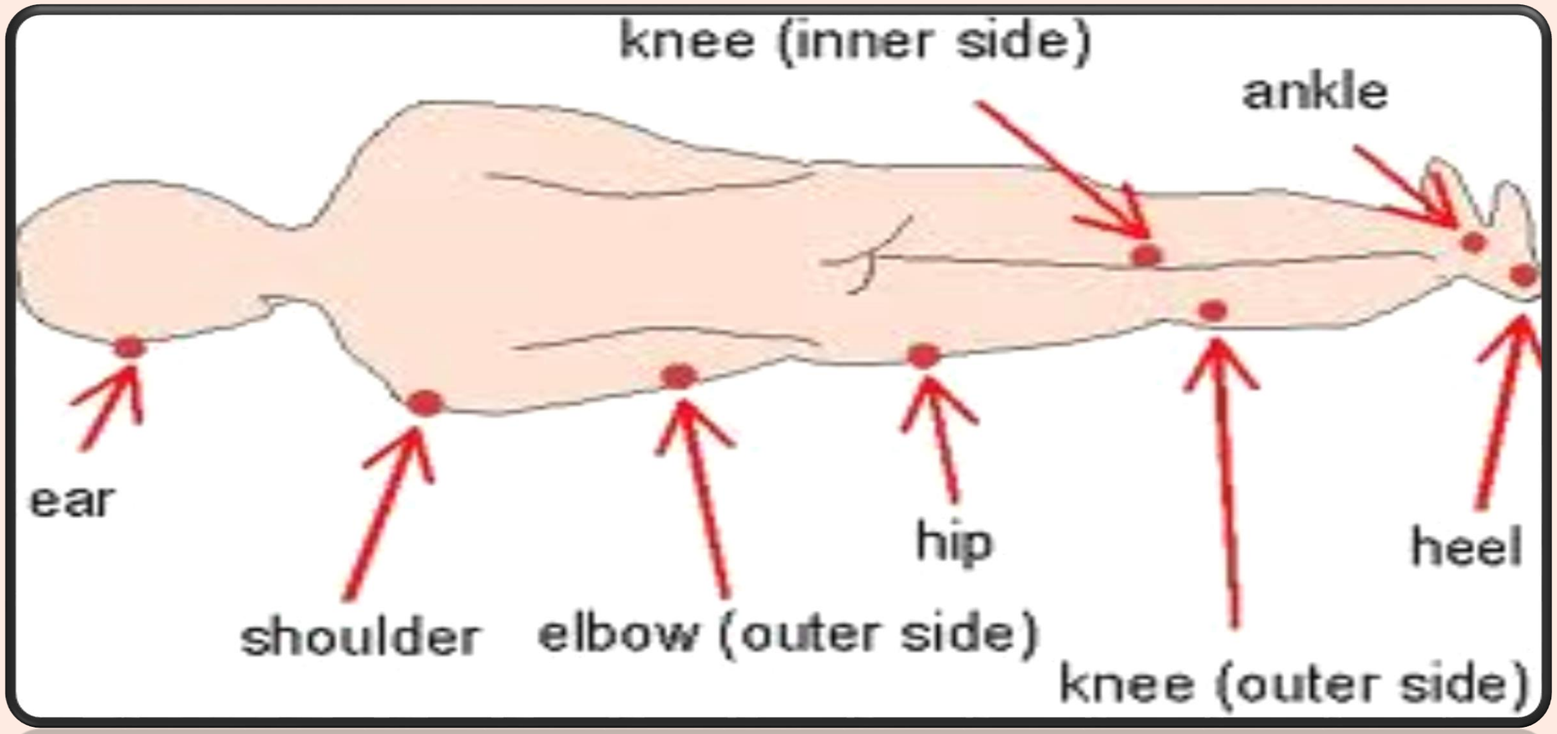
COMMON SITES- SUPINE

(Occiput, elbows, sacral region, heels and scapula)



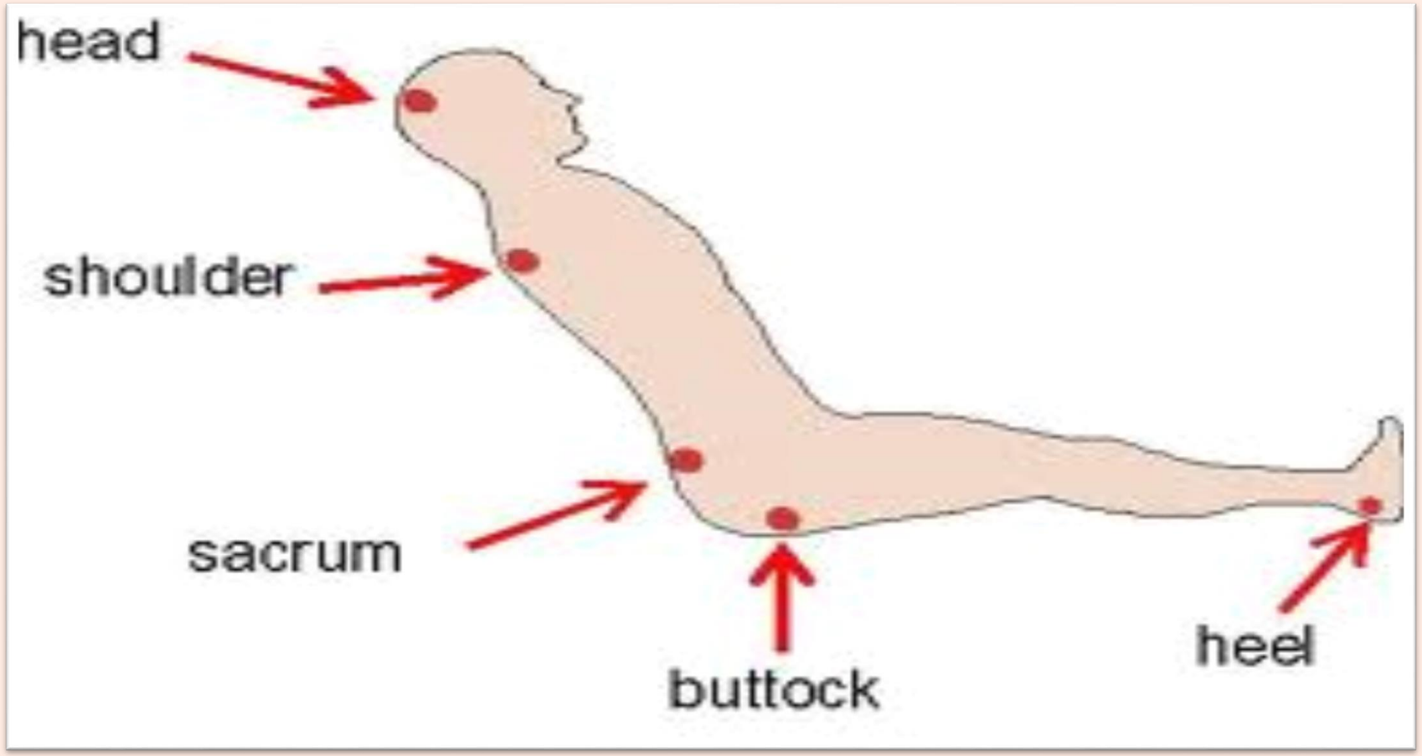
COMMON SITES- SIDE LYING

(Ear, Acromion process, ribs, greater trochanter, medial & lateral malleolus, lateral condyles)



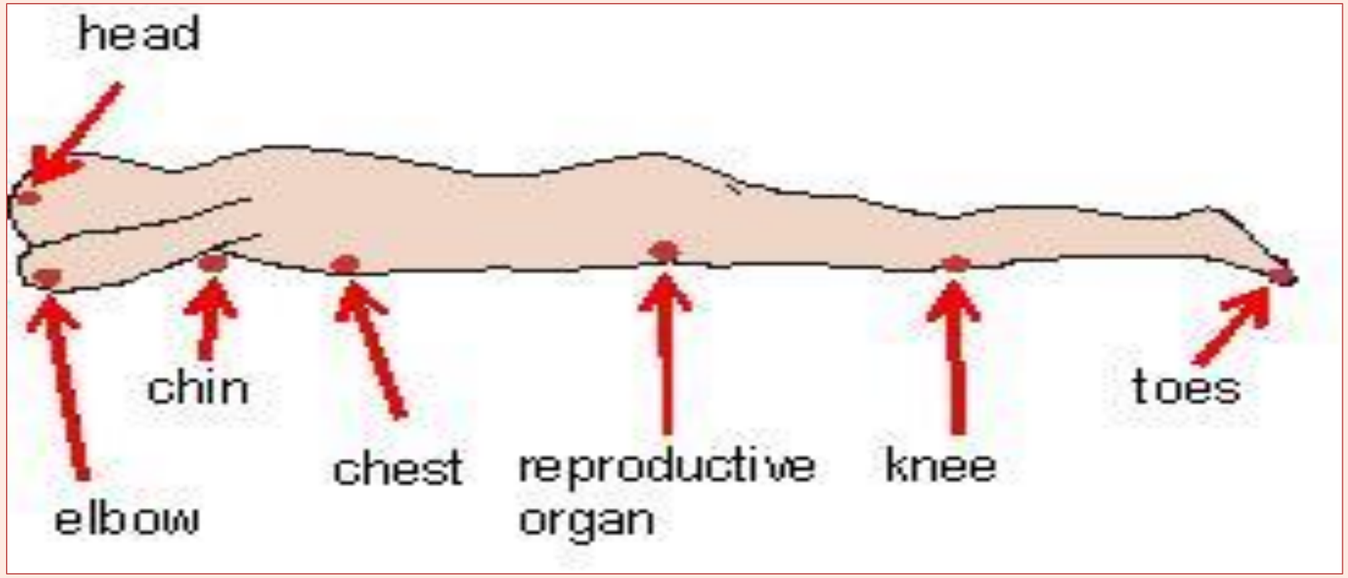
COMMON SITES- FOWLERS

(Head, Shoulder, Sacrum, buttock Ischial tuberosity and heel)



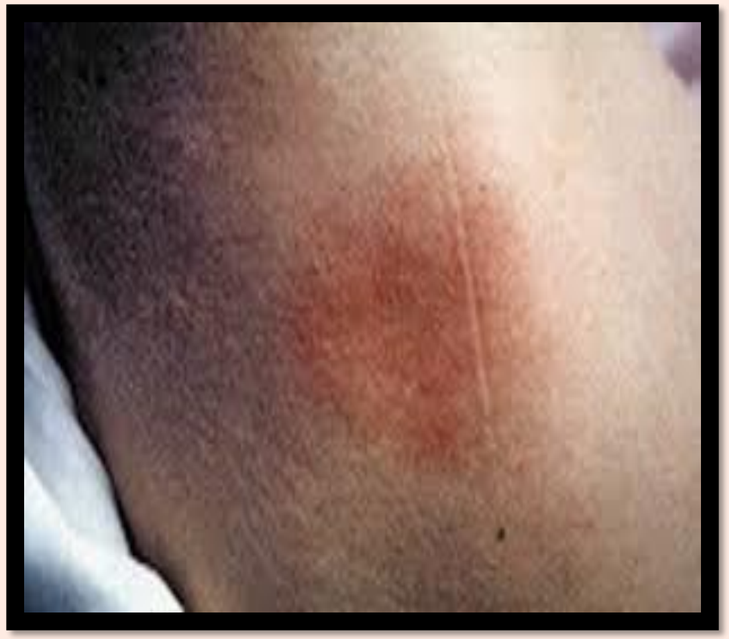
COMMON SITES-PRONE

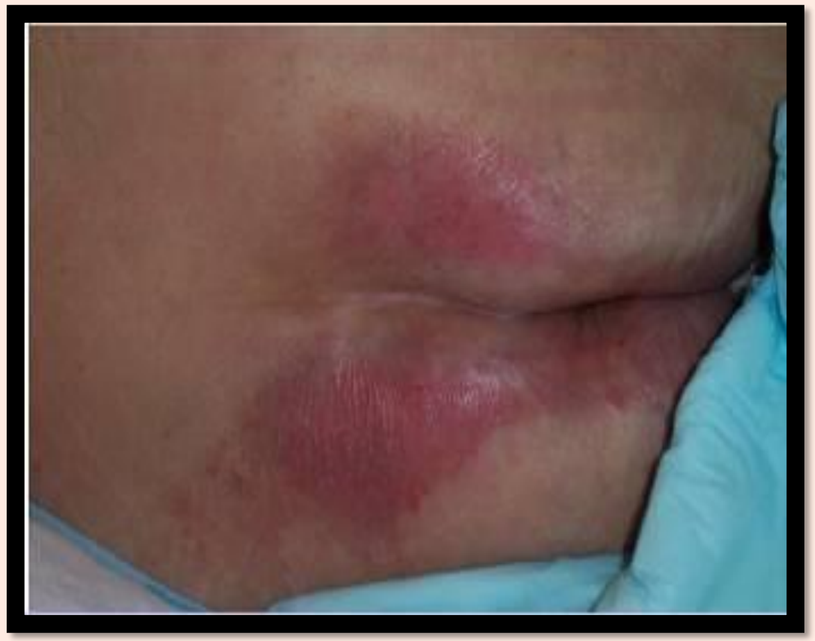
(Head, elbow, chest, reproductive organs, knee and toes)



STAGES OF WOUND

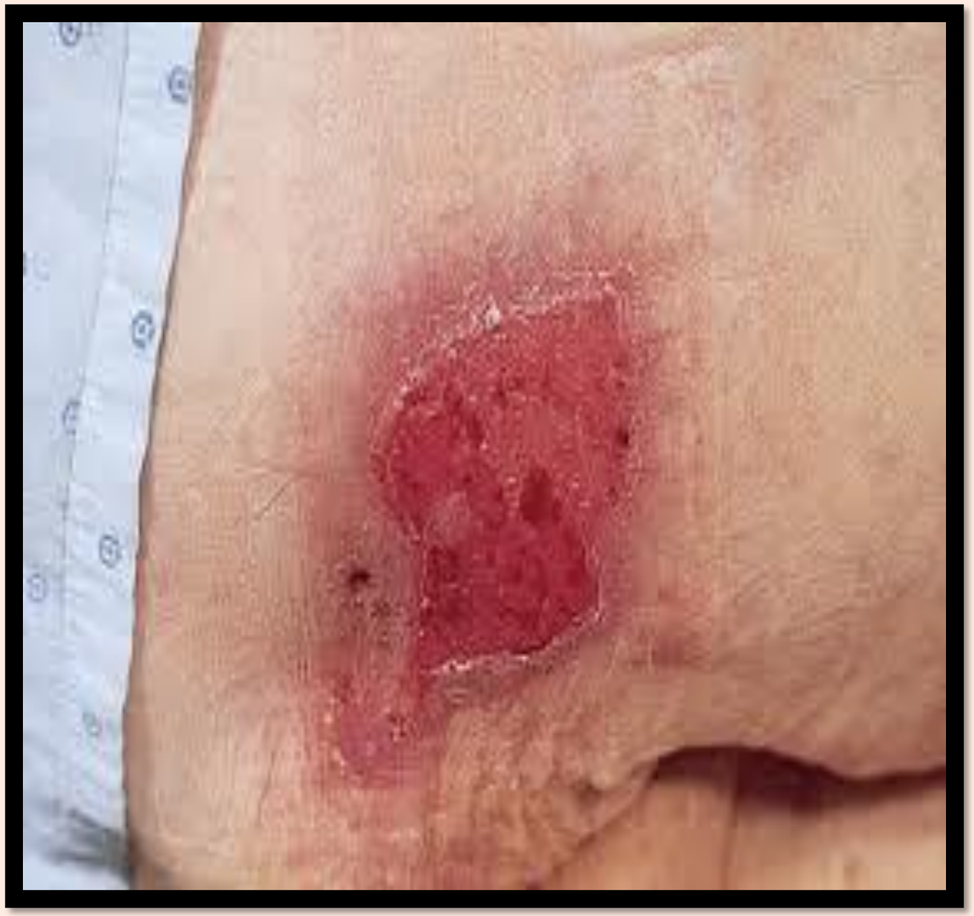
Stage –I
red/differently colored spot that do not blanch with pressure (Nonblanchable Erythema)

