KHETHANI ELDERLY CARE COURSE

We all have basic needs, the sick or elderly have to have someone to help maintain (keep) these basic needs: -

- To be kept in safe surroundings
- To be kept clean and comfortable
- To eat and drink regularly
- To excrete (send out) bodily wastes
- To communicate (talk) and express (say) their needs, fears and happiness
- To worship according to their faith

Think about what it would be like if you could not go to the toilet or make yourself a cup of tea. Would you be angry? Would you feel frustrated (upset)? Would you become depressed (unhappy)? Remember when some people feel these emotions they sometimes take out their anger on the caregiver and those close to them. A caregiver has to learn patience.

As you can see there are many qualities of a successful caregiver. She should be able to anticipate (foresee) the needs of the patient, to keep him free from harm, comfortable and moved regularly. She is a person the patient can talk to and be happy to have around.

Why do you want to be a caregiver?
Who can be a caregiver?
What kind of caregiver are you?
Who is your patient?
For a caregiver to be effective (good) she must also see to her own needs. She will need:-

- Time for relaxation, hobbies, exercise and study
- Time for spiritual growth, the church and community
- Support from family and friends and time to be with them
- She must live a fulfilled life, look after her own health and have an optimistic (hopeful) outlook on life.

Apart from all her other responsibilities a caregiver must be a teacher. We must remember that the caregiver will not be on the spot 24 hours out of every 24 hours. In many cases she might only be with the patient for a few hours so it is important that she teach family (from children to parents) or helpful neighbours to help. All have a role to play; even an elderly parent can perhaps read to the patient or just be there for company. Others must be able to turn a patient, give a bedpan/urinal, feed and give medication at the prescribed (fixed) time. The importance of changing a patient's position regularly to prevent bedsores must be stressed (taken seriously)

A caregiver must try to interact (work with) the family. They will all have problems – the expected loss of husband/wife, father, the breadwinner, and feelings of being unable to manage. Be able to listen to problems and assist (help) if you can. Have some knowledge of community resources (services) which can be called upon.

* A caregiver can be a man or woman. I have used "she" in the notes for easy reading.

MAKING A BED

Your patient may spend a lot of time or all the time in bed so it is important that we make a bed that is wrinkle free, clean and comfortable to be in. Change the sheets often so that the patient never has to lie in dirty sheets which is unhealthy. If possible it is good for the patient to get out of bed and move around a bit and this will make it easier for you to make the bed. A well made bed that is clean and wrinkle free will prevent pressure sores.

You will need

- Under-blanket – this protects the mattress and keeps the patient cool in summer and warm in winter
- Clean sheets
- Clean pillow cases
- Draw-sheet – this is a piece of cloth about one metre wide and two metres long for a single bed (the size of a single sheet folded in half down the long side)
- Plastic or rubber water proof sheet – this is for the patient who is likely to wet the bed (incontinent)
- Blanket/s
- Bedspread (optional)
- Two chairs next to the bed. One to put the clean sheets and pillow cases on and the other for the blankets removed from the bed. (If you don't have chairs or table, use a cardboard box, a sheet of plastic or paper. Do not put the bedding on the floor)
- Basket for dirty sheets or laundry bag

Making a bed

- Cover the mattress with an under-blanket
- Put the bottom sheet, right side uppermost and with its centre crease down the middle of the bed. Tuck in the ends and make envelope folds at the corners. (See How to make Envelope Corners) Make sure it is firmly tucked in so that there are no wrinkles.
- If the patient is likely to wet the bed (incontinent) put a plastic or rubber water proof sheet on top of the bottom sheet so that it is under the patient's buttocks (bottom)
- Fit the draw-sheet with only the ends tucked in with the rest of the draw-sheet hanging down beside the bed
- Place the pillows at the head of the bed
- Put the top sheet in position with the wrong side uppermost and centre crease down the middle of the bed. About 25cm should lie on the pillows. Make a pleat (fold) 15cm wide at the foot of the bed to allow room for the patient's feet when his toes are pointing upwards. Tuck the sheet in at the foot of the bed and make envelope corners. Tuck in the sheet at the sides except where the draw sheet hangs down
- Fit the blanket/s in the same way but without laying it/them on the pillow. Fold the head of the sheet down over the blanket. Make a pleat in the blanket (in the same direction as you did on the top sheet) tuck in at the foot of the bed and make envelope corners

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MAKING A BED WITH A PATIENT IN IT

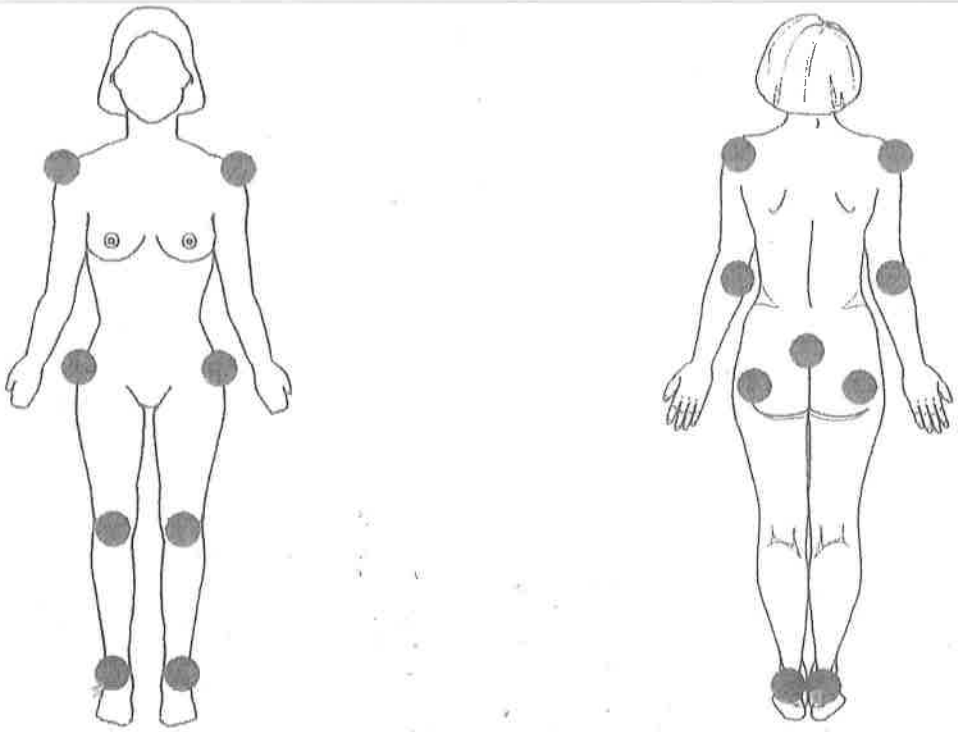
If the patient can't get up out of bed, you will have to change the sheets and make the bed with the patient in it. You can do this by making one side of the bed at a time. Always tell the patient what you are about to do. Talk to the patient and explain what you are doing as you go along and in this way the patient will assist you if she can.

- Get the clean sheets and everything you need and put them on a chair next to the bed
- Loosen the sheets and blankets at the edges
- Take off the top sheet and blankets.
- Cross the patient's arms and legs so that she can be turned more easily on to her side. Turn her on to the side of the underneath leg (You can use the back of a chair against the side of the bed to stop the patient from falling off the bed) Move the pillow over to that side
- Roll the length of the sheet to be changed right up to the patient's back (with drawsheet and waterproof)
- Roll the clean sheet lengthways in half. Lay the clean sheet on the bed with the rolled side near the middle of the bed close to the patient
- Roll up the waterproof in half. Position at the buttocks, with the rolled side closest to the patient. Do the same with the drawsheet
- Roll the patient back over on to the clean sheet and onto her other side. Move the pillow to that side. Remember to tell your patient what you are doing.
- Holding onto the patient move to the other side of the bed and take away the old sheet (with drawsheet and waterproof) Smooth the under blanket and unroll the new sheet (waterproof, drawsheet) and pull tightly so that there are no creases. Tuck in and make envelope corners. (see chapter "Making a Bed" for envelope corners)
- Help your patient to lie comfortably on her back with the pillow in the centre and place a clean sheet over her. Do not shake open the folded clean sheet over the patient. Place on bed and unfold it.
- Put the blankets over the patient and fold the clean sheet over the top of the blankets.
- Make sure there is enough room for her feet to move comfortably. (see pleat in chapter "Making a bed")
- Place dirty sheets in the basket or laundry bag

PRESSURE AREAS, BEDSORES (CAUSES AND PREVENTION)

PRESSURE AREAS

One of the most important tasks of a caregiver is the prevention of bedsores. Once these have formed they are very difficult to cure (heal). Unfortunately the ill and elderly who become less and less mobile are very prone to these. Bedsores are most frequently seen on the bony parts of the body where the skin is thin, as indicated in the following drawing.



