



Checklist on Hygiene and Grooming

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A dark red, glossy circle containing the text 'community inclusion' in white, lowercase, sans-serif font. The circle is centered between two light blue, semi-circular shapes that resemble stylized wings or a bridge.

community
inclusion



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Introduction

People who do not wash their body or their clothes very often commonly have a hard time building friendships, getting a job and obtaining fair access to services. Sometimes body odour is a sign that the person's home is dirty and dangerous or that they are neglecting to eat, visit the doctor when necessary or look after their family or pets.

Relatives, friends and staff can find it difficult to discuss personal hygiene and grooming with the people they support, and they may fear that the person will withdraw from vital services if the topic is raised. Sometimes, people mirror the person's withdrawal and lack of cooperation by withdrawing themselves, and staff may do this by allocating the work to the least qualified team member or prematurely discharging the person from the service.

The following Checklist and appendices offer some questions that you may wish to think about in deciding how to support the person. Each of these questions can be used to generate possible solutions. This is not a complete list of questions, and, since there is little research on this theme, new perspectives and insights are yet to emerge. A much longer report can be found [here](#).

You may like to simply browse this Checklist, looking for a single question that stands out. Sometimes the problem has a straightforward solution, such as getting the washing machine fixed, but often it is complex, so an approach using many of the viewpoints captured in the following questions will offer the best hope of success.

The Checklist is divided into six steps to provide some shape to the process, but the approach is rarely a linear one, and issues may need to be addressed in a different order or new questions generated to meet the unique circumstances of a particular person.

The first two steps, *How serious is the problem?* and *What has changed over time?* offer help with considering whether the person's self neglect is merely inconvenient or a serious matter. Step three, *How well do you really know the person?* and Step four, *Who else is affected?* explore the personal background to the issue as well as the individual's relationships. Step five, *What guidance and help is available?* seeks to engage colleagues, other agencies and informal community support (where appropriate) to create a coordinated response, and Step six, *How are you supported?* reflects on the needs of the person who is trying to assist the individual.

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First, how serious is the problem?

- **Squalor.** Is the person's home or room dirty, in poor repair, cluttered with hoarded items, unopened post, or infested with insects or rodents? Are there signs that the person has sores and poor healing, does not eat adequately, and does not visit the doctor or other helping agencies when appropriate?
- **Risk and safeguarding.** Is there an immediate and serious health hazard to the person, perhaps related to broken skin, incontinence and other causes of infection, or to other people or animals in the house, neighbours or other members of the community?
 - The local Safeguarding Adults Board may have provided guidance on this issue, and learnt lessons from Serious Case Reviews.
- **Facilities and equipment.** Does the person have effective and regular access to a safe, private and comfortable space where they can wash, shower or bathe, wash their clothes and attend to their personal presentation? Has the person been shown how to use the equipment and supported to do so?
- **Income.** Does the person have enough money to purchase cosmetics, grooming materials, natural fibre clothes and breathable shoes? If not, can anyone else provide money or these items?
- **Legal duties.** Do any legal powers need to be used to save life, protect others or prevent nuisance by forcing entry, removing the person, cleansing their body, imposing healthcare or cleaning or destroying their property? How will you assess mental capacity, obtain legal advice and choose the least restrictive option?
 - See appendix one for a summary of the legal framework surrounding serious self neglect.
- **Service Refusal.** If you raise the topic of personal care, will the person respond by withdrawing and refusing essential services? How do you know?



Second, what has changed over time?

- Is the person's personal hygiene getting better or worse and how quickly? What is likely to happen if you do nothing? What would need to happen to justify you referring the matter to a more senior person or taking more decisive action?
- Has anything changed, such as illness, bereavement, redundancy, loss of a home, relationship breakdown, trauma or abuse that might have led to a change in grooming habits?
- Consider how much control the person feels they have over their own life. Does the person feel able to set goals and achieve them in any part of their life and have they done so in relation to self-care?
- How does the person learn? Are there things that the person could learn about the consequences of poor self-care, how to buy good clothes on a small budget, establish a daily routine, use laundry equipment, use cosmetics, eat a healthy diet, lose weight or avoid excess alcohol and illegal substances?
- Has the person developed preferences or anxieties about particular hygiene routines? Perhaps using a bath evokes fear of falling, deodorants are viewed as a waste of money, soap contains unpleasant chemicals or a toothbrush is painful to use.



Third, how well do you really know the person?