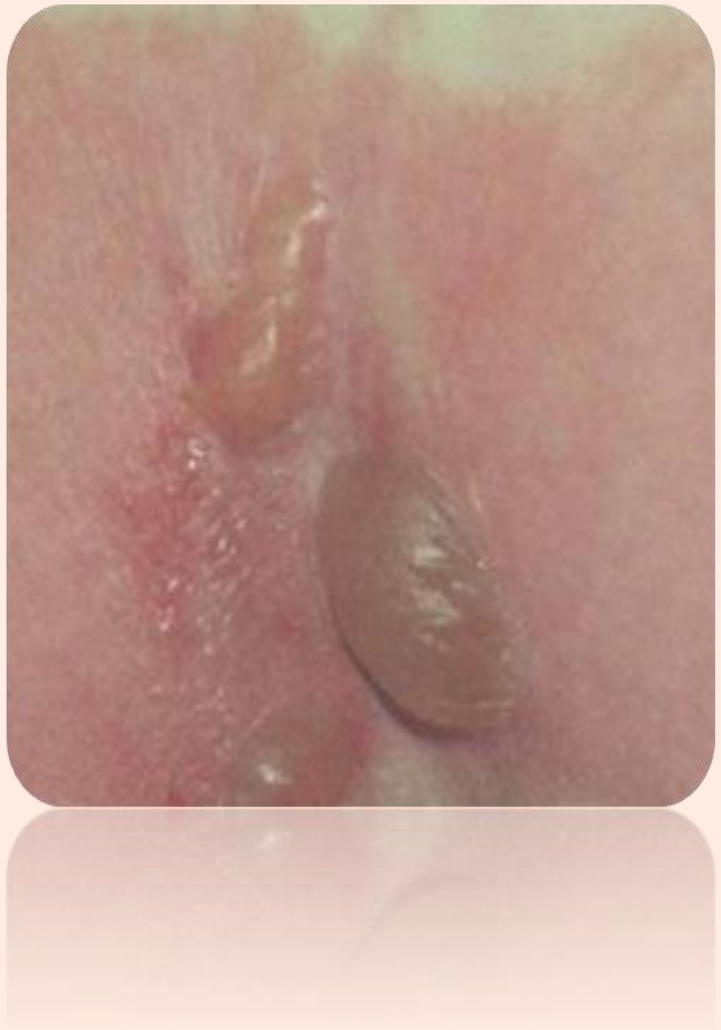




STAGE-II

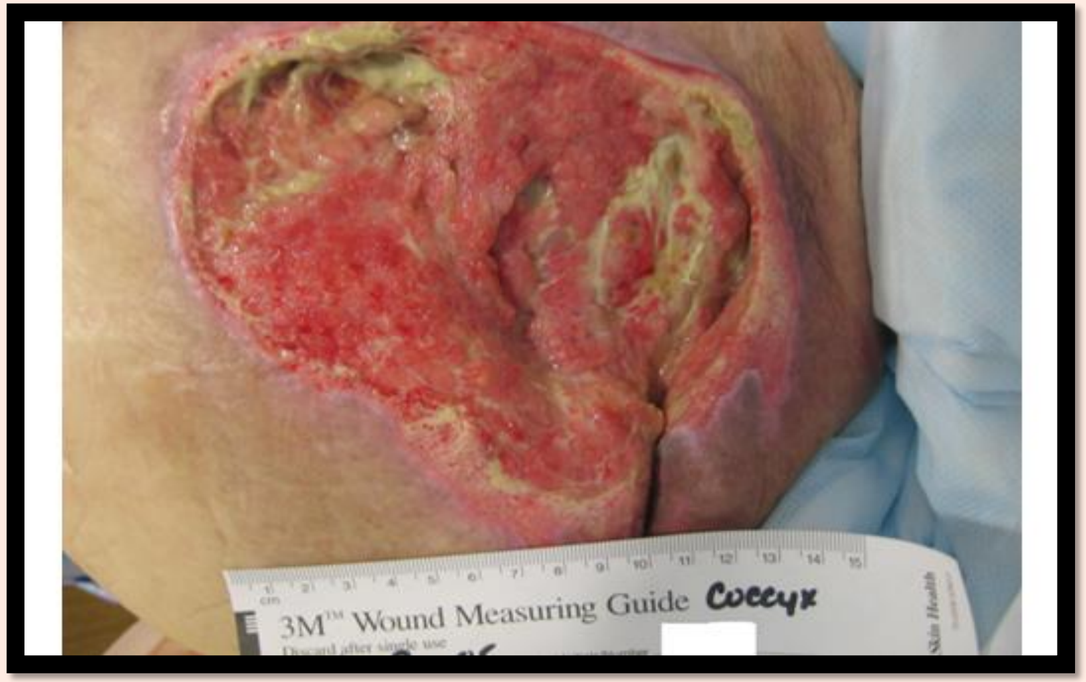
Shallow open ulcer, into the dermis





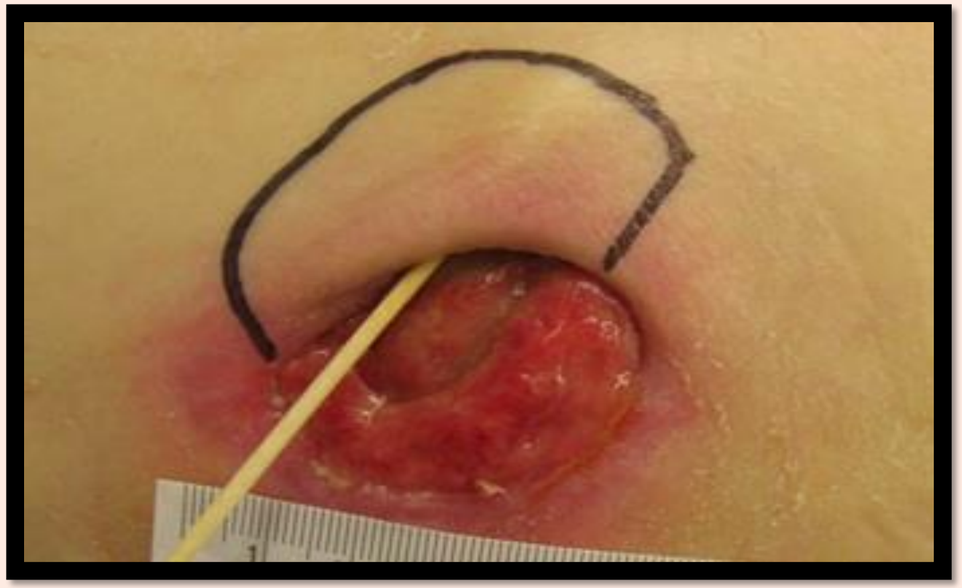
Stage –III

Full thickness ulcer



Tunneling

A narrow opening or passage way that can extend in any direction through soft tissue.



STAGE-IV

Exposed muscle, bone tendon

UNSTAGEABLE-

Pressure sore is unstageable if it has slough or eschar on top

ASSESSMENT

- Assess the pressure points
- Assess pain associated with wound
- Assess location
- Measure width, length and depth
- Stage
- Presence of exudate
- Assess for tunneling
- Chart the findings

MANAGEMENT

- Management depends on prognosis
- Always medicate patient for pain before wound care
- If slough, debride either surgically
- Give special attention for red granulation tissue.
- Use normal saline for wound cleaning (home made saline)
- Keep covered and moist.

MANAGEMENT

- If there is an odour or infection add metronidazole powder (ground up pill) to a GEL lubricant, white petroleum jelly and spread on wound.
- Charcoal under the bed will absorb odors.
- Avoid hypochlorite solutions like povidone-iodine and hydrogen peroxide
- Surgery consultation
- Negative Pressure wound therapy

HOME MADE SALINE & DRESSING SUPPLIES

- Normal saline: 200 ml of boiled water, add a pinch of salt. Wounds are not sterile. The saline has to be clean, not sterile.

- Gauze: take old cotton saris or dhotis, cut them into squares. Steam them for ½-1 hour.

PREVENTION OF BEDSORE

- Change the position every 2-3 hours
- Apply liquid paraffin/white petroleum jelly to the skin that is in dependent areas.
- Provide pressure re distribution surface

  eg: Water bed or airbed—still need to turn.
- Assess the skin—if there is a stage 1 skin lesion, then teach caregivers to turn, and excellent incontinence control.
- Maintaining good nutrition

AIR BED & WATER BED

PREVENTION-SSKIN

S
Supporting Surface

Make sure your patients get pressure relief on proper supporting surface

S
Skin Inspection

Regular skin inspection requires over all bony prominence at risk areas
Care givers must be able to pick up the earlier signs

K
Keep Moving

Proper positioning and frequent posture changes

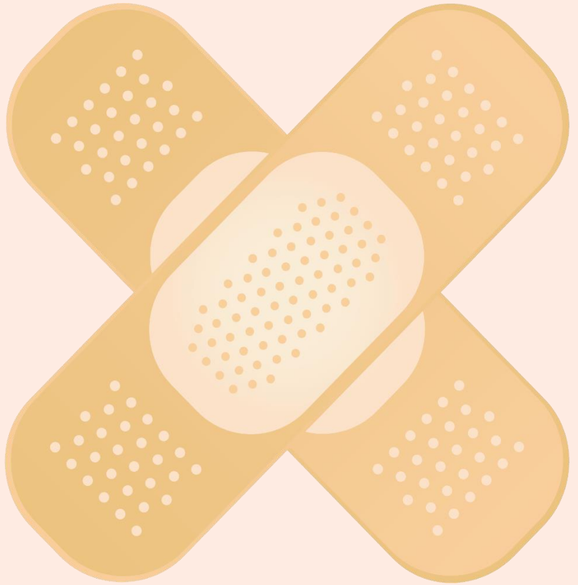
I
Incontinence/ Moisture control

Bladder and bowel care-Catheterize bladder if needed
Frequent change of dressings and diaper

N
Nutrition

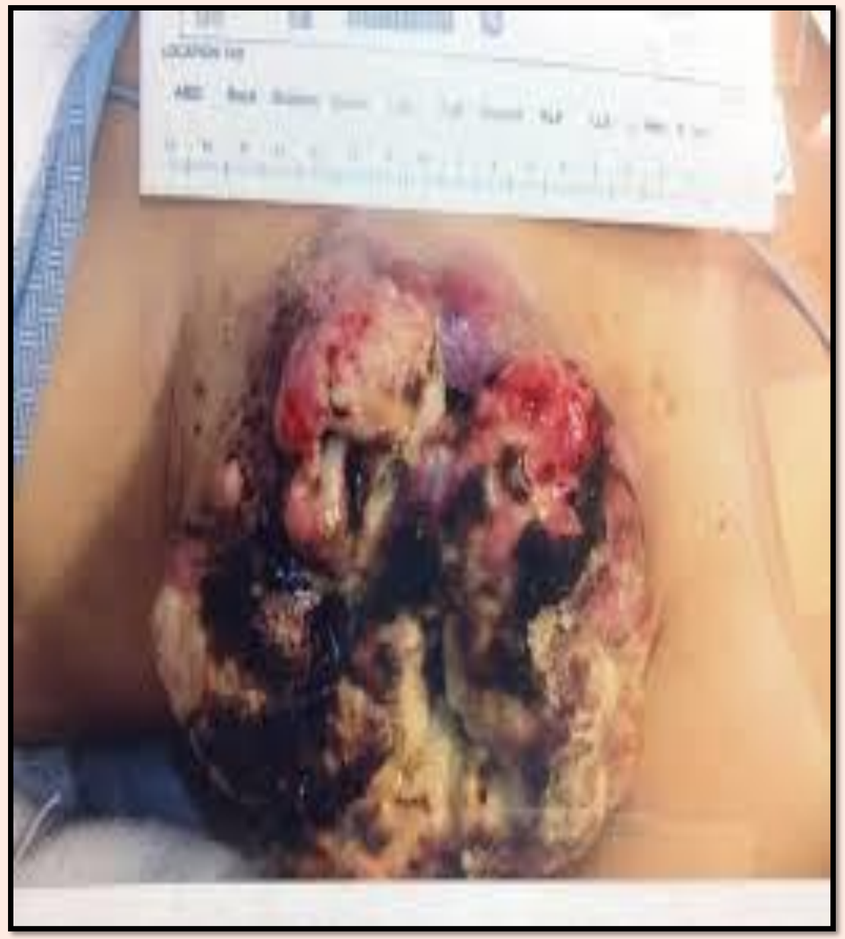
Nutrition & Hydration
Patient must have right diet and fluid intake

FUNGATING WOUND



DEFINITION

It is a primary or secondary malignant growth in the skin which has ulcerated and difficult to heal.



(It refers to a malignant process involving both ulceration & Proliferative growth)

Nodular fungus or Cauliflower shape

PATHOPHYSIOLOGY

Develop non tender skin nodules

↓

Enlarge nodules

↓

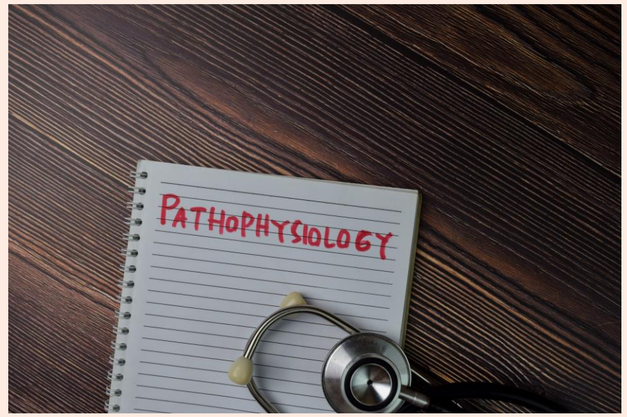
Disruption of capillaries &lymph vessels

↓

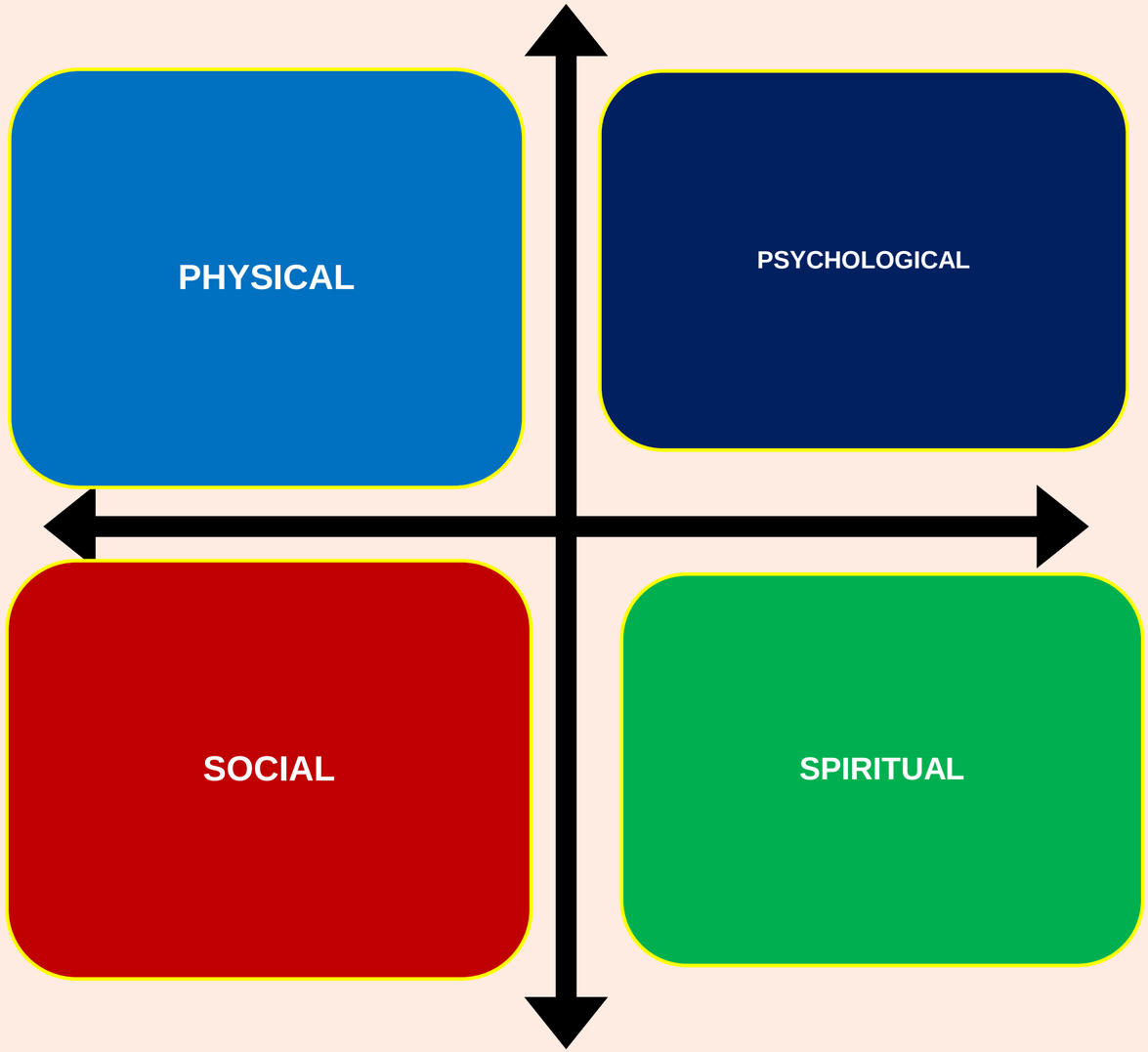
Altered coagulation &disorganised circulation

↓

Tissue hypoxia &Necrosis



PROBLEMS – FUNGATING ULCER








PHYSICAL

- Pain
- Malodour
- Bleeding
- Exudates
- Itching
- Infestation with maggots
- Communication difficulties

PSYCHOLOGICAL

- Altered body image
- Sexuality
- Denial
- Fear
- Depression & anxiety
- Shame
- Guilt






SOCIAL

- Family isolation
- Social isolation
- Social stigma /fear of contagion
- Effects on family
- Effects on sexual relationship & marital disharmony

SPIRITUAL

- Interference with religious rites
- Punishment from god
- Fear of impending death

ASSESSMENT

Wound location (mobility impaired, easily covered with public view)

Wound appearance

Surrounding skin

Potential for complications (potential for obstruction or hemorrhage from major blood vessels)

PRINCIPLES OF MANAGEMENT

- Palliation of symptoms
  1. reducing pain
  2. controlling odour & infection
  3. managing exudate and protecting surrounding skin,
  4. minimizing bleeding
- Holistic care
- Empowering patient and family in wound care

CRITERIA FOR WOUND DRESSING

Goal of care is to maintain or improve quality of life through symptom control:

- Empathetic care
- Provide a thorough bath before dressing
- Ensure the patient had a dose of analgesic before dressing
- Use normal saline for cleansing the wound

MINIMIZING PAIN

- Deep pain (aching, stabbing, continuous adjusting system analgesics)
- Superficial pain (burning, pricking etc local application
- e.g. sensorcaine, Lignocaine

MALODOUR

- Daily cleaning & dressing
- Local Metronidazole (Tablet crushed & powdered)
- IV Metronidazole irrigation
- Systemic antibiotics
- Frequent changing of dressing
- Charcoal dressing
- No hydrogen peroxide/ Betadine.