CAUSES

1. Pressure caused by patient staying in one position for too long, either in bed or in a chair.
2. Wrinkled sheets, crumbs in the bed.
3. Friction.
4. Wet or soiled bed.
5. Long illness, poor nutrition.
6. Injury caused by caregiver wearing a watch or ring or long nails.

PREVENTION

1. Don't allow the patient to lie in a wet or soiled bed.
2. Wash dry skin gently. Rub pressure areas two hourly with cream (Elizabeth Anne Baby cream or Aqueous cream)
3. Keep the sheets wrinkle and crumb free.
4. Change the position two hourly.
5. Make use of special foam egg shell mattress or foam rings. Synthetic sheep skin which is easy to wash, (bought from Chemist shop.) A pillow placed between the knees and ankles can also relieve pressure.
6. Good nutrition.
7. If possible don't let the patient stay in bed all day.

SIGNS OF A BEDSORE

1. Redness and warmth
2. Blister – (do not pop, infection may result)
3. Skin breaks down and leads to an ulcer

ONCE A BEDSORE HAS DEVELOPED SEE A DOCTOR, NURSE OR NEAREST CLINIC OR HOSPITAL AS SOON AS POSSIBLE

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BATHING, SPECIAL AIDS TO BATHING AND HAIR WASHING

Maintaining good personal hygiene is an essential part of caring for an elderly or sick patient. However you should be aware that when a person becomes dependent on another person for personal hygiene, they can experience a deep loss of independence and self-esteem which can lead to agitation and depression.

Bathing or taking a shower in the bathroom is the first choice for everyone, but there can come a time in the seriously ill or the elderly when this becomes too difficult. In most cases it is best to "help" the person with personal hygiene rather than doing everything for them. For example, if a patient can still move their arms, they can wash their own face and brush their teeth even if it is done very slowly. The advantage of this is that it keeps them from becoming completely dependent on you, relieves your work load as the caregiver and helps the patient to maintain mobility (keep the patient moving). So encourage your patient to participate (share) in the bath.

Some elderly people have a fear of water or showers and will fight against attempts to wash or bathe them. The solution here is to look for the reason. For example, it can be a deep rooted fear of falling, to which the solution is to install handrails. Or it may be a modest issue, in which case do not undress the person fully, just wash one part of the body at a time and keep the person covered or partly dressed when washing the patient in bed.

Never allow the patient to lock the bathroom door. Remember that bath oil will cause the bath to be slippery. Always check the temperature of the water in the bath or shower before your patient gets in.

BENEFITS FOR BATHING (Although the patient may be inactive they need to be washed frequently as the skin continues to function and sweat during illness.)

To clean the skin of sweat and dead cells
To refresh and relax a restless or stressed patient
To change clothing and soiled linen
To check the patient for bedsores
Gives the patient exercise
Helps the patient sleep better
Helps the patient feel better about themselves

WASHING THE PATIENT IN BED

You will need

- One large washing bowl or bucket with hot water
- Two or three towels
- Soap on a saucer
- Two face flannels
- Deodorant and talcum powder
- Body rubbing cream (Aqueous)
- One upright chair
- Clean night clothes
- Clean bed linen

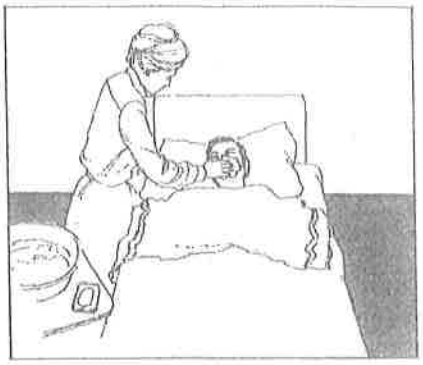
Method

Tell your patient what you are about to do, close windows and door, ensure privacy. Offer a bedpan or urinal.

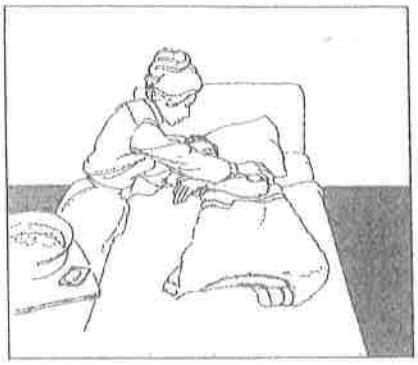
1. Remove night clothes
2. Remove bedding, leaving one sheet or light blanket to cover the patient.
3. Take away excess pillows leaving just one
4. Place one towel behind the patient's head
5. By this time the water should have cooled.
6. Start by washing the face, ask the patient if she uses soap and wash face, ears, neck. Rinse. Dry. Change face cloth. (If she is able to wash her own face this is to be encouraged)
7. Continue with arms, chest and tummy. Put towel under arm to protect bedding. Pay attention to under the breasts and underarm, apply a small amount of deodorant or talcum powder
8. Remember keep the patient covered except for the part being washed
9. Change water
10. Continue with legs, putting towel under each leg. Wash, rinse and dry
11. The genitals (private parts) ask the patient if she is well enough to wash herself. If she says yes, put a towel under her buttocks and give her a soaped flannel. When she is finished, rinse it and then give her a towel. Otherwise you can do this for her
12. Roll the patient over on to her side to wash her back
13. Give the back a wash, check for pressure areas and rub cream on. You can also check if the genital area has been cleaned properly
14. Dress the patient in clean night clothes
15. Quickly make the bed with clean linen (see Making the bed with the patient in it) the patient will probably be feeling tired at this point so offer her a cup of tea and let her rest.

Washing a patient in bed

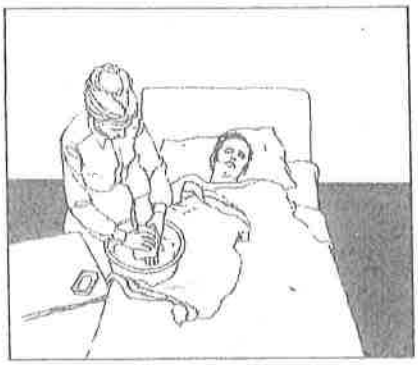
Although he may be inactive, a bedridden patient needs frequent washing: the skin continues to function and sweat during illness. Keep the patient covered with a bath towel or thin blanket except for the part being washed, and put a second one underneath him to protect the bed from splashes of water. The top covers of the bed can either be removed (put a towel over them and let the patient hold it in position while they are being taken off) or they can be protected by a towel and be folded back as required. Let the patient wash himself where he can, especially in the groins and between the legs. Change the water if it becomes cool or dirty. You will need: bath towels or thin blankets (2), bowl and jug of hot water, soap, face and body flannels, towels (2), and clean pyjamas or nightdress. Make sure there are no draughts in the sickroom.



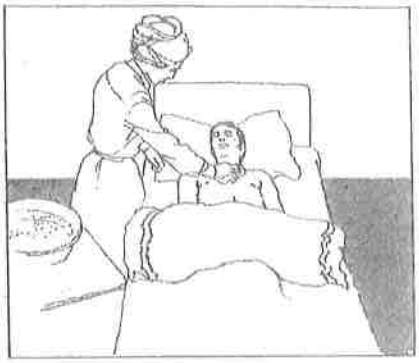
1 Remove pyjamas or nightdress. Wash, rinse and dry eyes (clear water), face, neck and ears.