BLEEDING

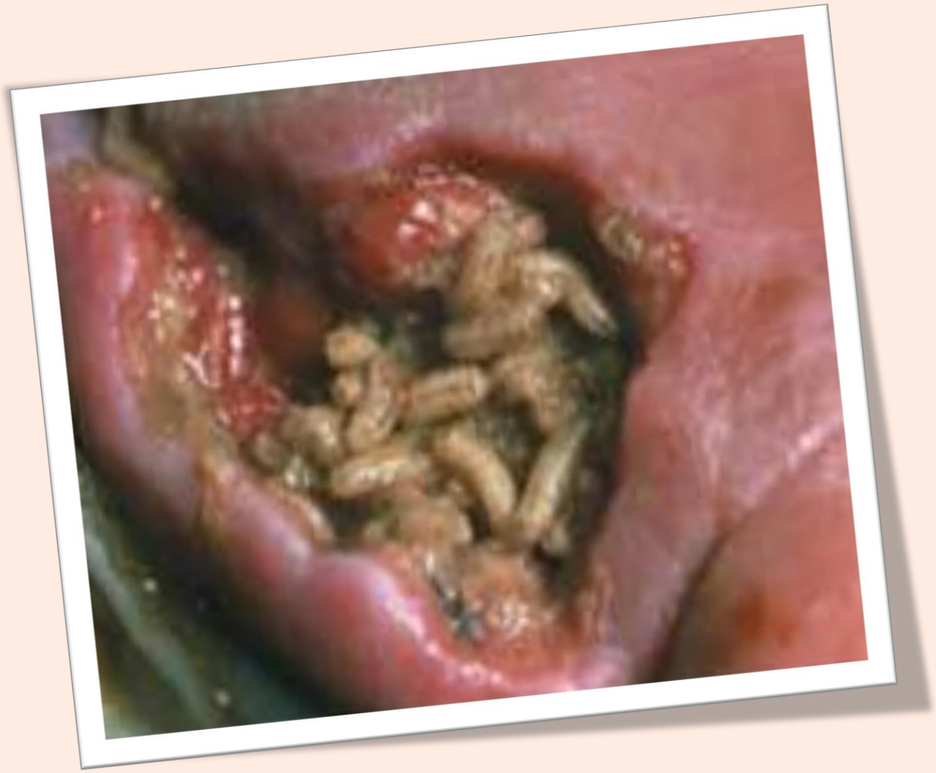
Prevention-

- Apply local pressure
- Sucralfate powder
- Tranexamic acid
- Systemic Ethamsylate
- Palliative Radiotherapy

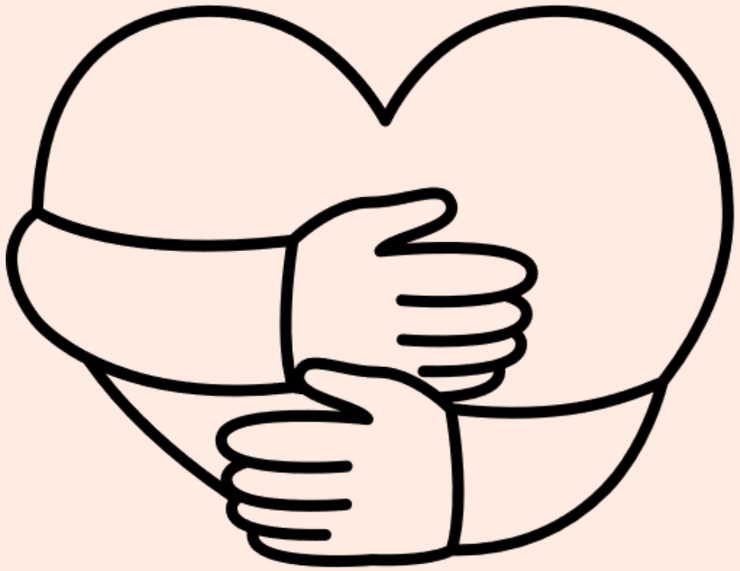
MAGGOTS

Prevention-

- Mosquito nets, maintain personal and environmental hygiene
- Apply : Turpentine
- Physical removal
- Wound should be covered with dressing all time and changed daily.



OSTOMY CARE



OSTOMY

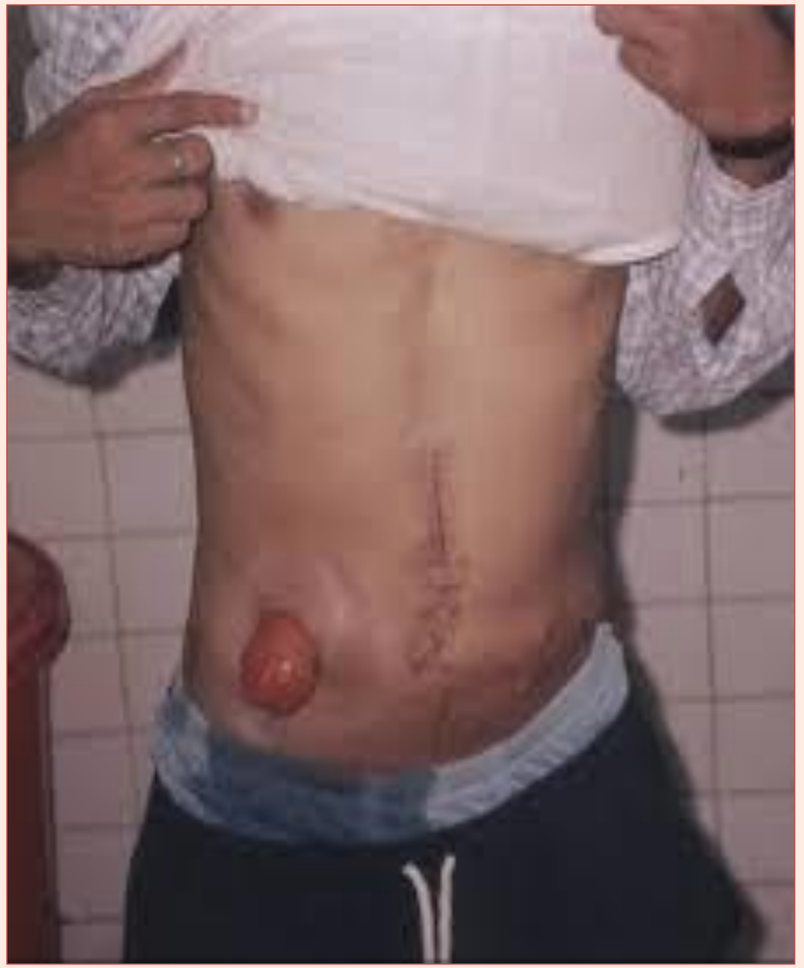
- Ostomy is an artificial opening
- Types

  1) INPUT OSTOMY

  Tracheotomy ,Gastrostomy , Feeding Ileostomy

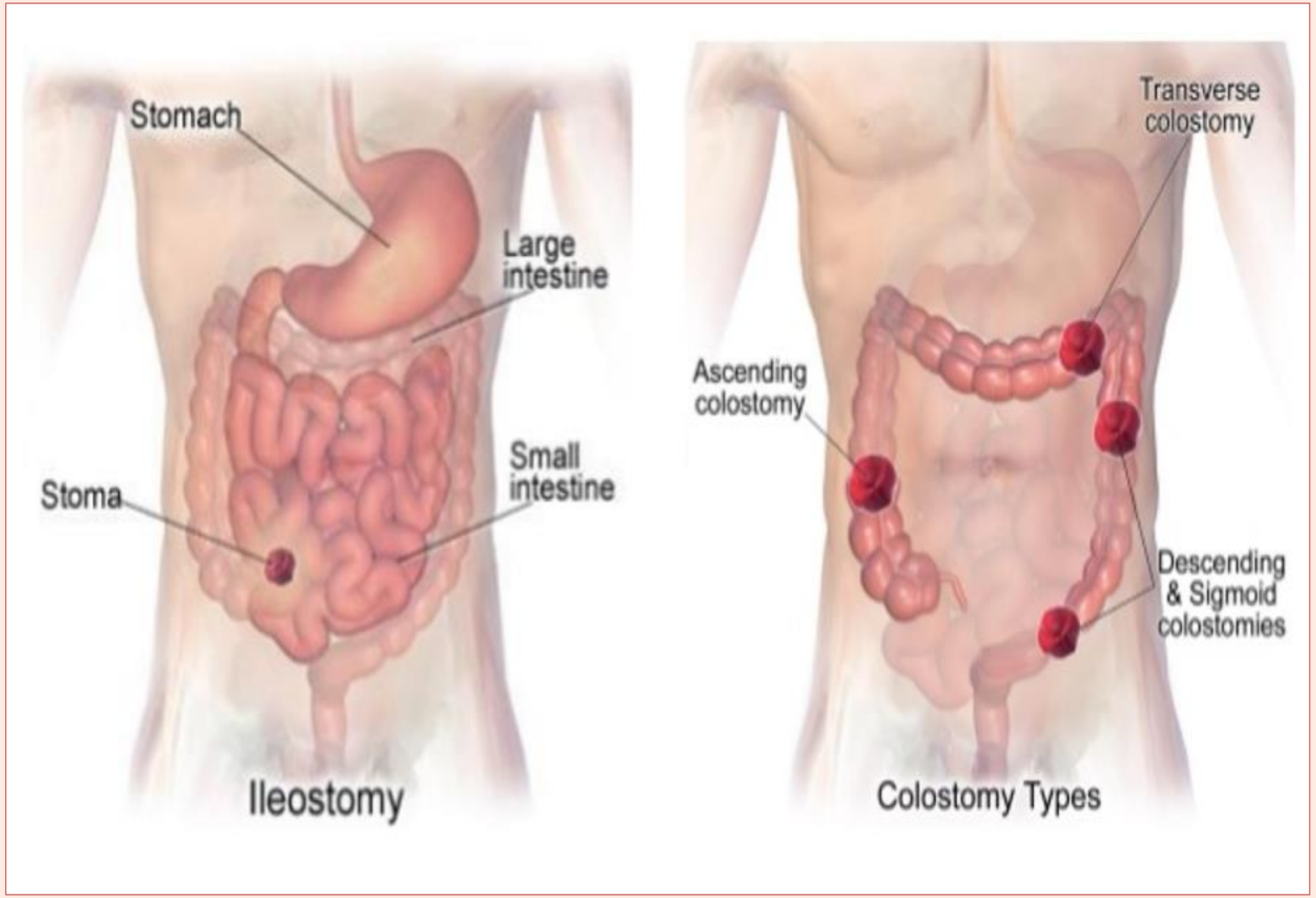
  2) OUTPUT OSTOMY

  Colostomy, Urostomy, Ileostomy

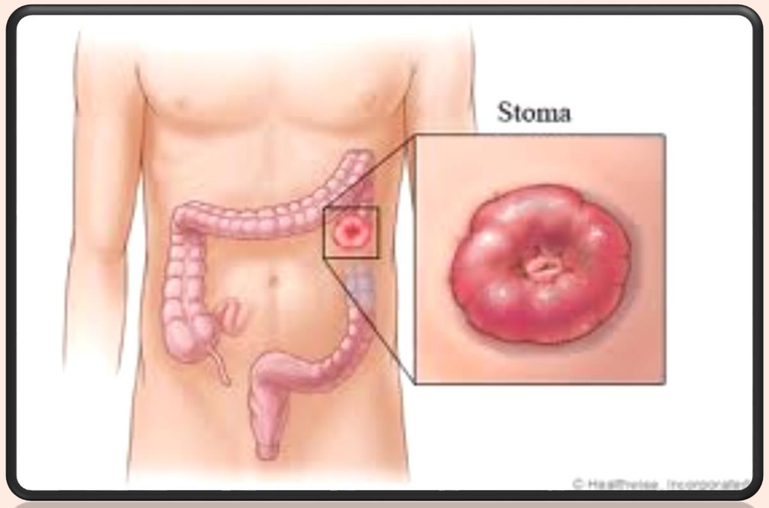


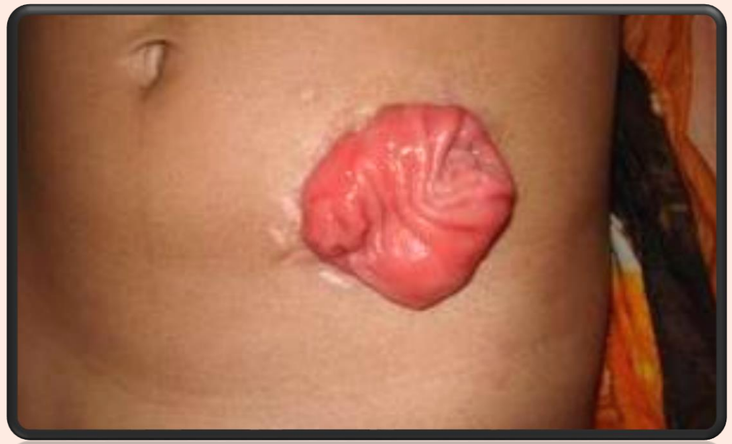
COLOSTOMY-DEFINITION

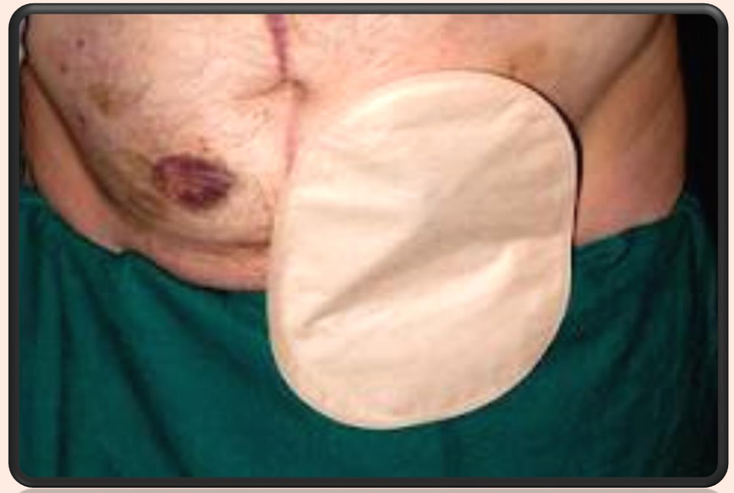
Surgical opening made from the large intestine through which feces & flatus are excreted


Stomach
Large intestine
Small intestine
Stoma
Ileostomy
Transverse colostomy
Ascending colostomy
Descending & Sigmoid colostomies
Colostomy Types

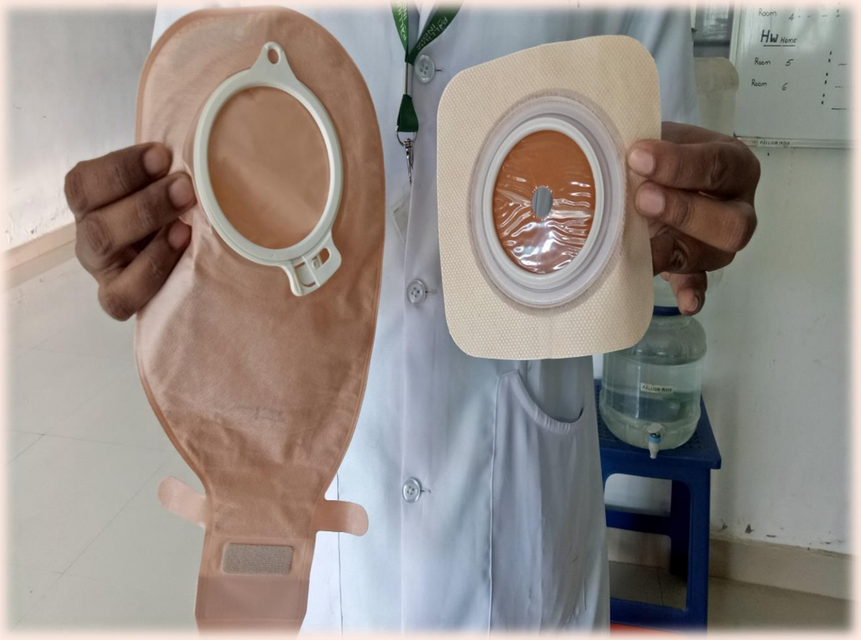
COLOSTOMY

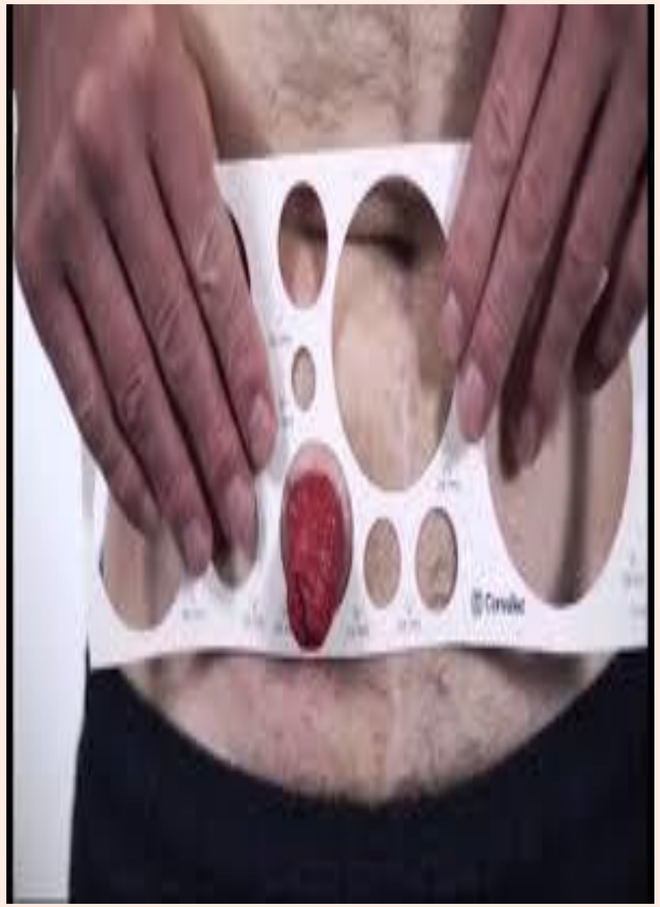






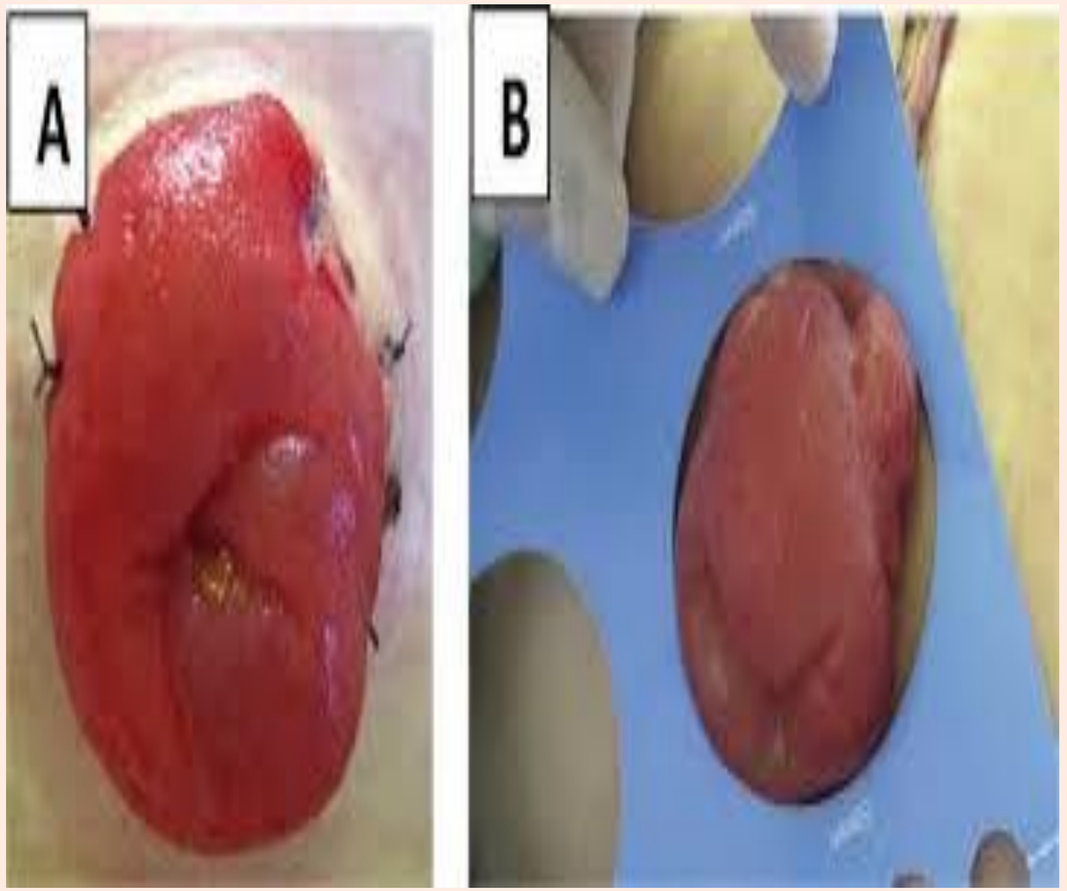
COLOSTOMY APPLIANCES



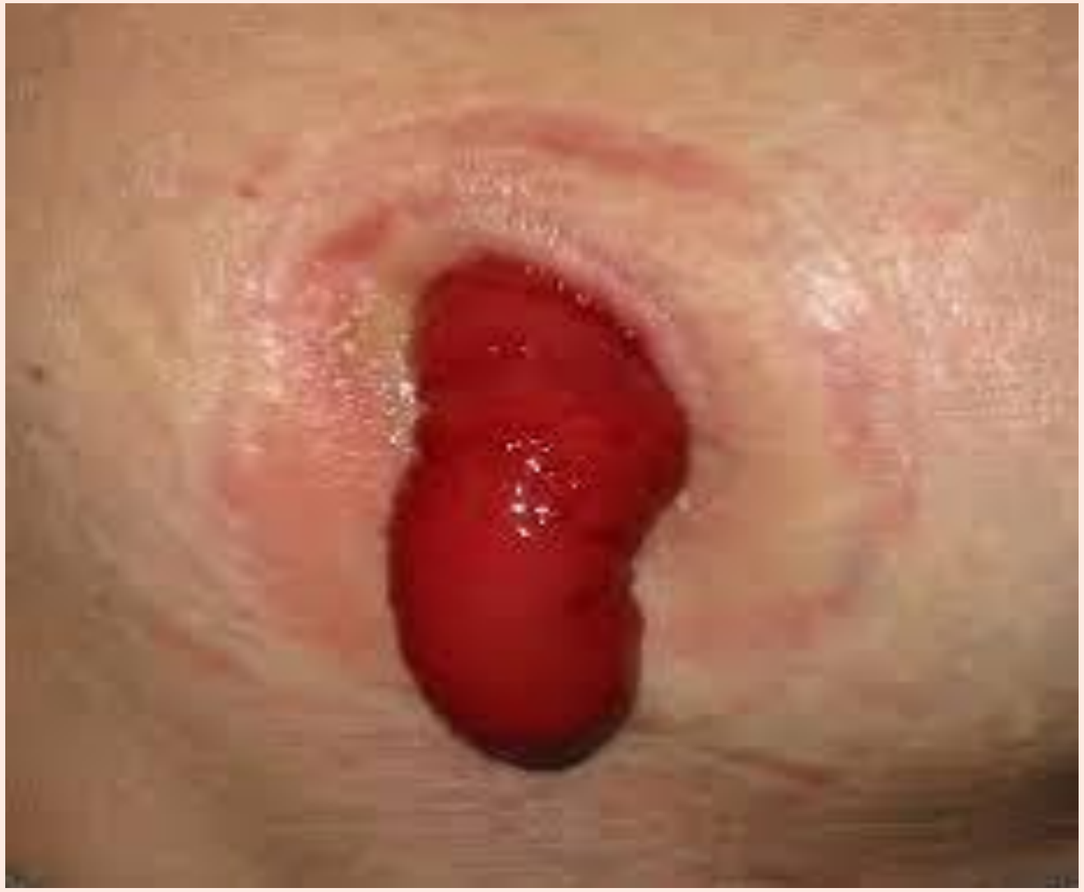


ASSESSMENT

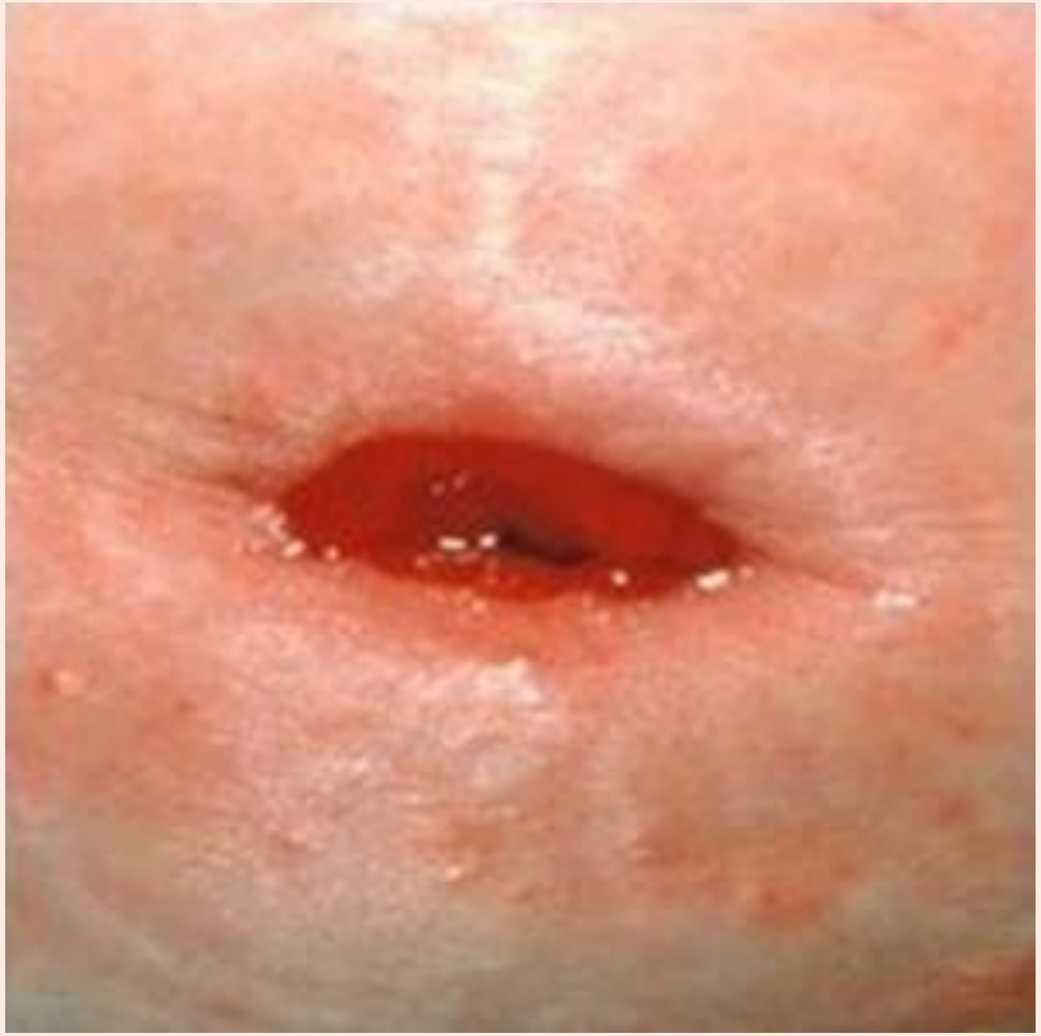
Stomal Oedema



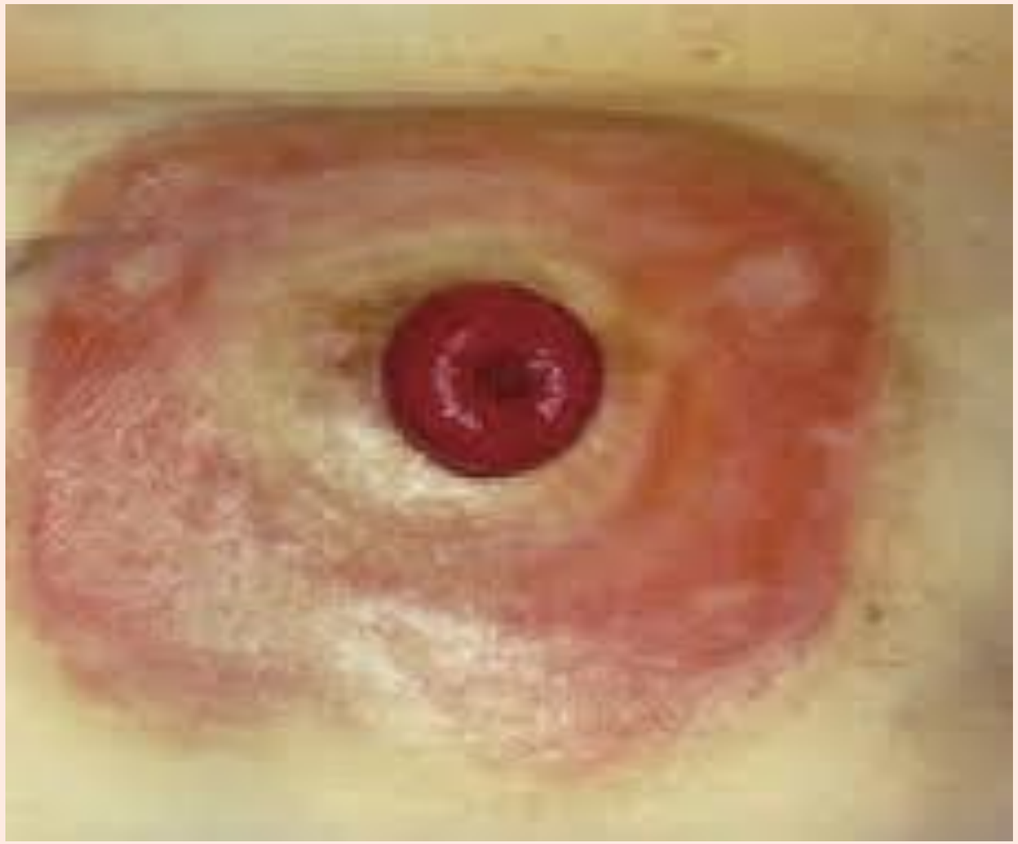
Stomal Prolapse and bleeding

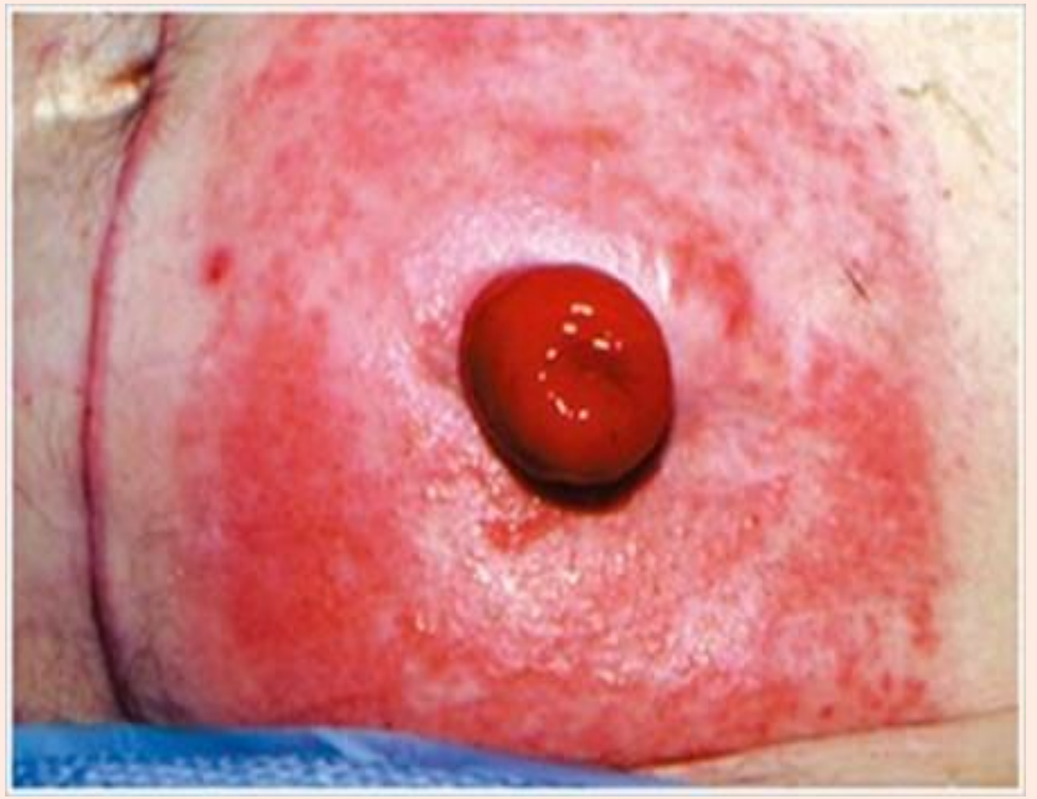


Retraction



Peri-Stomal Reaction





SKIN CARE

- Wash with soap & water
- Keep Peristomal skin clean & dry
- Use correct size bag
- Empty the bag when it is ¾ full
- Use cotton clothes to cleaning
- Apply karaya powder with egg white if skin is excoriated
- Apply zinc oxide for peristomal skin
- Avoid powder or cream on peristomal skin

KARAYA PLANT

KARAYA POWDER

DIET

- Control gas forming foods
- Avoid chilly, spicy foods
- Control onion, cabbage, garlic, meat (smell)
- Use same oil for cooking (diarrhea)
- Use high fiber diet & increase fluid intake (constipation)

TRAVELLING

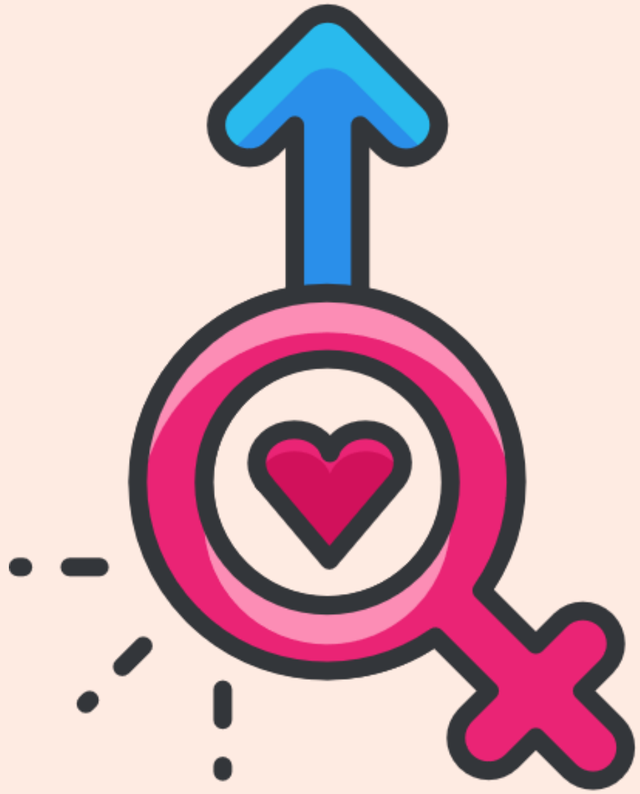
- Protect stoma with a purse or hand bag
- Keep extra Collecting bag in case of long journey

CLOTHING

No Restriction

SEXUAL LIFE

- Support
- Advice
- Encouragement
- Counseling







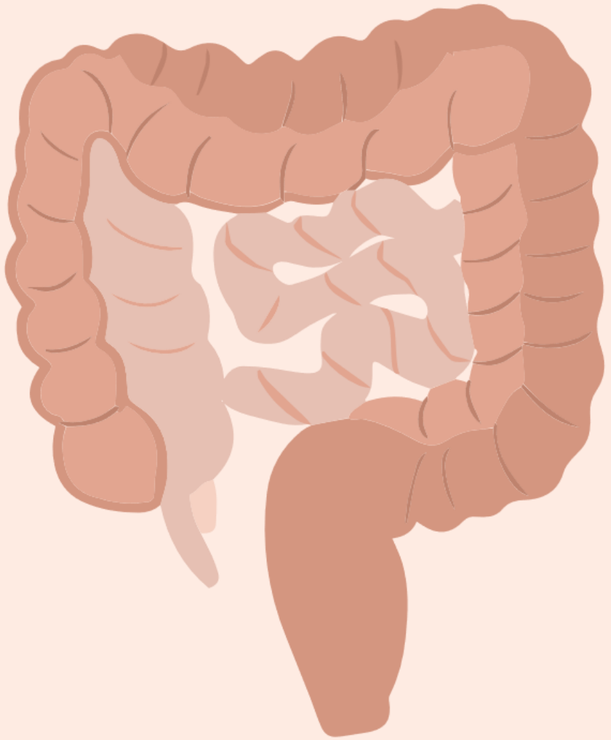

BAG CARE

- Use correct size bag
- Empty bag when it is ¾ full
- Use soap & water to clean the bag
- Put charcoal in bag to prevent foul smell
- Dry the bag in shade
- Avoid rough brushing or stone wash

COLOSTOMY IRRIGATION

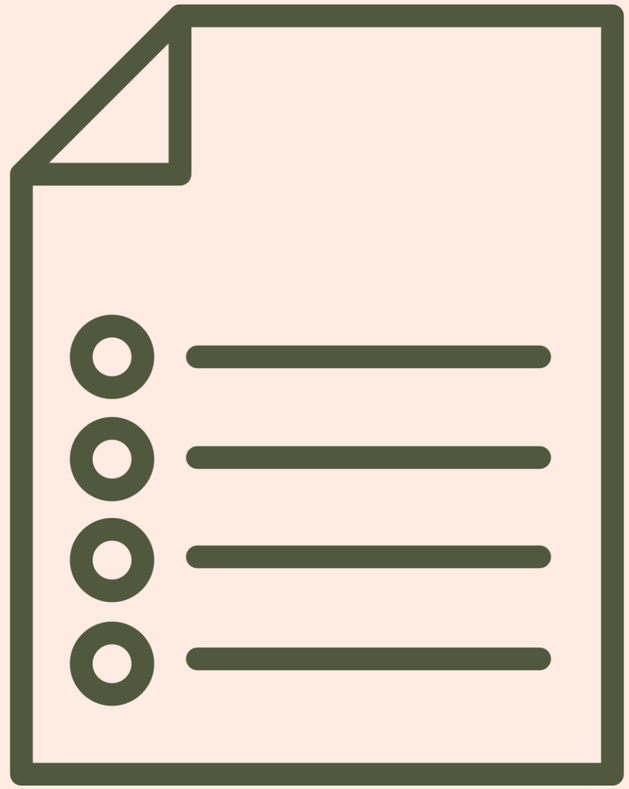
PURPOSE:

- To establish a regular bowel habit
- To clean the colon of gas, mucus,& feces
- To prevent skin excoriation

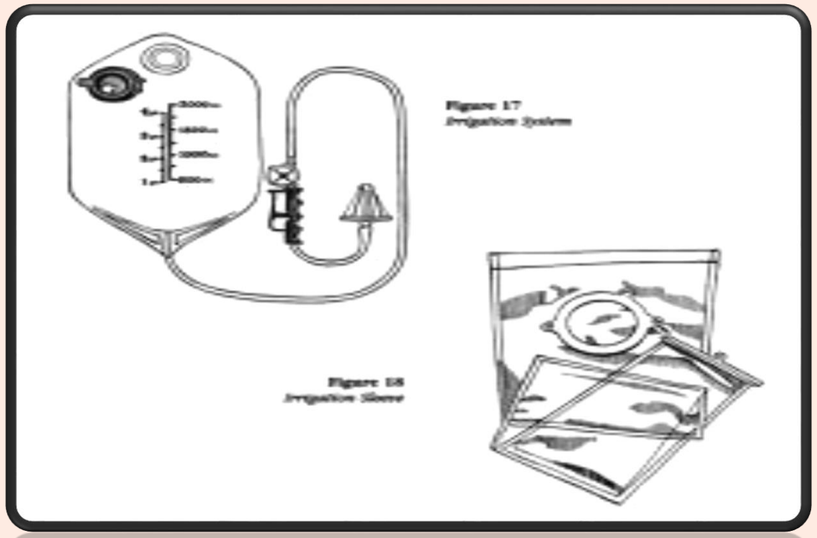


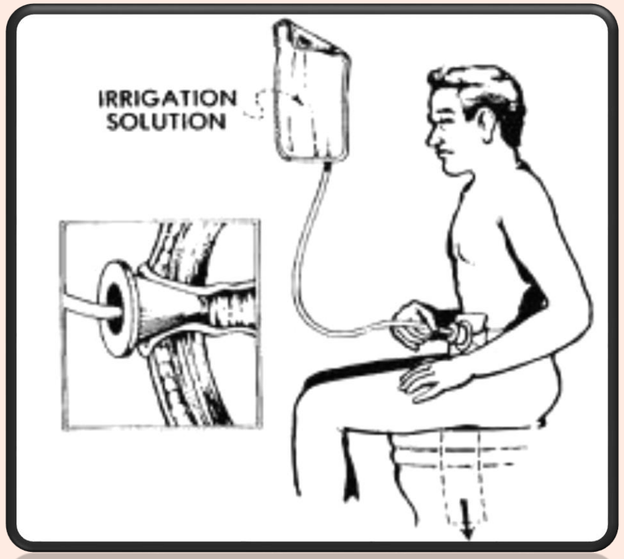
INSTRUCTIONS