2 Wash, rinse and dry one arm, then the other, working from the armpit to the fingers.

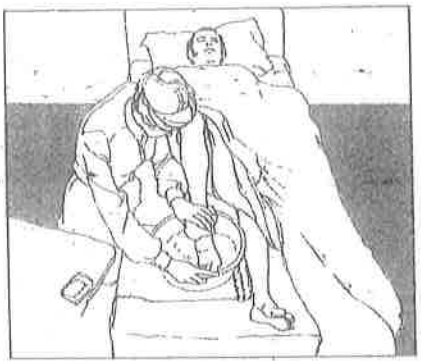


3 While arms are being washed, the patient finds it refreshing to put his hands in the water.

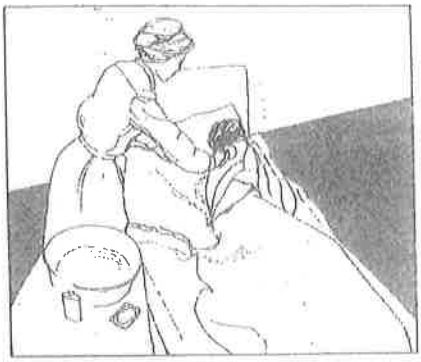


4 Fold the towel down to the waist: wash and dry the patient's chest and then his abdomen.

5 Cover the patient up to his chin: wash, rinse and dry each leg in turn, working from thigh to ankle.



6 Wash the feet in the bowl. Wash groins and between legs if patient cannot do it himself.

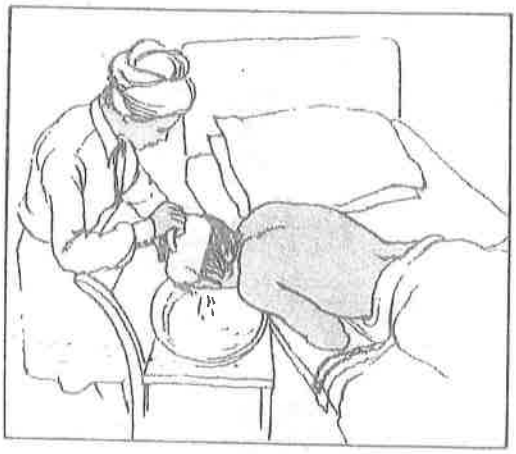


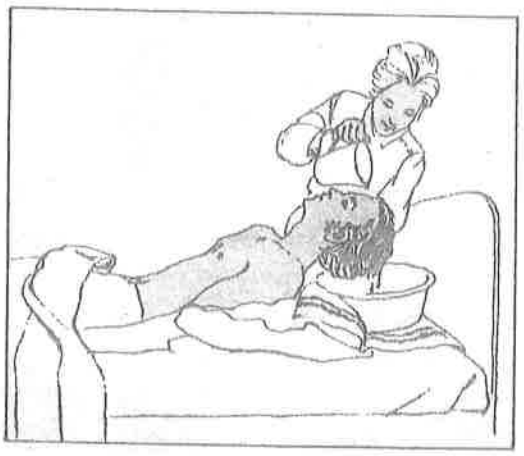
7 Turn patient on to his side -- towards you to prevent him falling; wash and dry his back.

HAIR WASHING (in bed)

Hair will need to be washed once a week. If the patient is too unwell a little talcum powder sprinkled on the hair brush and brushed through the hair will take away some of the grease built up in the hair. Choose the warmest time of the day to wash hair. Make sure there are no draughts in the room. Have plenty of plastic to protect the bed. You will need a bowl, a jug of warm water, the patient's usual shampoo, and a towel. If the patient is well enough to lie face downwards with his head over the side of the bed, wash her hair in this position. Otherwise move the patient down in the bed, support neck and shoulders with pillows, cover with plastic and towel and place bowl underneath the head. (See drawings below) A plastic bag can be used instead of a bowl. The plastic bag is split open and tied around the patient's forehead with an opening at the top to catch the water. Plug the patient's ears with cotton wool and place a folded face cloth on her forehead to catch any drips. Wash and rinse well. Towel dry and use a hairdryer if available. Comb neatly. Remake the bed and leave the patient comfortable.

Keep hair well brushed and combed at least twice a day.





NAIL CARE

Cut nails regularly. Finger nails should be filed.
Toe nails should be cut straight across. You may need the help of a chiropodist.
It can be very comforting to soak the elderly patient's feet in warm water and then rubbing oil or cream into the dry skin.

OBSERVATIONS

Doctors and nurses become very skilled observers. A great deal can be learnt by using their senses. A caregiver can become just as skilled.

What are our senses?

1. Eyes
2. Ears
3. Nose
4. Hands
   (Taste)

1. By LOOKING at your patient, using your EYES you can observe if your patient is:

Worried, Sweating, In pain, Dribbling, Pale, Flushed, Spotty, Happy/Sad, Crying.

2. By HEARING, using your EARS you will observe if the patient is:

Coughing, Breathing Noisily, Crying, Slurring his speech, Talking incoherently.

3. By SMELLING, using your NOSE you will tell if:

The bed is soiled, The patient's breath is not good, Flowers in the room.

4 By TOUCHING, using your HANDS you can tell:

Patient is hot/cold, The skin is rough/dry/clammy.

T.P.R. (TEMPERATURE, PULSE, RESPIRATORY)

These three observations are done together.

1. **TEMPERATURE:** The normal temperature is 36 – 37 degrees Celsius. (97 – 99 Fahrenheit) This is taken by placing a thermometer under the tongue for two minutes.

   Method:

   - Make sure the patient is comfortable and has not drunk anything hot or cold twenty minutes before.
   - Clean the thermometer with spirits. Shake the thermometer down to below normal. (36-37 degrees)
   - Place bulb end under the tongue.
   - Leave for two minutes.
   - Read thermometer and record.

If the patient is frail or confused it will not be advisable to put the thermometer into the mouth. Then it is advisable to put it under the armpit. Not quite as accurate but is safer that a bitten thermometer. It is usually 0.5°C lower.

BLOOD PRESSURE:

This is taken with an instrument (Blood Pressure or BP machine). It can tell you how hard the heart has to work to pump the blood through the body. You will not have a machine. But on a hospital or clinic visit it may be taken.

OBSERVATION OF BODY WASTES:

URINE: If a patient cannot go to the toilet, a bedpan or urinal (bottle) is used which makes this a simple observation. To give a bedpan always warm it first. Same for the urinal. Take it to the patient covered, and also give some toilet paper. Remove the pan/urinal when the patient is finished. Give him a bowl, soap and towel to wash hands. Wash your own hands.

Normal Urine is pale yellow. It is usually passed four to five times a day an amount of 1200 to 1500 mls in 24 hours.

Changes which may take place:

Cloudiness. Dark in colour. Reddish brown. Very pale.
Changes in amounts and frequency:
Small frequent amounts. Small infrequent amounts. Large amounts.

Any changes should be reported to the doctor or community nurse.

A small sample should be saved.

NB: Everyone should drink 6-8 glasses of water per day to help elimination of waste products.

SPUTUM: Secretions coughed up from the lungs (not to be confused with saliva from the mouth)

Normal Sputum is cream coloured.

Changes which may take place: Greenish colour. Blood or pus present.

Any changes should be reported to the doctor or community nurse and a small specimen saved.

NAUSEA AND VOMITING: Always a sign that something is wrong. Report to the doctor or community nurse. Being sick is not only unpleasant but it usually frightens the patient. Reassure him, support his head and hold the bowl for him. Encourage him to breathe deeply. When the attack is over, let the patient rinse his mouth out with water. Then wash his face with a damp, warm face cloth and change any bedding or clothes that have become soiled. If intense pain follows vomiting, tell the doctor immediately.

Nausea is the feeling of wanting to be sick

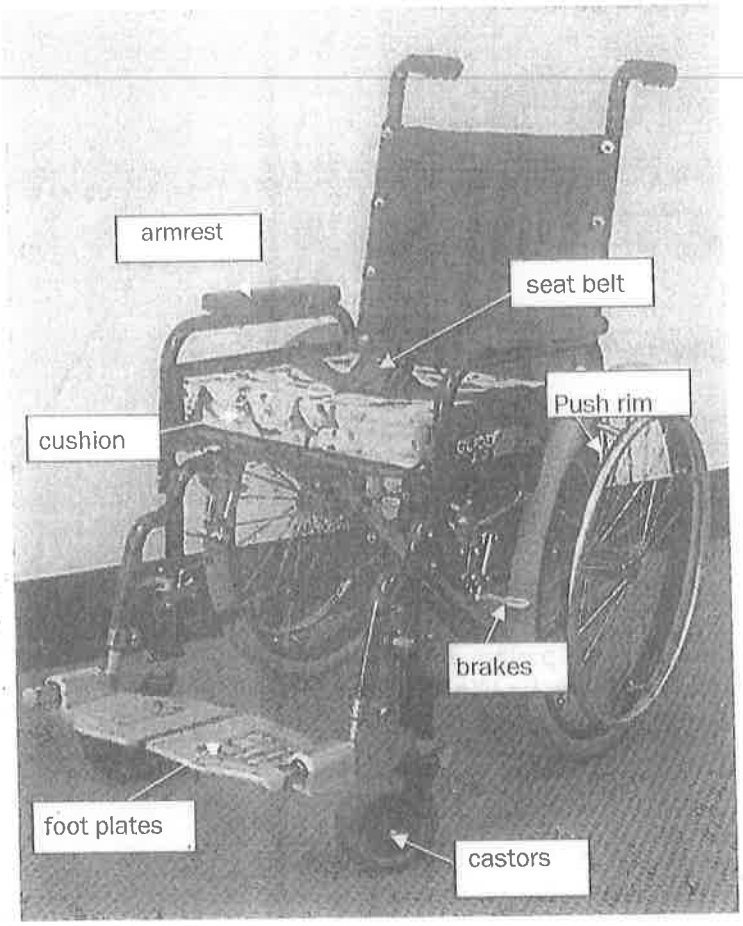
Vomiting is the outcome.