- Irrigation needs to be continued LIFE LONG
- Habit formation only after 21 days
- Irrigate daily at a fixed time



COLOSTOMY IRRIGATION PROCEDURE

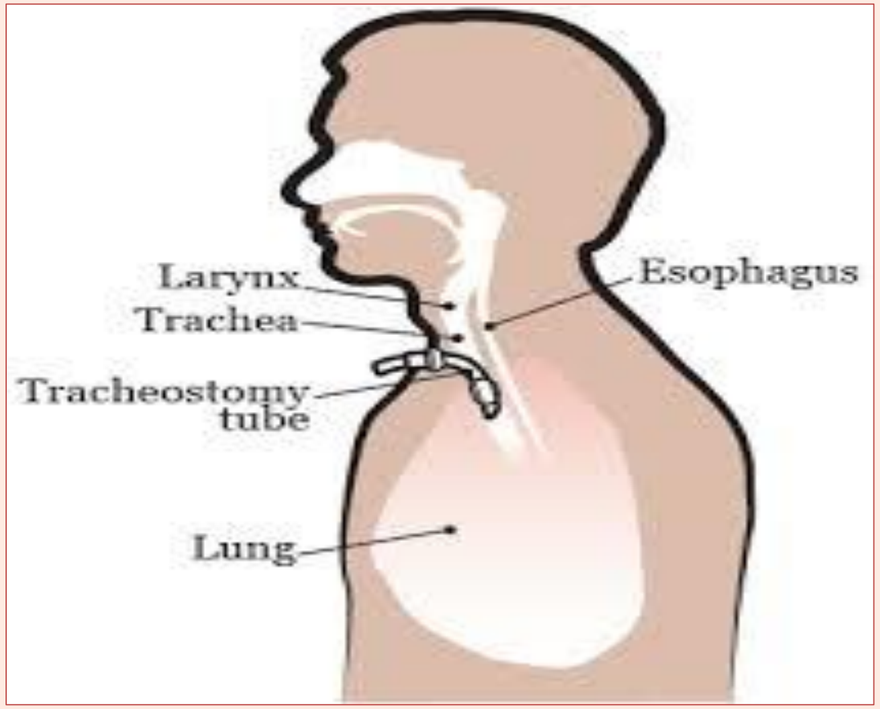




TRACHEOSTOMY

DEFINITION

Tracheostomy is an artificial opening made in the trachea in to which a tube is inserted to establish and maintain a patent air way.



TRACHEOSTOMY PARTS

TRACHEOSTOMY PARTS

- Outer tube remains held in place by a ribbon or tie(should not be removed)
- Inner tube which fits inside the outer tube and can be removed for cleaning purpose.
- The obturator is used as a guide to the outer tube while it is inserted in to the trachea.

CLEANING - INNER TUBE

Train the patient to clean the tube self with the help of a mirror.

- Inner tube-thorough cleaning of the tube inside and outside with running water. Sterilization of the tube in boiling water for 10 minutes. After that clean with normal saline and re insert.
- Outer tube not to remove. Clean the tube plates with saline soaked gauze thoroughly

CLEANING - OUTER TUBE

- Changing tie of the outer tube
- It is applied to fix tube in position.
- Change when it is dirty. It should not be too tight or loose. One finger gap.
- Changing the tie self attempt not to be made by the patient.

SKIN CARE

- Clean the skin around the tracheostomy tube with saline soaked gauze.
- Keep the skin around tracheostomy tube clean and dry
- Vaseline gauze is helpful to prevent Excoriation around the tube

SUCTION & HUMIDIFICATION

- The suctioning of the trachea is done very gently not more than five to ten seconds to prevent Hypoxia.

- Humidification of air place a wet sterilize gauze on the top of the tracheostomy tube, this helps in humidifying the inhaling air and filters the dust.

SPEECH THERAPY

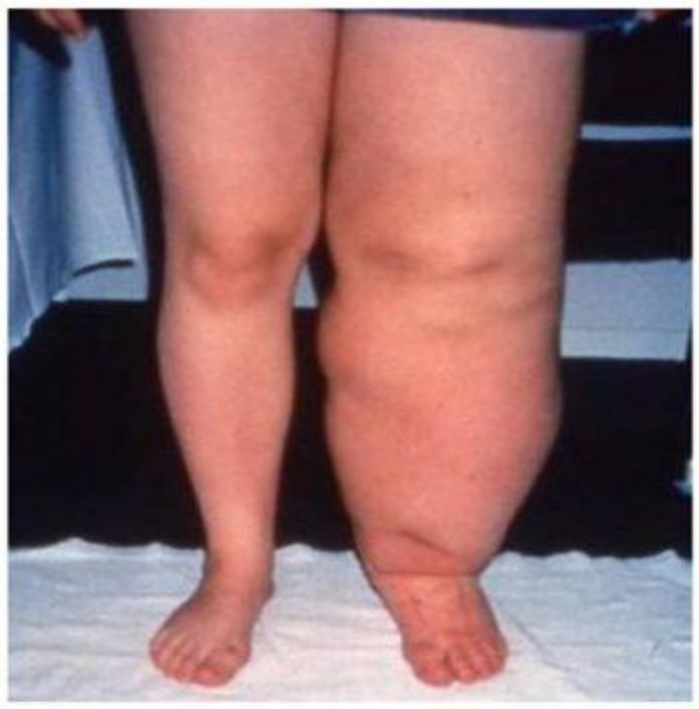
The patient should be taught how to talk- take a deep breath and then close the tracheostomy tube with a finger and then speak one or two words. Again take a breath and then do like wise

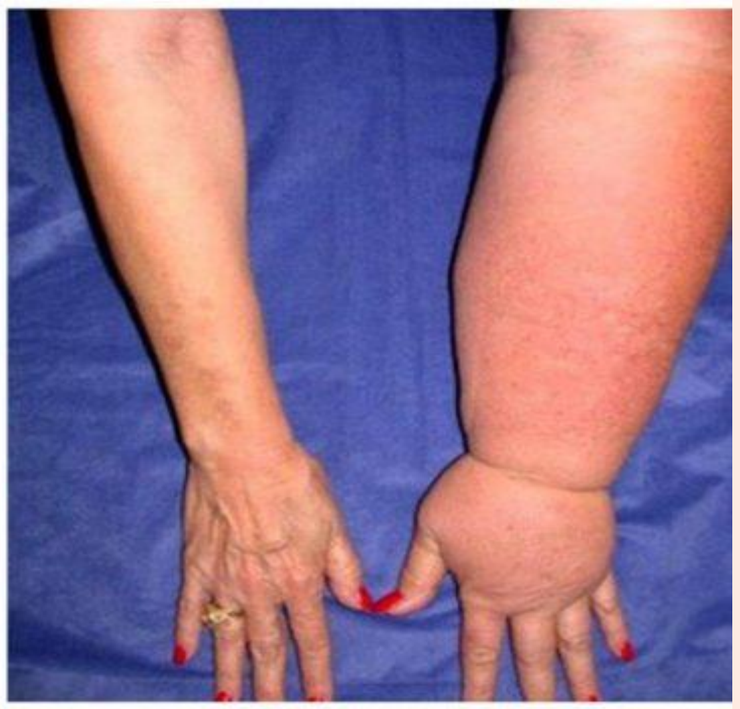
ROLE OF ASHA & ANM

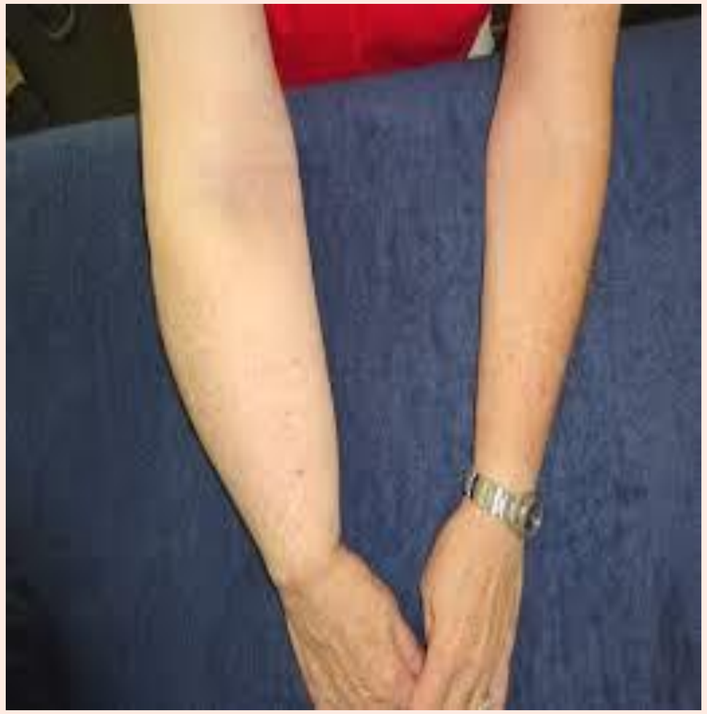
- Identification of Palliative care Patients.
- Rapport building with patient, family and community
- Health education for the family
- Use proper communication skills
- A good counsellor
- Team work with other health care staff
- Update knowledge
- Referral as per needed
- Home care Visit and Follow up
- Documentation and reporting

LYMPHOEDEMA

LYMPHOEDEMA UPPER & LOWER LIMBS

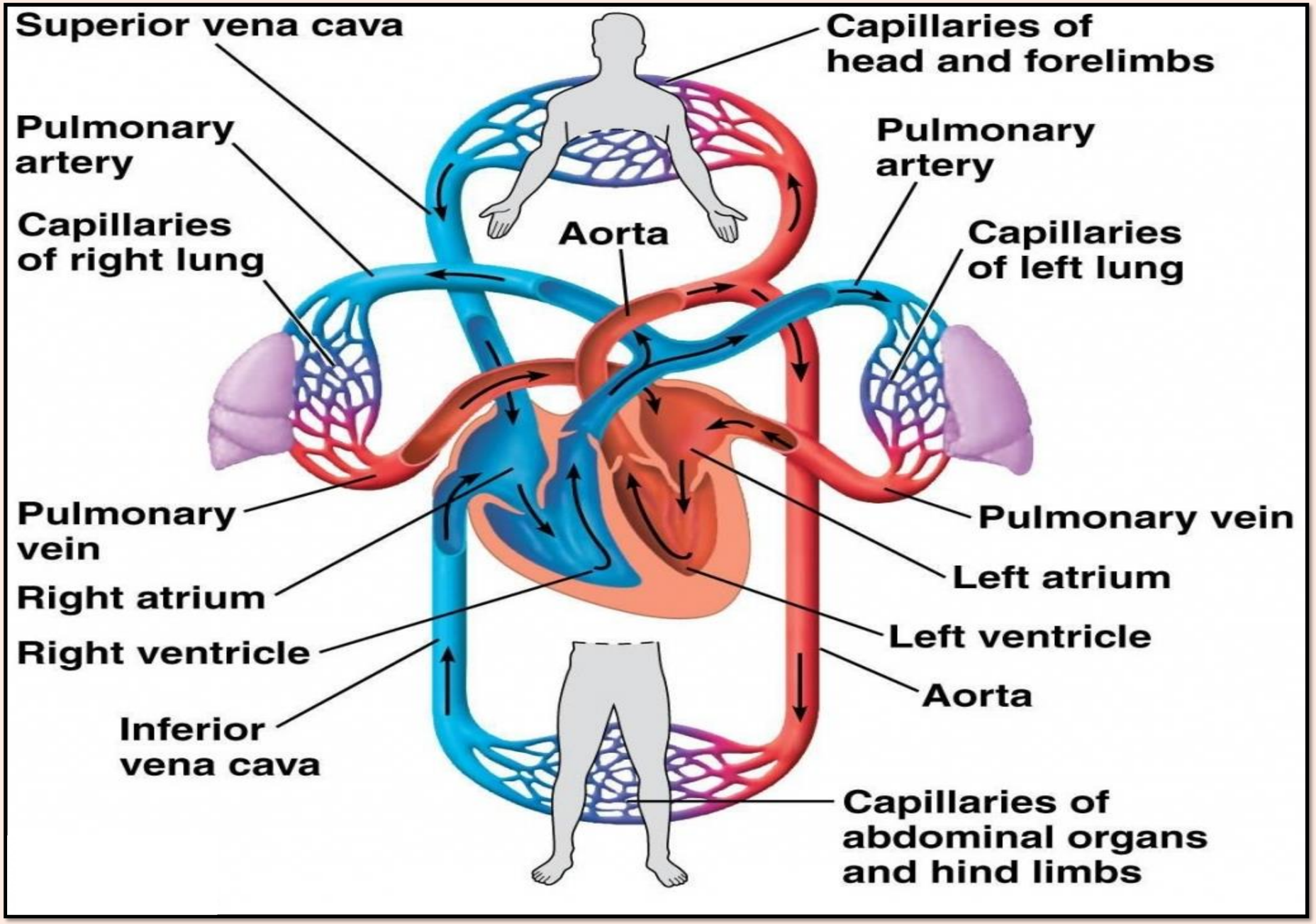


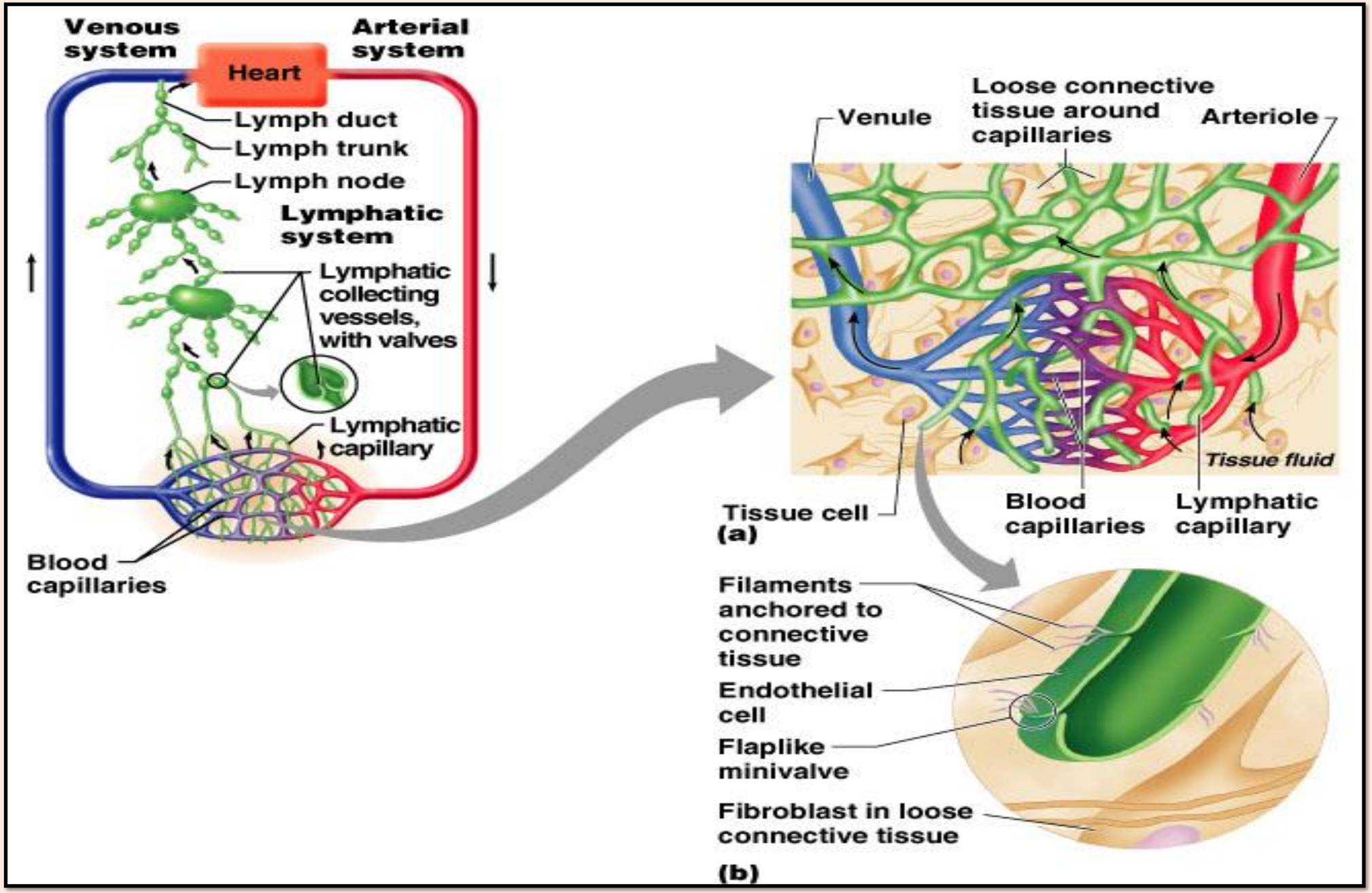


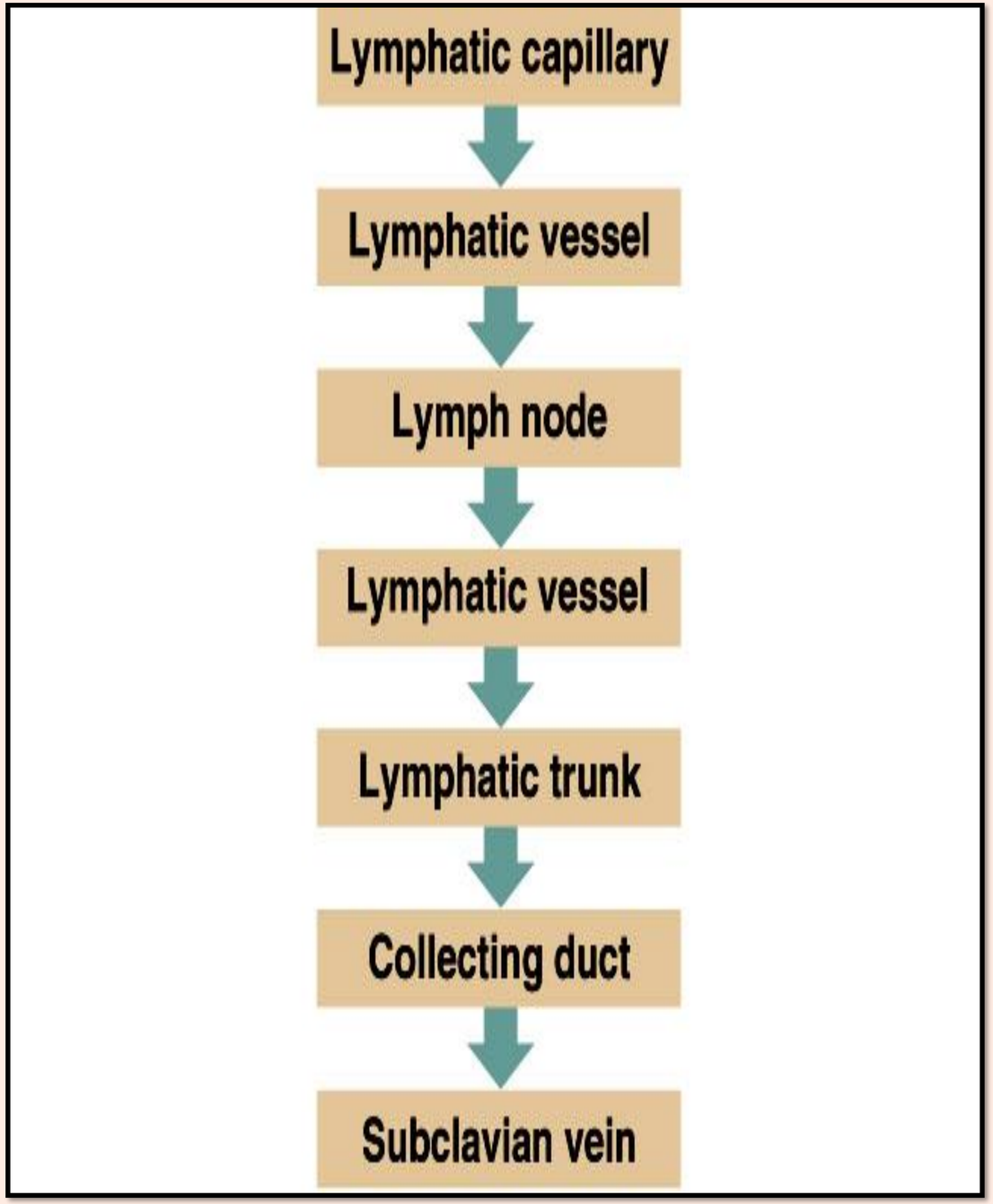


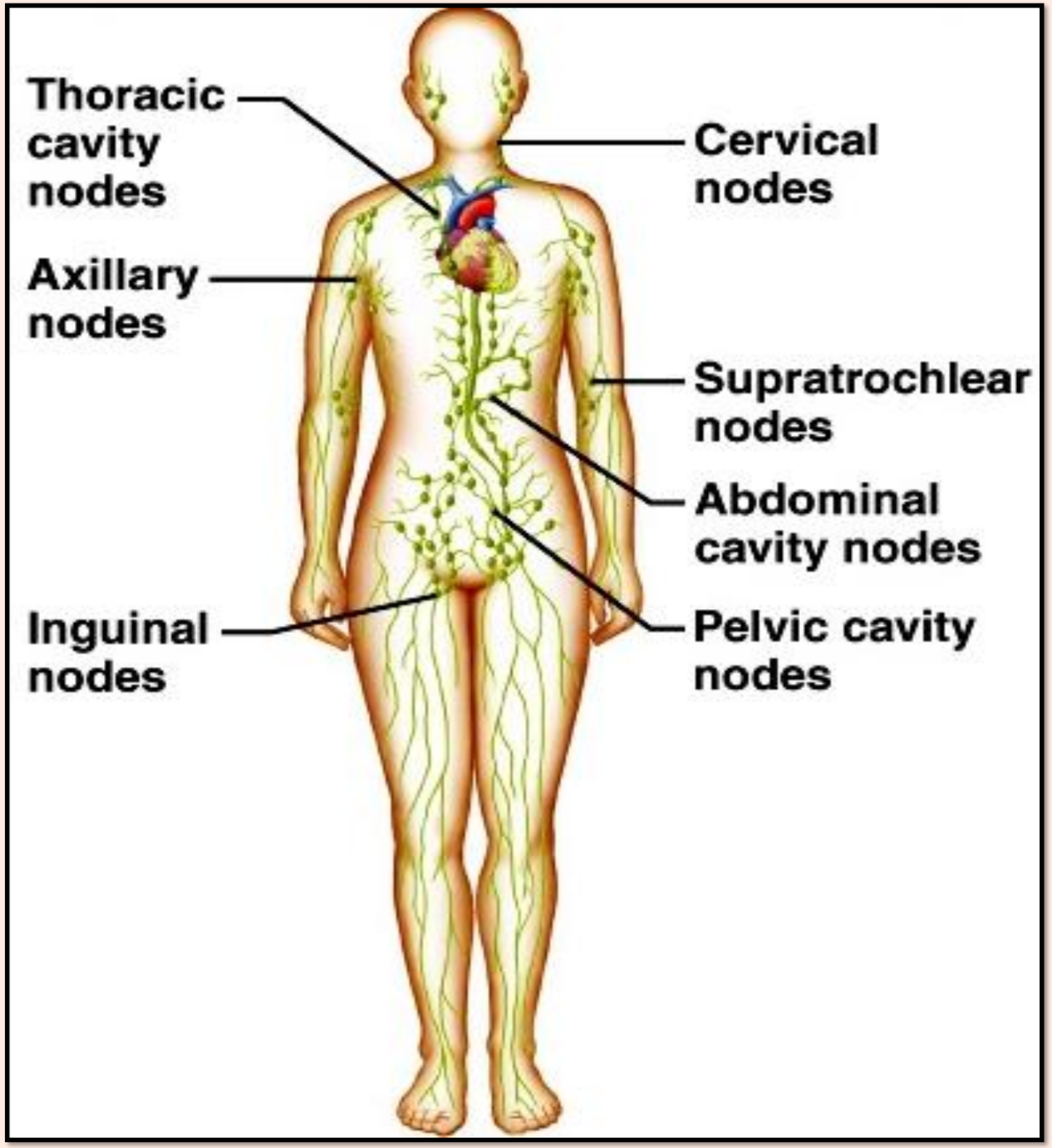
LYMPH

Tissue fluid (interstitial fluid) is collected through lymph capillaries then enters the lymphatic vessels to lymph nodes. It contains protein, lipids &water