Observe the amount and colour

Undigested food.

HOW TO USE A WHEELCHAIR

Details on how to fold, safely lift, move, general safety and cleaning the wheelchair.



FOLDING AND UNFOLDING

Folding the wheelchair

- Fold the foot plates up.
- Hold in the middle of the seat at the front and back, and pull upwards until the chair is fully closed.

Unfolding the wheelchair

- Push down and out on the side edges of the seat (where the upholstery is fixed to the metal frame).
- Use the palms of your hands to prevent your fingers being caught between the seat and the frame.

LIFTING THE WHEELCHAIR

- Put the brakes on to prevent the wheels from spinning when lifting.
- Hold onto the stable parts of the frame when lifting.
- When possible lift the wheelchair with two people.

GETTING IN AND OUT OF THE WHEELCHAIR

Remember:

- Always put on the brakes when getting in and out of the wheelchair.
- Always lift the footplates up when getting in and out of the wheelchair.

KERBS, STEPS AND RAMPS

Remember to tell the patient what you are about to do.
It can be frightening to be tilted backwards without warning.

Pushing the wheelchair up a kerb

- Place your foot on the tipping lever and lift the wheelchair off its front wheels and onto its back wheels, push the wheelchair forward and onto the kerb
- Put the front wheels down on the top of the kerb.
- Push steadily and firmly (large wheels will roll up).
- Ensure the wheelchair is safely on a flat surface.

Pushing the wheelchair down a kerb

- Reverse the wheelchair to the edge of the kerb, with the rear wheels positioned squarely to the kerb.
- The person assisting should lower the rear wheels down the kerb slowly and roll the wheelchair away from the kerb, keeping the body close to the back of the wheelchair.
- Slowly lower the front wheels placing your foot on the tipper leaver to assist bringing the wheelchair back into an upright position.

CLEANING AND MAINTENANCE

- Always store the wheelchair in a clean, dry place indoors.
- Wipe over the upholstery with damp cloth and mild detergent. Dry well to avoid rusting of screws.
- Check tyres, brakes and upholstery. If problems are evident please contact your Occupational Therapist. (or Maintenance Company)
- Use a bike pump to pump up tyres if needed. Your local Petrol Station should be able to assist. Tyres will need sufficient pressure so that they are firm when pressed.

HYGIENE

- It is of vital importance that good hygiene is maintained at all times in and around the house.
- The outside rubbish must not be left lying around. Use a dust bin lined with a plastic bag if there is a collection service. Keep the bin well away from the dwelling.
- If there is no collection service all rubbish must be burnt or buried.
- All animals must be kept away from the water supply, fenced in if possible. Animals should not be allowed in the house.
- The house must be swept and cleaned daily.

The sick room should be damp dusted daily so as not to have dust flying around.

- Hands must be washed after using the toilet.
- Hands must be washed before handling food.
- Hands must be washed before and after entering a sick room.

Soiled linen should not be flushed down the toilet, if it is infected it can be soaked for 15 minutes in a solution of JIK (1/4 cup to 5 litres of water) then rinsed and washed in the family wash.

Special attention must be given to the preparation of food: all surfaces and utensils must be clean; food must never be left uncovered to prevent flies from infecting it.

HYGIENE
UNIVERSAL PRECAUTIONS

These are precautions that must be taken at all times when caring for the sick, whether they are HIV positive or not.

People that are HIV positive can easily get common infections. They cannot infect a caregiver or another person with the HIV virus during normal daily activities. Children with HIV/AIDS cannot infect other children during normal play at school.

Universal precautions MUST be used in all situations by anyone who is helping an ill person at home. Universal precautions are:

1. ALWAYS WASH YOUR HANDS with soap and hot water before and after touching an ill person or after changing their bed sheets and clothing.
2. ALWAYS KEEP CUTS AND WOUNDS COVERED – on the caregiver and on the patient.
3. WEAR LATEX GLOVES WHEN TOUCHING BODY FLUIDS, i.e. BLOOD, urine, stools, vomit, or if you have cuts or broken skin on your hands.
4. NEVER ALLOW ANOTHER PERSON'S BLOOD OR BODY FLUIDS to come into contact with your skin. Wash off blood or body fluids under running water immediately
5. NEVER SHARE SHARP INSTRUMENTS which might have blood on them such as razors, needles or knives.
6. ALWAYS STERILISE INSTRUMENTS (boil them in water) before they are used on another person.

If a caregiver injure themselves with an instrument that has blood or bodily fluids from the patient on it (eg. A needle stick injury), they must:

1. Keep the wound bleeding
2. Disinfect the wound
3. Speak to a senior Health Care Worker as soon as possible or go to the clinic. They will give you advice and refer if needed.

It is good practice to wash your hands before entering a room where the patient is and upon leaving. The same applies when you put on gloves, wash your hands before putting them on and after discarding them. Wash hands before and after going to the toilet. Wash hands before preparing food. Keep food covered. Eat only fresh food. Boil water if it does not come from a clean source.

CARE OF WOUNDS

This is a very big subject. A wound is a break in the skin which can be caused by an injury, an operation, an insect bite or bed sores. They come in all shapes and sizes and can be very deep – even to the bone. The caregiver must know a few basic principles of wound care.

- All equipment must be kept separate from household equipment and after use must be washed and kept covered.
- The doctor or clinic sister will give instructions on how the wound should be treated and what, if anything, should be applied.

THE DRESSING TRAY

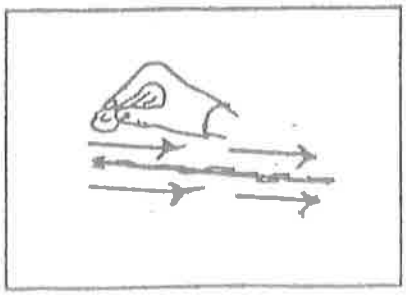
- Plastic to protect bedding
- Plastic apron to protect caregiver
- Dispensable gloves
- Cup or clean bowl for cleaning solution, i.e. a teaspoon of salt to a cup of water or as prescribed by the doctor.
- Gauze dressings
- Cotton wool
- Scissors, bandage and pin or adhesive tape, elastoplasts
- Clean teaspoon for spreading ointment on gauze (if prescribed).

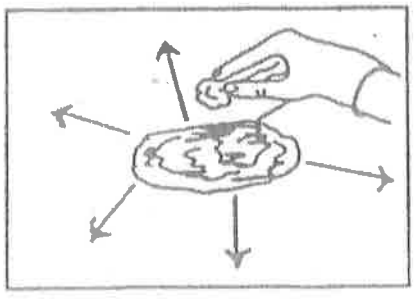
PREPARATION

- Tell the patient what you are going to do
- Ask if he/she wants to pass urine
- Close windows, exclude draughts
- Make sure the patient is comfortable, offer the bedpan or urinal
- Expose only the wound area
- Protect the bed and patient's clothing with the plastic
- Line a bucket with plastic bag for the dirty dressing

CLEANING AND DRESSING THE WOUND

- Wash hands
- Put on gloves or use plastic bags as gloves
- Remove dirty dressing, place in plastic bag lined bucket
- Put on fresh gloves (or use new plastic bags over hands)
- Clean wound with gauze swab or cotton wool by taking the swab in one hand (clean hand) and dip it into cleaning solution. Transfer the swab to your other hand (dirty hand). Wipe wound either top to bottom or inside to outside as shown in diagram.





- Place dirty swabs in plastic bag lined bucket
- Repeat until wound is clean
- If prescribed, put ointment onto gauze using the back of the spoon and place over wound. Cover with gauze
- Hold in place with bandage or tape
- Wash gloves well.
- Make patient comfortable
- Tie up plastic bags, burn if possible, otherwise tie and place in outside dust bin.
- Wash hands and all equipment in hot soapy water. Dry and place in covered tray.

NB If seeing more than one patient new gloves must be used for each patient.

HOW TO PREVENT INFECTION OF WOUNDS

- Sick room should be well ventilated
- Keep the room clean and free of insects
- Try to disallow pets into the room – otherwise only for short periods of time
- Don't allow patient to touch the wound
- Don't cough or sneeze over the wound
- Keep everything clean, wash hands and use gloves for re-dressing
- Keep bedding clean – air in the sun
- Report any redness, swelling or pus to the doctor or clinic sister.

INFLAMATION is the body's response to bacteria, injury, sprains or burns.

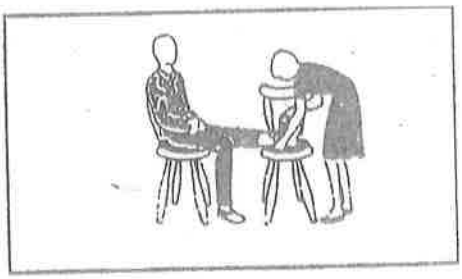
SIGNS OF INFLAMATION

- The area is red, hot, swollen
- Patient complains of pain
- Patient has difficulty in moving painful parts

TREATMENT

- Rest
- Patient may be prescribed an antibiotic
- Give plenty of fluids

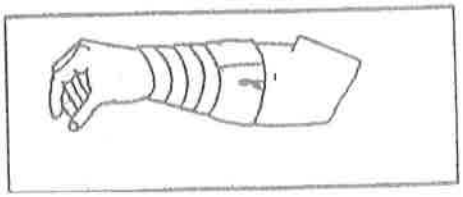
Rest and a good diet with plenty of protein are aids to help wound healing



BANDAGING

A bandage is any clean material used to hold a dressing place:

Strips of material
Pantyhose
Stretchable roller bandage



Roll a bandage around wrist/ankle twice to hold in place. Apply in straight turns around wrist with two-thirds overlapping. Finish off with a straight turn. Check the circulation by asking patient if it is too tight.

MOUTH CARE

Normally in good health the mouth is moist and fresh. We drink about eight glasses of water a day and clean our teeth twice a day. Your bed bound patient must also be given the chance to clean his teeth twice a day and more if perhaps he has vomited. As the mouth is largely hidden, the patient, family and caregivers may not recognise problems when they occur. As an exercise the student is asked to hold her mouth open for several minutes. Saliva (spit) will begin to pool about the lower teeth. At the same time the tongue will dry. Drooling eventually will occur. Suddenly, what we have taken for granted, swallowing spit, becomes precious (valued). Examination of the mouth is one of the most important tasks.

DRY MOUTH

Common causes of dry mouth are - Medications, dehydration, mouth breathing, surgery or radiotherapy to the mouth, infections of the mouth. For most patients simple treatment such as frequent sips of water, ice chips, and swabbing of the mouth with a moist sponge on a stick are usually sufficient. Lemon drops or other sour sweets can stimulate saliva, and the sour flavour is often preferred by dying patients. The Doctor may prescribe medication.

DIFFICULTY HANDLING SALIVA, DROOLING

Patients with Parkinson's disease, brain injury, dementia and developmental disorders are prone to this. Drooling carries a great social stigma and can be very disturbing to patients and families. Medication can be of some help but in some patients the dry mouth that can result may be as troubling as the earlier drooling. A ready supply of tissues or other absorbent material should be kept available at all times.

CANDIDIASIS

Candida infections of the mouth occur frequently, especially in patients who are on steroids and in diabetics. Thrush is easy to recognise, White cottage cheese-like plaques are found in the mouth. Vitamin deficiencies, poor nutrition and dry mouth contribute to this disorder.

CLEANING THE MOUTH

EQUIPMENT FOR PATIENT TO CLEAN TEETH IN BED

A towel
A mug of water, warm or room temperature, ask the patient.
Mouthwash (bicarb, glycerine, borax)
Tooth brush and toothpaste
A bowl to spit

If your patient has dentures it is equally important to clean these.

- Ask your patient to remove them. Place them in a container.
- Take them to the bathroom and brush them under running water with toothbrush and toothpaste.
- If they are stained they can be cleaned or soaked in a special denture cream.
- Rinse before returning.

Cleaning the mouth of patient too ill or weak to attend to his own is important. This must be done very frequently as a dry mouth soon becomes cracked, infection appears, little white spots called thrush or brown deposits gather in the mouth.

EQUIPMENT FOR CAREGIVER TO CLEAN PATIENT'S MOUTH

1. ½ glass of water with one teaspoon Bicarbonate of Soda added or container of mouthwash and water.
2. Cotton buds or stick covered with cotton wool (as many as thirty can be used if the mouth is very bad.)
3. Swabs
4. Towel to protect the bed. Plastic bag for used sticks.
5. Small bottle of glycerine.

PROCEEDURE

1. Make the patient comfortable – tell him what you are going to do.
2. Place the towel under the patient's chin
3. Wash your hands, put on gloves
4. Remove dentures if any.
5. Dip the covered stick in solution of Bicarbonate of soda and clean all surfaces of the mouth.
6. Discard each stick as soon as it is soiled. Continue until mouth is clean. Go behind the gum, inside the cheeks, under the tongue.
7. If the tongue is very dirty it may be cleaned with a toothbrush dipped in the Bicarbonate of Soda.
8. Use a swab (wound around your index finger) to wipe out the mouth using the mouthwash or water
9. Finally apply the glycerine to the lips

In the very sick patient this will have to be done every two to three hours. Have a tray permanently set at the patient's bedside

Wash hands, remove gloves, wash hands

Leave your patient comfortable.

TOILET CARE

For a long as possible your terminally ill patient or the elderly will gallantly (bravely) try to go to the toilet – as it is the most comfortable way to go! The bedpan is seen as something to be avoided for as long as possible – we all want to keep our independence, we don't want to be a burden to others, and a bedpan is seen as an embarrassment.

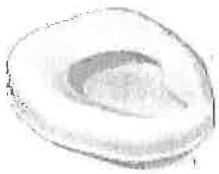
An alternative these days is a commode which is not too unsightly and can stand in a corner of the room with a cushion on it.

TOILETING AIDS.

Commode

Hand Rails

Raised Toilet Seat.



Bedpan

Female Urinal

Male Urinal

USING THE BED PAN

To put a patient on a bedpan you will need:

- A bed pan, please warm it under the hot tap, metal bedpans retains heat, so check to make sure it is not too hot before putting it under a person.
- Sprinkle baby powder on the edge of the bedpan to make it easier to slide under the person.
- A cover (towel) for the bedpan.
- Toilet paper.
- A bowl of warm water, towel, soap to wash hands afterwards.

1. Tell the patient what you are going to do.
2. Ensure privacy and exclude draughts.
3. Wash your hands and put on gloves.
4. If the patient can't move easily you may need assistance.
5. Either lift the patient or he will lift himself.
6. Ensure clothing is not in the way.
7. Slip the pan underneath the patient ensuring that it is in the correct position.
8. Adjust the pillow so that the patient is adequately supported.
9. If the patient is well enough, leave him on his own for a few minutes with the paper.

10. Remove pan and cover it. Put it on a chair. Do not put it on the bed side table. Check that the bowels have acted, additional help may be needed. (laxatives, suppositories or enema).
11. Roll the patient onto his side, check and wash.
12. Change the sheet if necessary, put in a linen saver.
13. Make patient comfortable, give him soap and hold a bowl of water to wash his hands.
14. Remove pan, empty in the toilet, use a toilet brush, first measure urine if necessary, note the colour etc. Also the stool.
15. Clean with soap and water and disinfectant and dry the pan.
16. Remove and dispose your gloves, wash hands.

HOW TO HELP A PERSON WHO CANNOT RAISE HIS BUTTOCKS TO USE A BED PAN

1. Roll the patient on his side. Put a waterproof sheet under the buttocks to protect the bed from spills.
2. Place the bedpan against the buttocks of the patient with one hand.
3. While holding the bedpan in place, gently roll the patient onto his back and up onto the bedpan.
4. Raise the head of the bed a little if the patient is allowed. If the patient is in a sitting position it may be easier for him to have a bowel movement.
5. Give the patient privacy if possible, but if he is weak, don not leave him alone.
6. When the patient is done, lower the head of the bed.
7. Roll the patient on his side just enough to carefully remove the bedpan.
8. Cover the bedpan with a towel and put it on a chair. Do not put it on the side table.