Superior vena cava
Capillaries of head and forelimbs
Pulmonary artery
Pulmonary artery
Capillaries of right lung
Aorta
Capillaries of left lung
Pulmonary vein
Pulmonary vein
Left atrium
Right atrium
Left ventricle
Right ventricle
Aorta
Inferior vena cava
Capillaries of abdominal organs and hind limbs

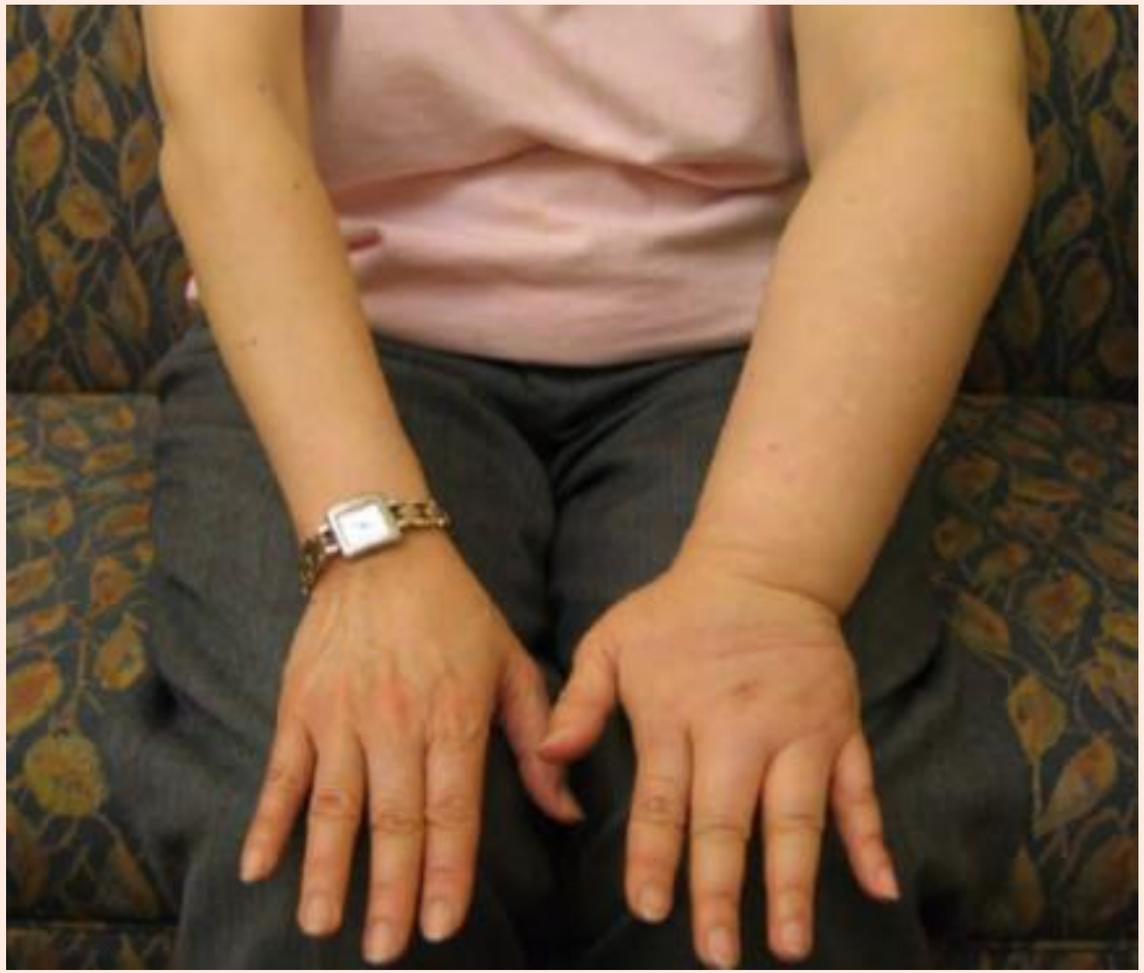

Venous system
Arterial system
Heart
Lymph duct
Lymph trunk
Lymph node
Lymphatic system
Lymphatic collecting vessels, with valves
Lymphatic capillary
Blood capillaries
Venule
Loose connective tissue around capillaries
Arteriole
Tissue fluid
Tissue cell
Blood capillaries
Lymphatic capillary
(a)
Filaments anchored to connective tissue
Endothelial cell
Flaplike minivalve
Fibroblast in loose connective tissue
(b)


Lymphatic capillary
Lymphatic vessel
Lymph node
Lymphatic vessel
Lymphatic trunk
Collecting duct
Subclavian vein


Thoracic cavity nodes
Axillary nodes
Inguinal nodes
Cervical nodes
Supratrochlear nodes
Abdominal cavity nodes
Pelvic cavity nodes

LYMPHOEDEMA-DEFINITION

It is the swelling of interstitial tissue as a result of lymph drainage failure when capillary filtration is in normal



CLASSIFICATION
PRIMARY & SECONDARY

Nonmalignant

- Trauma-RTA ,burns
- Infection- cellulites
- Iatrogenic- surgery, radiotherapy

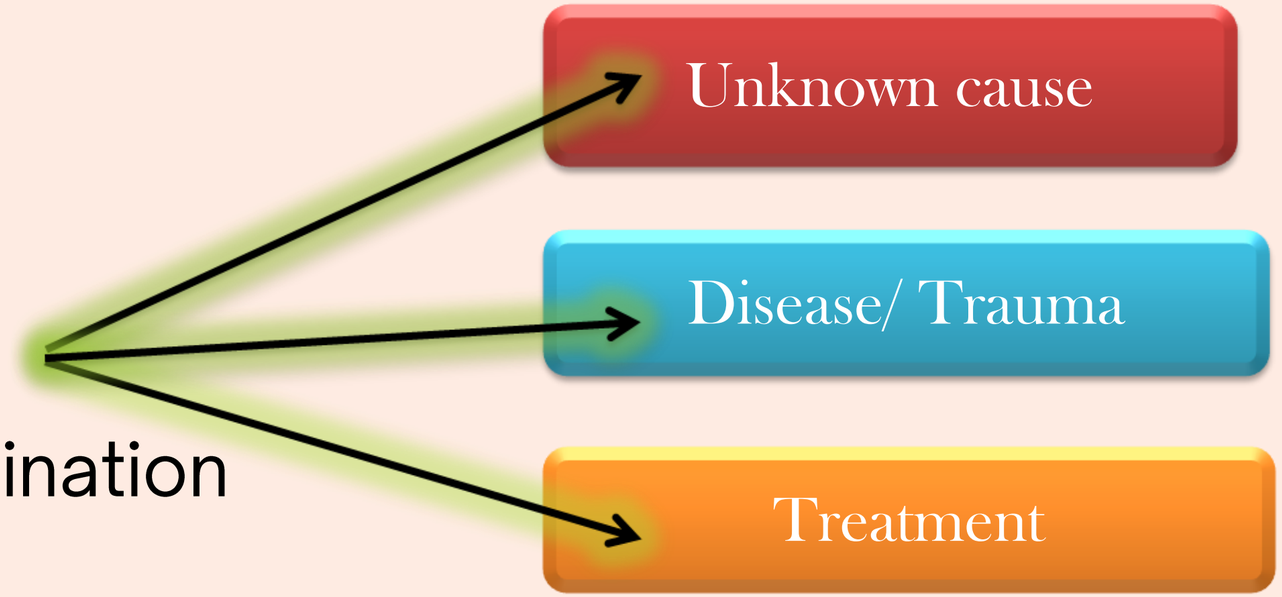
Malignant

- Primary- lymphomas
- Secondary- recurrences

DIAGNOSING LYMPHEDEMA

History

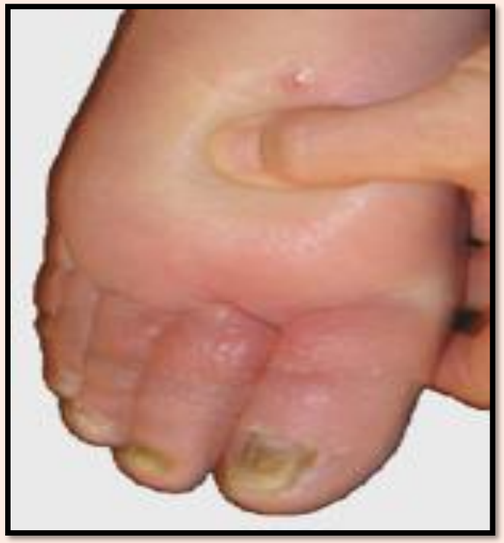
Clinical examination



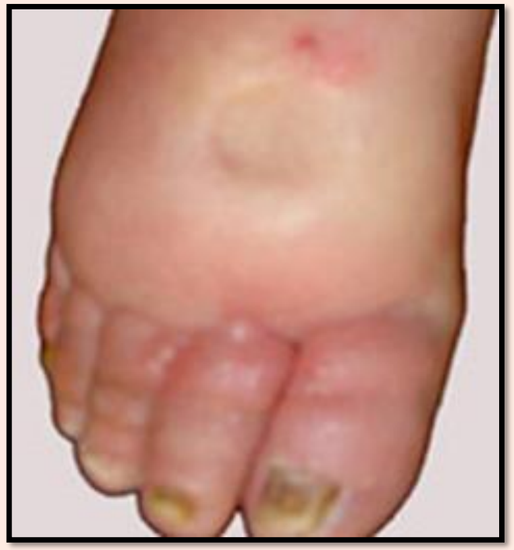
DIAGNOSING LYMPHEDEMA

Pitting Edema Test

Stage I ➔ At this stage the tissues are swollen but are still soft.



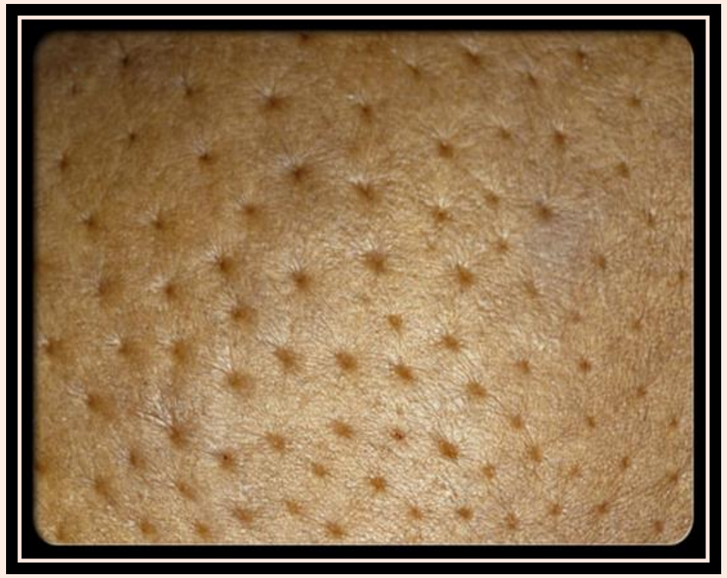
Gentle pressure on swollen tissues.

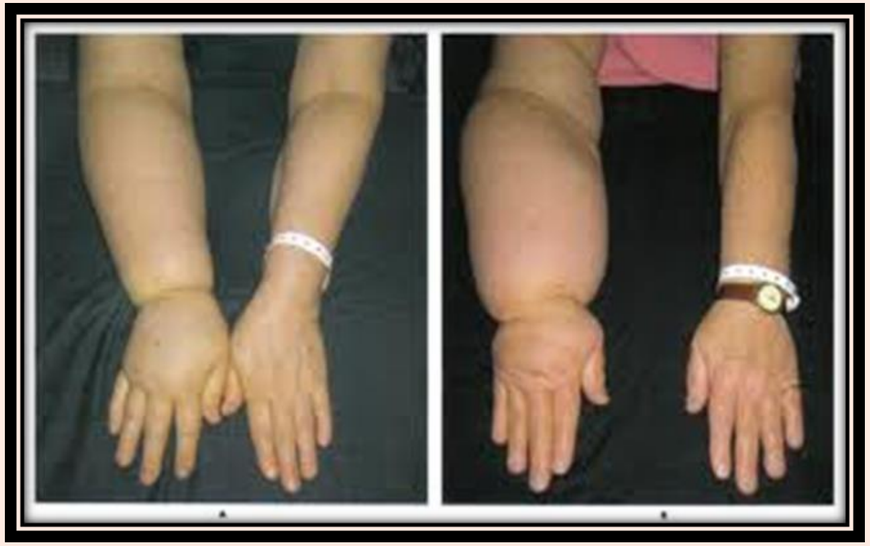


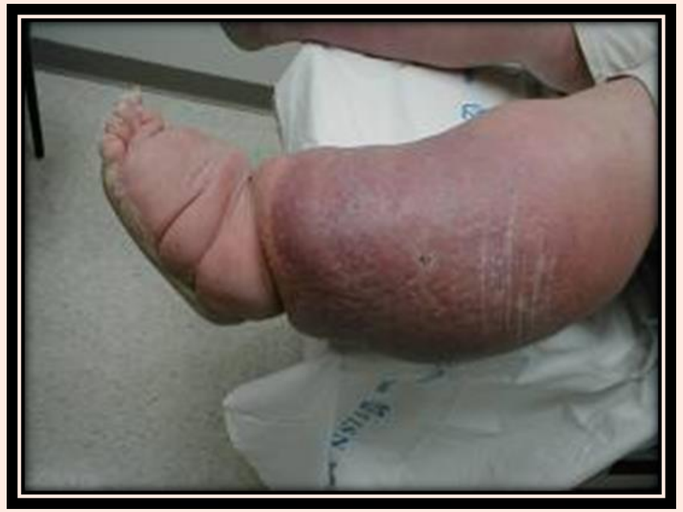
Pitting edema of lymphedema.