USING THE URINAL

This is so much easier, you will need:

1. A urinal
2. A cover (towel) and toilet paper
3. A bowl of water, soap and towel

- If the patient is very ill you may have to position the urinal for him. Otherwise he will manage. It may be easier to put his legs over the side of the bed if possible.
- Measure the urine and record if necessary.
- Wash and dry the urinal.
- Make the patient comfortable, give him soap and hold a bowl of water to wash his hands.

HOW TO CLEAN THE PATIENT AFTER USING THE BEDPAN

1. Gently roll the patient on his side.
2. Clean the buttocks of the patient with toilet paper first.
3. Next, use a wet washcloth to clean the area. If necessary, use soap and water to clean the area well. If the patient is a female be sure to clean from front to back.
4. Dry the area between the legs.
5. Check the skin for redness or sores. Tell the Doctor or clinic sister if you see any redness or sores. Medicine may be prescribed.

INCONTINENT CARE

Incontinence is a very distressing problem, which can affect the seriously ill, and the aged.

Male urinary incontinence

Incontinence is easier to manage. An open-ended condom can be put onto the penis and secured by strap. This in turn can be attached to a tube, which leads into a transparent

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polythene bag. The condom should be changed on alternate days and the bag emptied at least twice a day. The bag can be attached to the side of the bed. Be careful that the tube does not twist so that the urine can't run through.

Female Urinary Incontinence

An indwelling catheter may be used. This is a tube into the bladder via the urethra, but can cause many complications.

A nappy-type article can be obtained from the chemist. A great deal of attention needs to be given to the skin. It must be kept well washed and dried and barrier creams need to be applied.

NB: The Independent Living Centre can give a lot of up-to-date advice on this subject.

Incontinence of stool

This occurs in the very sick and frail. Use protective measures: nappies or incontinent pads placed carefully. Special attention must now be given to cleaning the patient and the use of barrier creams.

Disposal of nappies, incontinent pads etc.

In the rural areas all these soiled articles are burnt or buried. In town they must NOT be flushed down the toilet. They should be placed in plastic bags tied and placed in the outside bin.

CONSTIPATION

Is the passing of small hard stools and going for several days without a stool. This is often caused by dietary habits, stress and lack of exercise.

- Drink 8 glasses of water per day
- Exercise as much as possible
- Don't take laxatives
- Eat plenty of fruit
- Eat whole grain cereal
- Handle stress
- Relax. Ensure privacy

The main thing is a well-balanced diet – high in fibre, i.e. vegetables, cereal and fruit.

If these measures don't work consult the clinic or community nurse who may order laxatives, suppositories or enema.

GETTING OLDER

Growing old is a natural process. (It is not necessarily an illness). As we grow older, certain changes take place in our bodies. Our bodies start to slow down very gradually. Although some people never seem to grow old, most of us are affected by the changes in our bodies in some way or another. These changes affect us throughout our lives but when we are old, we find it more difficult to accept them and to adjust our lives accordingly. We also become dependent on others who may find this a burden, especially if the necessary adjustment has not been made. It is important to give some thought whilst you are still fit as to what to do when you are not.

It helps if caregivers of the elderly understand some of the changes that take place as people grow older. In these notes we look at the changes in the bones, muscles, the nervous system, the urinary system, the respiratory system and the mind.

The Bones of an older person get more brittle and shrink, break easily and take a long time to heal. Therefore it is important to protect the elderly from falling. Joints get stiffer, harder to move, can be painful, especially hip and knees.

The Muscles, which help us to move and protect our internal organs, grow weak. Therefore important to do gentle exercises and eat a balanced diet.

The Nervous System, which is a communicator between various parts of the body sending messages to the body tissues. This works more slowly and therefore causes slower thought, memory and understanding. In advancing years the nerve endings become weak and lose their sensitivity. This all affects sight, hearing, smell, touch and taste, which affects the appetite. Also the messages to the brain are affected in some people and therefore they may become forgetful and sometimes live in the past.

The Digestive System, which breaks down the food we eat is ground by the teeth and moistened with saliva. It is then passed down to the stomach. As the body ages it no longer digests or absorbs food so readily. Older people produce less saliva and they lose their teeth or they may have difficulty in chewing and swallowing (as with Parkinson's Disease). This may cause indigestion and constipation.

The Urinary System The muscles become weaker which causes urine to be passed more frequently and can lead to incontinence. This can become a great concern and they may drink too little, but their need for fluid is much the same as in youth, and the risk of dehydration is as high. Sipping six to eight glasses of water a day should be sufficient. The bladder may not empty properly and infections can result. Kidneys may not work as well – they may have to go to the toilet more frequently.

The Mind In many elderly people their mind is often very good. Changes may come on gradually but should be recognised, so that treatment may help prevent a severe breakdown.

The Respiratory System The elderly may become prone to chest infections during the colder weather. (Therefore important to watch for changes in breathing) Emphysema is another complaint, especially if the patient is a smoker, and may have to have oxygen.

The Skin gets drier, more fragile, breaks easily and is slower to heal.

The Hair and Nails Hair goes grey, and thins. Fingernails get thinner and more brittle and go yellow and dull. Toenails get hard and difficult to cut. Ridges or lines might indicate a problem such as not eating enough healthy food and infections can develop.

There are some things a caregiver can do help her elderly patient to improve some of these obstacles. For instance plenty of exercise is important. Your patient should walk as much as possible for as long as possible, and this will help their mobility. Let them do as much as they can for themselves. Because age slows down physical activity, energy requirements can decline by as much as 5% for each decade (10 years). Excess weight can creep up as a result of lowed metabolism (process by which food is converted into energy) and decreased energy needs. Therefore older people should try to exercise regularly. Obesity poses an even greater health risk in later life than in youth.

Encourage a healthy interest in surroundings. If there is a garden let the patient spend some time, weather permitting, outside for a walk or sitting in a chair.

Encourage reading, visiting, do everything you can to stimulate the patient and to maintain his interest in life and what is going on around him. Other suggestions of stimulation are; listen to music or novels on tape (tape aids for the blind) the patient does not have to be blind to enjoy these.

Good nutrition is also very helpful. Those living on their own do not always bother to prepare nutritious meals. U.S. research now suggests that the body's demand for vitamins and minerals actually increases with age.

Remember elderly people also have problems:

Money problems – pension is not enough
Lack of housing
Loss of friends and relatives.
Worried about loss of memory and hearing
Loss of mobility, fear of falling.

These worries may cause depression and make them difficult to please. One of the most common problems is falling and can cause serious problems.
Physiotherapists recommend that the older person should do daily exercises in order to improve their balance. (These exercises are also good for people in their middle age.)

ELDERLY PEOPLE WHO ARE NOT PHYSICALY WELL SHOULD BE EXAMINED BY A NURSE OR A DOCTOR BEFORE THEY START DOING THE EXERCISES!

<u>To Improve the Blood Circulation</u>
These exercises can be done while standing or while sitting

Alternately, lift the right leg and then the left leg
Do this as fast as you can
Bend and straighten the left leg. Repeat with the right leg. Do as many as you can
Bend and straighten fingers. Repeat.

<u>To Stretch Joints</u>

Standing or sitting upright, without turning the body, turn the head first to look at the right shoulder and then the left shoulder.
Nod the head several times. Stretch it backwards as far as possible. Then forward onto the chest as far as possible

Lift both arms to the sides so that they are shoulder level. Twist the upper part of the body, to the waist only and turn to look at the right hand behind you. Turn and look at the left hand. Repeat

DEATH AND DYING

INTRODUCTION

It is very often the patient's wish to die in his own home. Relatives feel they should agree but are worried that they may not be able to cope and give the patient the support and help he needs. The aim should be to make the patient's last days happy and pain-free in surroundings with people he loves.

Problems

- Coping with our own feelings and fears about death
- Knowing how to make the patient comfortable
- Recognizing the signs of impending death
- Knowing what to do when the patient dies

Many people hesitate to talk about death. This is perhaps because it is an experience we will all have to share. When faced with someone dying we are reminded that we have to die one day and our own worries about death and dying. Death and grief are something we all have to come to terms with and in doing so, we pass through several stages.

First denial - how can this happen to me?
Then anger - why should it be me?
Then depression and anxiety - will I be a burden? How is the family going to manage?
Finally acceptance – of what has happened or what is to come.

These stages do not necessarily happen in this order and one day we accept what is happening to us and on another we are back in denial.

If relatives understand these stages and emotions it will help them to give the support and understanding the patient needs.

The Community Health Worker can answer the patient's questions about his illness. His Minister or Rabbi may support him when he has doubts and fears.

As relatives or friends, you too have to face the coming loss, first with shock and disbelief, then often with anger and guilt, feeling you are in some way responsible, that perhaps you have not cared enough for your loved one, and finally you too will have to accept that the patient will die. Once you have faced the situation, you can plan how to help the patient through these last days.

Making the Patient Comfortable
The dying person has emotional, spiritual and physical needs. In gaining the strength and courage to face death with dignity, many people find their religious beliefs all important, and they may seek support from representatives of their religious faith.

Physical Needs
The dying person has similar needs to any ill person. If he has pain, talk to the Doctor because it is important that the pain is dealt with.

Keep his skin clean and change his position often. In some cases, at the very end, it will not be appropriate to turn your patient in bed, because this could be more disturbing or painful at this time. There is no need to be concerned about bedsores if the patient is actively dying at the very end. Maintaining comfort is most important. Whatever is done should be based upon your patient's comfort.

Mental confusion may become apparent, as less oxygen is available to supply the brain. The patient may be disturbed by "strange dreams". Reassure your patient as he awakens from

periods of sleep, reminding him of the day and time, where he is and who is present. This is best done in a casual, conversational way.
Secretions may collect in the back of the throat and rattle or gurgle as the patient breathes through his mouth. He may try to cough up mucous. His mouth may become dry and encrusted with secretions. Secretions may drain from the mouth if the patient is placed on his side and supported by pillows. Cleansing the mouth with swabs dipped in glycerin or mineral oil or even cool water will help to relieve the dryness that occurs with mouth breathing. Offer water in small amounts to keep the mouth moist. A straw with one finger placed over the end can be used to transfer sips of water to the patient's mouth.

Breathing may become irregular with periods of no breathing (apnea) lasting around 20 – 30 seconds. The patient may seem to be working very hard to breathe and may make a moaning sound with each breath. As the time of death nears breathing may again become regular but shallower and more mechanical in nature. Raise the head of the patient if he breathes more easily this way. The moaning is not necessarily indicative of pain or distress, but often is only the sound of air passing over very relaxed vocal cords. As the oxygen supply to the brain decreases, the patient may become restless. It is not unusual for patients to pull at bed linens, to have visual hallucinations or even to try and get out of bed at this point. Reassure the patient in a calm voice that you are there. Prevent him from falling if he tries to get out of bed. Soft music or a back rub may help quiet him.

The patient may feel hot one minute and cold the next as the body loses its ability to control its temperature. As circulation slows down, the arms and legs will become cool and may be bluish in colour. The underside of the body may darken. It may be impossible to feel a pulse at the wrist. Provide and remove blankets as needed. Sponge the patient with a cool washcloth if this promotes comfort. Change perspiration soaked garments and bed linens only if the patient wishes.

Loss of control of bladder and bowel function may occur around the time of death. Protect the mattress with a plastic sheet. Keep plastic garbage bags or waterproof padding under the patient, and change as needed to keep the patient comfortable

The Doctor or Clinic Sister will probably be visiting you and give you advice.

Signs of Approaching Death

These signs do occur at other times but together they warn of approaching death

The patient seems weaker and sleeps a lot
He does not wish to eat or drink
He may be incontinent
As his circulation fails his fingers, toes and nose become blue or mottled
His skin feels cold but clammy
His vision may blur, but hearing is good until the end
His breathing becomes noisy and difficult
He may become drowsier or go into a very deep sleep or coma, or remain quite conscious until the last
He may hallucinate (see things that are not there)

What to do

Sit with him, hold his hand and stroke it gently. He can probably still hear and feel you
When his breathing stops and you think he is dead, let the Doctor know
Lay the patient flat and close his eyes
Replace dentures in mouth and place one pillow under the chin to keep the mouth closed
Tidy the bed; cover the face if you wish
Tidy the room and put flowers by the bedside
Wait for the undertaker to come
After the body has been removed, place the mattress and pillows in the sun. Clean and air the room thoroughly

To the Relatives

Having a long term problem of sickness or disablement is a great strain on any family, both mentally and physically. Do not feel guilty if you feel impatient, this is a natural reaction, only try not to show your impatience.
Avoid getting over-tired – this is not easy but you can cope better if refreshed. Can another relative or friend relieve you for an hour or two while you get out of the house? Have your hair done. Do not feel guilty if your loved one dies whilst you are out of the room. Very often they wait for you to leave before dying.

Have you talked your problems over with the family Doctor or District Nursing Sister? Have you asked in the Library for addresses and information about specialist societies which might help you? For the deaf, blind and those with AIDS.

Above all, try to keep your sense of humour, it will help you to cope.

Summary

Finally, remember that the moment of death, even when long-expected, is always a shock for the family. They will need your concerned support, sympathy and professional approach.

ALZHEIMER'S DISEASE AND OTHER FORMS OF DEMENTIA

Working with a patient with dementia can be very demanding and will require a lot of understanding and patience from the caregiver.

What is Alzheimer's disease?

- It is a physical disease of the brain
- As the disease progresses, the brain becomes more and more damaged
- The person is no longer able to lead a normal life and will need assistance
- Anyone can get this disease but it is not contagious
- It progresses at different rates. How it starts and progresses will vary from person to person
- There is no cure for Alzheimer's disease and other forms of dementia
- There are drugs available to treat the symptoms of the disease

Types of Dementia

In South Africa the most common forms of dementia include

- Alzheimer's
- Vascular/multi-infarct dementia
- Alcohol dementia
- Post-traumatic dementia
- HIV/Aids-related dementia

It is possible to have more than one form of dementia at a time.

What are the warning signs of Alzheimer's?

- A memory problem which is NOT caused by alcohol abuse or head injury and which worsens with time.
- Language problems: difficulty in naming objects, finding the right word to use in a sentence, and often talking nonsense.
- Zips and buttons are difficult to fasten. Sufferers find it hard to dress themselves.
- They may not care about how they look and may not want to bath.
- They may have extreme mood swings; a change of mood for no reason, like being calm then suddenly becoming scared, angry or aggressive, within minutes.
- Their judgement may be impaired. They behave in a strange manner, like wearing underclothes over top clothes or taking off clothes in public. They will not recognize that it is night-time and want to go shopping.
- Many sufferers get lost in familiar places. They may forget where the toilet is.
- Even recognition of their own family and friends becomes difficult.
- They may recall memories of childhood times, but cannot remember anything that happened the same day.
- They may become suspicious of other people and may accuse them of stealing or hiding things.

Signs and symptoms in the mild and moderate phases are:

- Increasing and persistent forgetfulness
- Difficulties with abstract thinking
- Disorientation
- Judgement loss
- Personality changes
- Memory loss
- Increasing dependence on others
- Urinary and fecal incontinence
- Difficulties with communication

How to cope with dementia (many of these skills will apply to all your patients)

The key to coping with dementia is to focus on what the person can do rather than what he or she is not able to do. Caregivers will need to be patient and understanding. A constantly creative attitude is essential. Every person experiences the disease differently, and therefore techniques used to care for a person will vary. Always remember you are interacting with an adult and DO NOT talk to your patient as if they are a child. Do not argue, criticize or reprimand (lecture), raise your voice, or shout. Count to ten; walk away for a short while to calm yourself. Remember that you can control your actions and responses, your patient cannot. Do not speak about your patient in front of them. Be respectful. Do not try to rehabilitate. (restore, mend) Don't ask open ended questions, keep it simple. Appear friendly and watch your non-verbal communication. Acknowledge (accept) your patient, respond to their emotions, hug, pat or hold their hand if appropriate. Stick to a routine (usual, everyday practice) as much as possible. Slow down routines if necessary. Complete one task (job) at a time. This will help the patient focus on the task at hand. Always tell your patient what you want to do and give reasons for a task. Avoid overcrowded and/or noisy environments, too many loud distractions (disturbances) at the same time may be disorientating (confused especially with regard to where they are). Limit visits to familiar and small places.

Creating a Caring Environment

A person with dementia is more likely to have an accident because he or she forgets where things are and how to use them.