SKIN CHANGES

- Skin changes
- Deep creases
- Thick/ hard Skin







PROBLEMS OF LYMPHOEDEMA

PHYSICAL & PSYCHOLOGICAL

- Pain & Discomfort
- Impaired mobility
- Difficulty moving/Loss of function
- feeling of heaviness of tightness
- Swelling of part or all of your leg or arm including fingers or toes
- Body Image
- Loss of independence
- Loss/change of employment
- Difficulty in wearing cloths & shoes
- Anxiety & Depression
- Social isolation

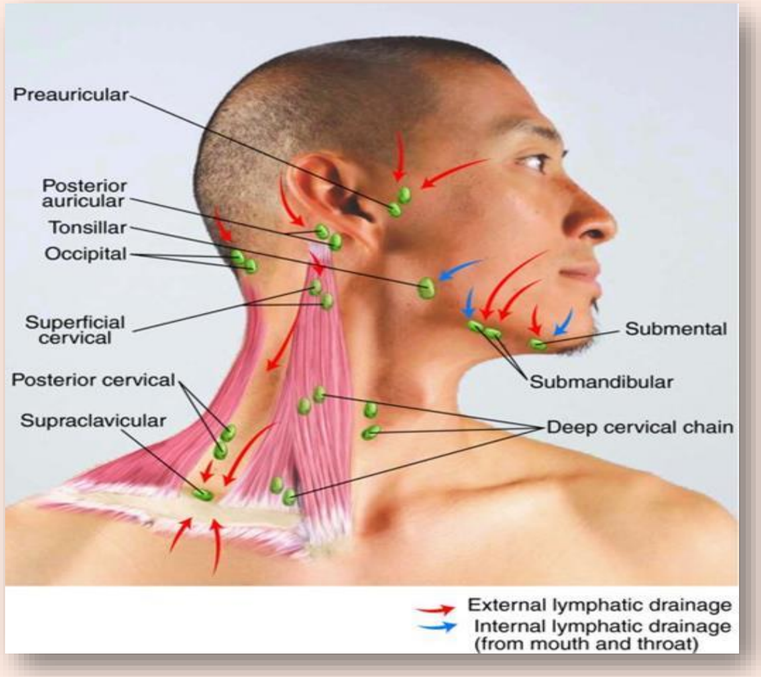
MANAGEMENT

- Skin Care
- Massage
- Compression Bandaging
- Exercise
- Intermittent Pneumatic compression

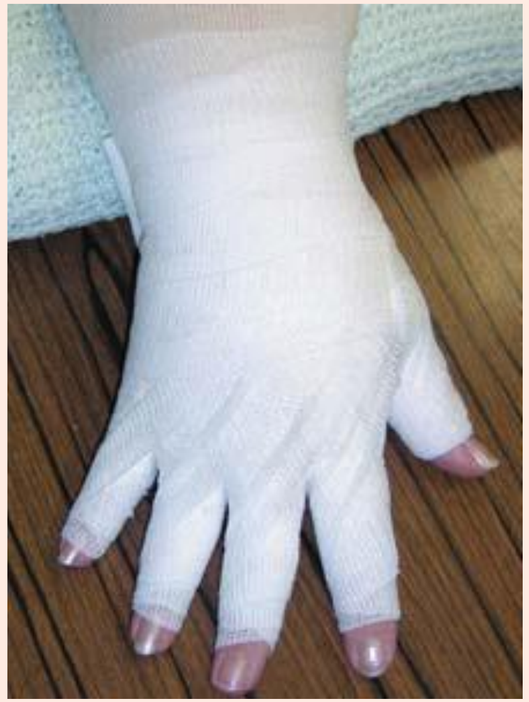
SKIN CARE

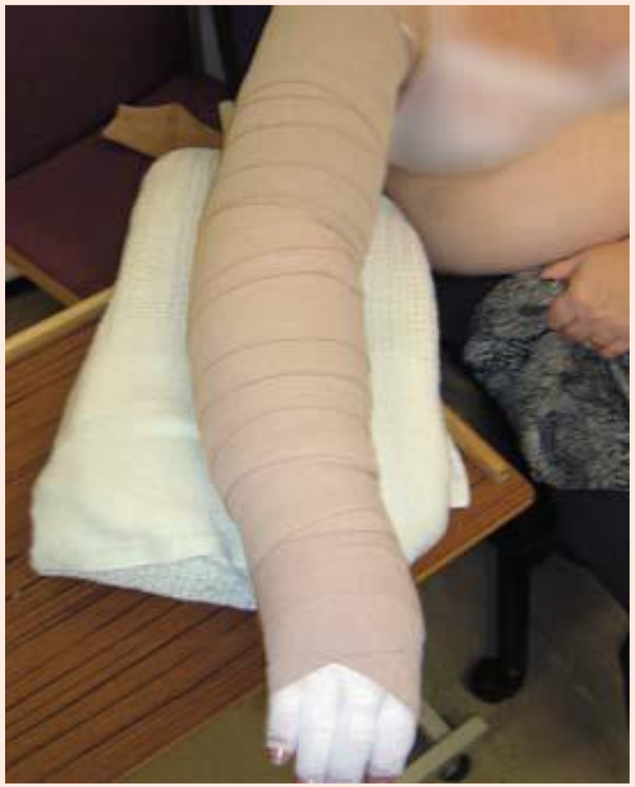
- Apply simple moisturizing cream
- Keep the skin clean &dry
- Meticulous drying between the digits
- Avoid injections/ venipuncture
- Avoid blood pressure cuffs
- Avoid razors & Avoid injury, keep cuts clean & dry
- Avoid carrying heavy things.

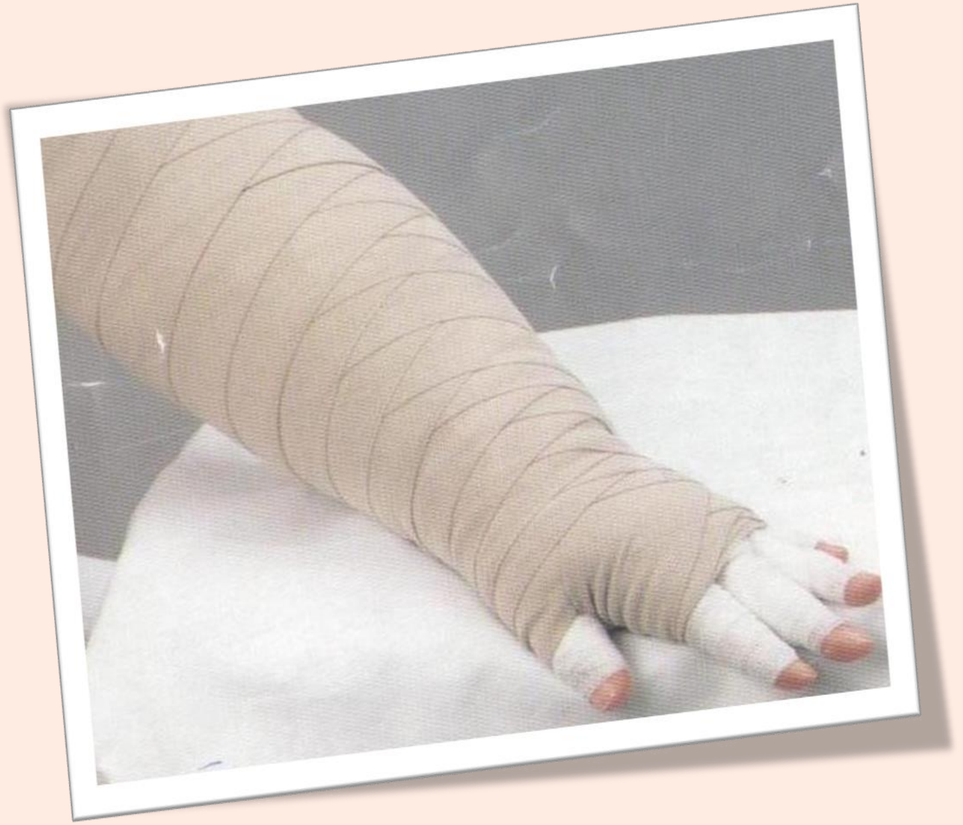
MANUAL LYMPHATIC DRAINAGE



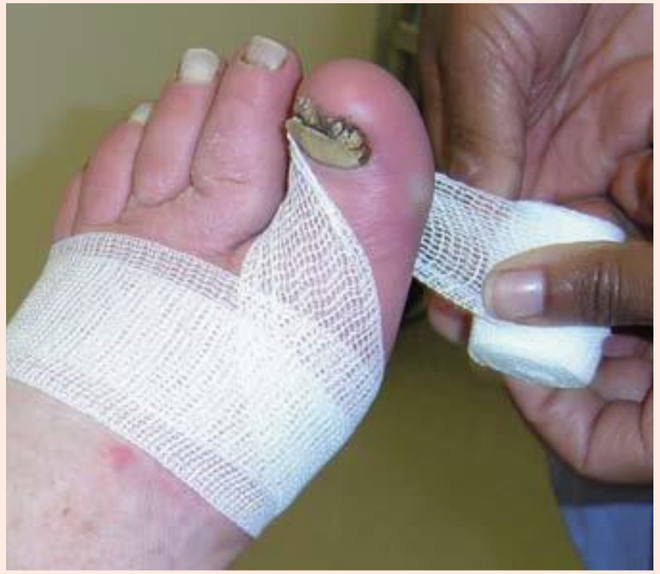
BANDAGING

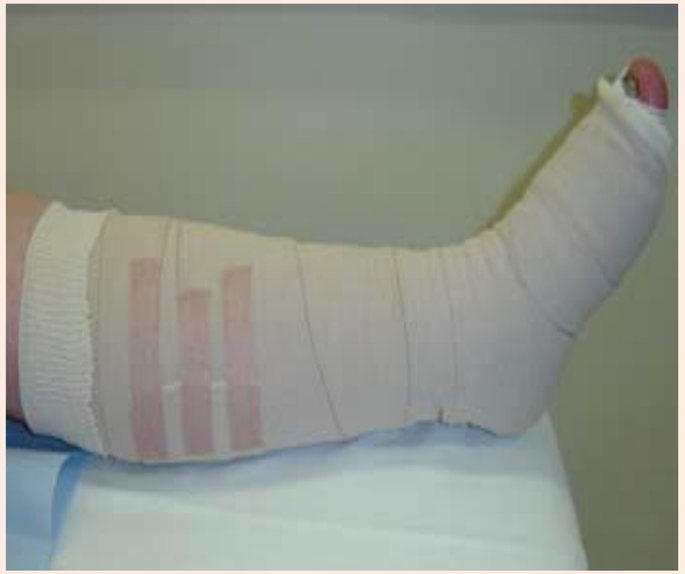




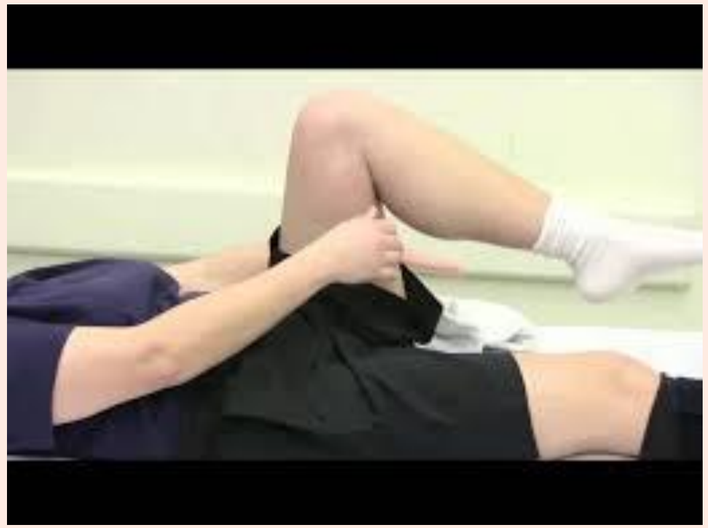


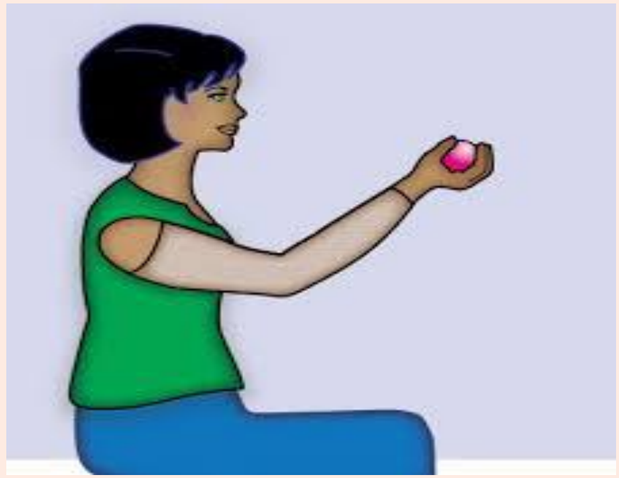
BANDAGING





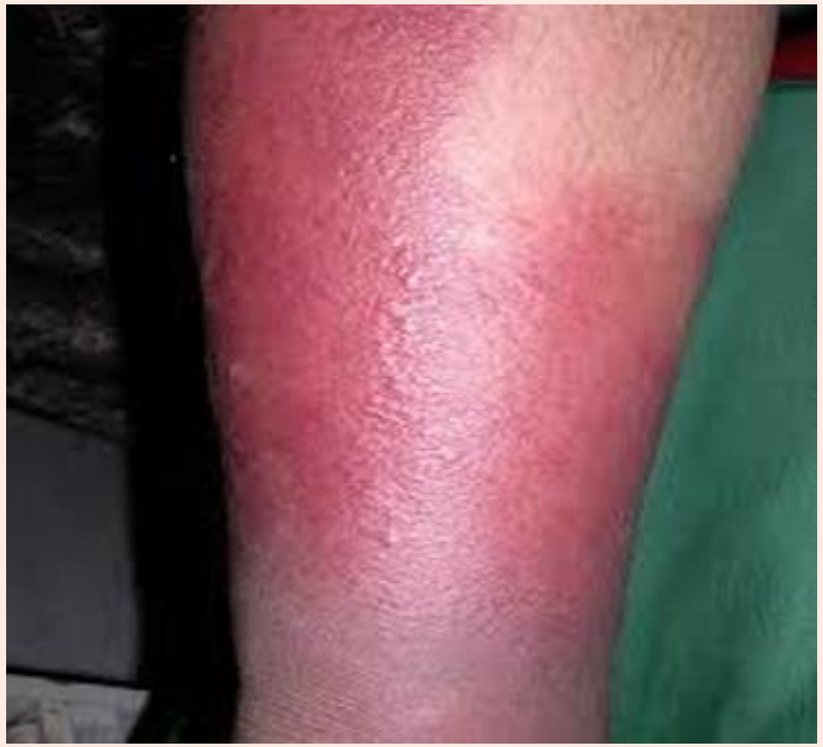
EXERCISE



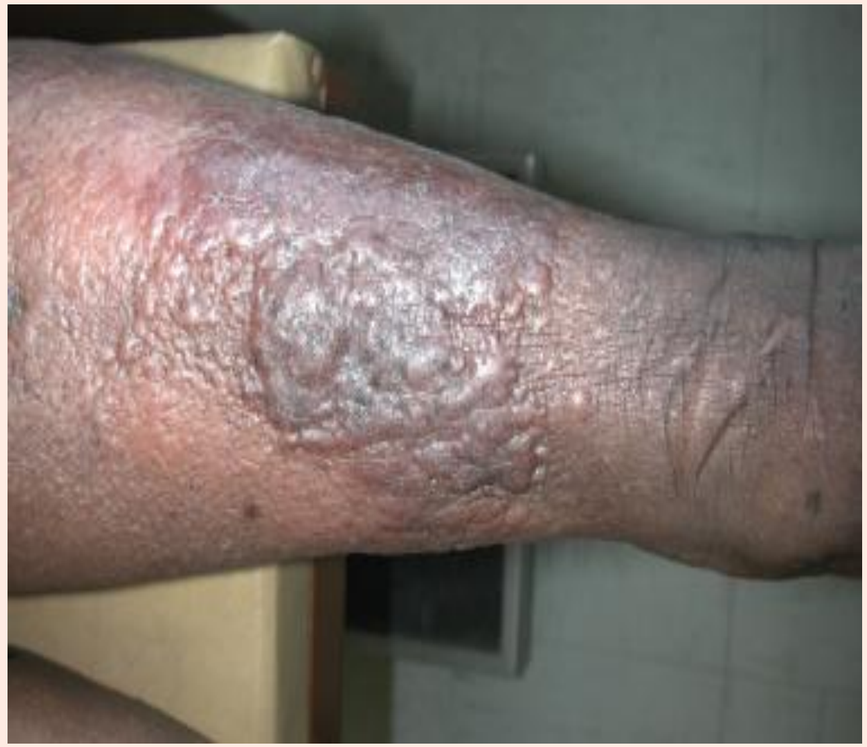


COMPLICATIONS OF LYMPHOEDEMA

Cellulitis



Lymphorrheoa



ROLE OF ASHA AND MPW

- Identification of Palliative care Patients.
- Rapport building with patient, family and community
- Assess the health status of patient and family
- Symptom assessment
- Use proper communication skills
- Team work with other health care staff
- Health education for the family
- Referral as per needed
- Home care Visit and Follow up
- Documentation and reporting

Thank You