Safety Tips

- Install safety devices, like child-proof locks
- Lock up cleaning fluids, firearms, medicines, alcohol
- Add extra lighting or place contrasting coloured rugs at entrances and steps
- Monitor the temperature of taps and food
- Supervise all medication
- Remove anything which might cause a fall
- Be prepared for emergencies and have emergency telephone numbers handy
- Don't leave open fires or heaters unattended

Activities

It is important for a person with dementia to continue with activities and routines for as long as possible. These include:

- Exercise – a daily must
- Listening to familiar music and watching memorable videos
- Encourage involvement in manageable household tasks
- Encourage family and friends to visit. Short, regular visits by small groups, would be ideal
- Retain a current pet or introduce a new pet. A pet is therapeutic
- Involve and include the person in outings such as shopping or visits to friends and family

THE DO'S AND DON'TS WHEN CARING FOR A PERSON WITH DEMENTIA

DO	DO NOT
1. Acknowledge them 2. Count to ten and walk away 3. Remember that you can control your actions and responses, they cannot 4. Appear friendly (watch non-verbal communication) 5. Give reasons for a tack 6. Respond to emotions 7. Encourage control, independence, decision making 8. Speak calmly at eye level (make eye contact) 9. Use humour when appropriate 10. Have patience 11. Touch/hug if appropriate 12. Develop a "behavior profile" 13. Break down tasks into manageable tasks 14. Ensure that the task is at the persons level 15. Treat as an individual ADULT with rights 16. Maintain routine as much as possible 17. Communicate with the family and visitors 18. Encourage the family to make an album with photographs 19. Be the person's advocate (supporter)	1. Raise your voice or shout 2. Argue 3. Ask open-ended questions 4. Rehabilitate 5. Discuss them in front of them as you never know just how much they understand 1. Reprimand or criticise

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THE SIGNS AND SYMPTOMS OF DEMENTIA

Signs and Symptoms	Feelings
Memory loss	Afraid, anxious
Disorientation	Panicked, lost
Speech problems	Trapped, frustrated
Task problems	Useless, angry
Recognition problems	Alone, insecure
Depression	Hopeless, uninterested
Aggression	Furious, unco-operative
Hallucinations	Confused, distressed
Walking about	Agitated, restless

Dysphagia - difficulty swallowing
Dysparaxia - poor co-ordination
Dystonia - muscle spasms, twisting of the limbs
Hallucinations - something imagined
Disorientate - lost or confused especially to direction or position

FREQUENTLY ASKED QUESTIONS ABOUT HIV/AIDS

Q: What is the difference between AIDS and HIV ?

A: HIV is the virus that causes the disease AIDS. AIDS is the group of illnesses acquired when the immune system is unable to defend against infection. AIDS is the terminal stage of infection by the HIV. In the early stages of HIV infection, infected person look and feel totally well. Only when the immune system gets impaired do they begin to feel ill. The time between infection with HIV and becoming ill with AIDS may range from 2-10 years or even longer.

Q: Can donating blood put you at risk of HIV infection ?

A: When you donate blood, blood is removed from your body not put into it. Remember you cannot get the HIV unless infected blood enters your body. You can easily avoid this by ensuring that only disposable needles and IV sets are used during blood donation.

Q: What is 'Window period' ?

A: The blood test to detect HIV in the body (ELISA TEST) doesn't become positive immediately after the entry of virus into the body. It takes between 1-3 months (maximum 6 months) for this test to become positive. This time between entry of virus into the body and the blood test becoming positive is known as 'Window period'. The person is infectious i.e. able to transmit the virus during window period.

Q: Can I get AIDS virus in a barbershop ?

A: Chances of getting infected with HIV in a barber's shop are extremely rare. However, it is best to ensure that the barber uses a new blade while shaving you. Also make sure all his equipment- scissors, razors etc. are clean and dry before he uses them

Q: Can I share a toilet with someone who has AIDS ?

A: Definitely. You cannot get and HIV infection from a toilet, public or private, clean or dirty. The AIDS virus cannot survive outside the bodily fluids or in the open for very long.

Q: Can I get the AIDS virus through kissing ?

A: While dry kissing in which there is no exchange of body fluids is safe, there is some risk of HIV infection being transmitted through deep kissing particularly if some has got bleeding gums or cuts and sores in the mouth.

Q: Can I get HIV from a mosquito bite ?

A: No, it is not possible to get HIV from mosquitoes. While sucking blood from someone mosquitoes do not inject blood from any previous person. The only thing that mosquito injects is saliva, which act as a lubricant and enables it to feed more efficiently.

Q: Can I become infected with HIV through biting ?

A: Infection with HIV in this way is unusual. There has only been a couple of documented cases of HIV transmission resulting from biting. In these particular cases severe tissue tearing and damage were reported in addition to the presence of blood.

Q: Is there a risk of HIV transmission when having a tattoo ?

A: If instruments contaminated with blood are not sterilized between clients there is a risk of HIV transmission. So one should insist on use of sterilized or disposable needles before tattooing.

Q: Am I at risk of becoming infected with HIV when visiting the doctor's or dentist's ?

A: Transmission of HIV in a healthcare setting is extremely rare. All doctors are supposed to follow infection control procedures called universal precautions when caring for any patient. They are designed to protect both patients and doctors from the transmission of HIV. Insist your doctor or dentist to follow these precautions while giving care to you.

Q: If an employee has HIV, should he or she be allowed to continue work ?

A: Yes, HIV remains dormant in an infected person's body for many years. Workers who have no symptoms associated with AIDS should continue to work, and should be treated no differently from other workers. Those with AIDS or AIDS-related illness should be treated in the same way as any other employees who are ill, In fact, this attitude will go far in helping curb the menace of AIDS.

Q: Can oral sex cause AIDS ?

A: Oral sex (mouth or tongue touching genitals) may carry risk of HIV infection especially if there are cuts or sores present in the mouth or on the genitals.

Q: Are condoms the only answer to safe sex ?

A: No. While good quality lubricated condoms reduce the risk of HIV and STD infections, no condom can be said to be absolutely safe. Condoms can tear or have microscopic holes which make them ineffective. The only safe sexual behaviour is to have a mutually faithful sexual partner, who is not infected with HIV, or to practice sexual abstinence or thigh sex "hlobonga".

Q: How will I be sure that my future marriage partner is not infected with HIV ?

A: The only way to be certain of a person's HIV status is through a blood test. So nowadays it is advisable to do an HIV test before marriage.

Q: How should an HIV – infected person cope with his / her condition ?

A: While testing HIV positive is a traumatic experience, it is important to learn how to cope. A good counselor, friend or family member with whom one can share anxieties and fears is helpful. One should follow a healthy lifestyle and eat nutritious, balanced meals. Responsible sexual behaviour is critical – remember condoms are not 100 % safe. An HIV positive woman should know the risks of getting pregnant. Financial planning for the future will reduce stress. It is most important to take control of your life and have further blood tests to see when you should start taking anti retroviral medicines (ARV'S) knowing that these must be taken all your life.

Q: Why do people who are infected with HIV eventually die ?

A: When people are infected with HIV, they do not die of HIV or AIDS. These people die due to the effects that the HIV has on the body. With the immune system down, the body becomes susceptible to many infections from the common cold to cancer. It is actually these particular infections and the body's inability to fight the infections that cause these people to become so sick, that they eventually die. Remember that everyone of us eventually dies. Taking ARV'S can lift up the immune system so that the body can again fight infections and thus keep one healthy and prolong life for a very long time.

Q: Are all the children born to HIV infected mother infected with HIV ?

A: No. about one-third of children born to HIV positive mothers become infected with HIV. However nowadays if one gives ARV'S to these mothers during pregnancy and labour and then to newborn child this risk of infection can be reduced considerably.

Q: What is the truth about the AIDS cure claims published daily in newspapers ?

A: Traditional medical practitioners tend to believe that they can cure AIDS by giving immunopotentiating drugs and herbal remedies. Due to lack of knowledge about conducting clinical trials scientifically, hasty conclusions are drawn on simple outcome measures such as weight gain or feeling of well being. Such improvements are dubbed as AIDS cure claims. Many AIDS cure claims tend to get published in newspapers. Unfortunately, these claims are not based over adequate scientific evidence and they are just made to extract money from these poor sufferers. HIV / AIDS patients in search of hope tend to get easily attracted towards such claims and take the treatment. However there is no scientifically documented approach to AIDS cure as of today in any of medical sciences as yet in the world. HIV infected individuals should not get mislead by such claims. Taking ARV'S consistently for life is the only sure way of keeping well.