- **Have you identified their strengths, talents and skills?** What strengths, abilities, successes and rights does the person have and how are you upholding these? As part of a person-centred plan, are you clear about the kind of life the person wants to live and what hygiene standards that will require?
- **What is the person's opinion of media images of the body and their own body?** How does the person view past and present media representations of health, fitness and beauty? Does the person feel good about their bodily appearance or are they ignoring or punishing their body?
- **What is the person's own explanation?** Before considering your ideas about what is happening in respect of the person's self-care, try to find out their own explanation for their circumstances and behaviour. How does the person's identity (age, gender, ethnicity, and so on) and stage in the life-course affect their personal hygiene and self care?
- **Does the person lack mental capacity?** Are they able to receive information, understand it, work out a response and let other people know?
- **What has their past experience of using services taught them?** Have the services that the person has used in the past sent out specific, consistent and helpful messages about personal hygiene?
- **Is there a disability or illness that either causes the hygiene problem or makes it hard to maintain personal hygiene?** Is the person ill, disabled, visually impaired, experiencing mental health problems or taking any medications that might increase sweating or affect body odour, cause bad breath or make washing and caring for their clothing and appearance impossible, impractical or ineffective?
 - See appendix two for a summary of the relationship between health, illness, medication and body odour.
- **What message is the person's appearance sending out?** Is the person's choice of clothing and appearance a badge of membership of a particular group or a signal to others to keep away? What message is it intended to convey and what does it mean to others? What about those who are dressed by others?



Fourth, who else is affected?

- **Who else is affected by the problem?** Are neighbours, friends, other residents or relatives at risk, complaining or punishing the person for their behaviour or circumstances? Might they help? What is the person's family and cultural history of self-care habits?
- **Who does the person feel most relaxed talking to?** How does the person feel about hearing comments about their personal hygiene from you or other people? Are they angry, in denial, humiliated, ashamed, defiant, embarrassed, suicidal, obsessional or anxious? Do they mind causing offence? Do they withdraw from social contact?
- **Does the person know about your concern about their personal hygiene and grooming?** Can they see, smell or feel the problem for themselves and can they think it through? Have you used the right language and a respectful manner that is clearly understood and acceptable to the person?
- **Are other agencies involved?** Have agencies withdrawn their services in response to the person's self-neglecting behaviour? Are relatives, neighbours, friends or telecare systems available to help establish a routine of personal hygiene?
 - Examples in appendix three show that success is elusive and often only achieved over the long term, making it difficult for services that restrict their activities to brief interventions to make much difference.



Fifth, what guidance and help is available to the person?

- **Treatment.** Does the person have a mental or physical health issue, substance misuse problem or body odour problem that can be treated by referral to a doctor, psychiatrist or dentist? Can a pattern of good sleep, food, activity and social contact be established to provide a healthy routine?
- Does the person already have a diagnosis or a history of involvement with helping agencies because of a history of self neglect?
- **Person-centred teamwork.** Have people from different teams and agencies got together to pool their ideas of whether to intervene and how to support the person? Has the person been involved as much as possible in this?
- **Protocols and Assessment Tools.** Is there any local policy or an inter-agency protocol, perhaps as part of your safeguarding process? Does it need to be researched, written, disseminated, supported with training or updated? Have assessment measures, mental capacity and risk management tools been used?
 - West Sussex has a local inter-agency policy that addresses severe self-neglect - where the problem is more serious than poor personal hygiene.
 - See appendix four for more information about assessment tools.
- **Services, community and informal support.** Do you have contact with a supportive mobile hairdresser and launderette, domestic help agency, chiropodist, plumber, infection control service and house clearance agency that will help someone with poor hygiene?



Sixth, how are you supported?

- **Your behaviour.** Do staff offer positive role models in their own personal hygiene, appearance and presentation?
- **Your attitudes.** Is the person surrounded by staff, relatives or neighbours who adopt an intrusive, controlling and overly critical stance?
- **Theory.** What theoretical approach to self neglect informs your work? Do you see this person's self-neglect as principally about communication, meaningful occupation, distress, empowerment, education, illness, personality, learnt behaviour, motivation, or something else?
- **Supervision and training.** Is supervision and training available to help you to explore your own feelings, assumptions and responses to the person? Should someone else be helping or taking over from you?
 - Appendix five offers further reading.



Appendix One – The Legal Context

Where neglect and squalor become serious and the safety of the person or others is put in jeopardy, then legal action may become necessary. The following table sets out some of the possible considerations and legal options. It is important to consider how these different rights and duties interact with one another and legal advice should be obtained prior to taking formal action.

Question	Possible legal action if this is the case
Is the person protected under equalities legislation?	Ensure that any actions taken are not considered as discriminatory ⁱ under the Equalities Act 2010.
Does the local authority have a duty towards the person?	<p>The NHS and Community Care Act 1990 requires local authorities to carry out an assessment for community care services and provide any such services that are needed.</p> <p>Section 29 of the National Assistance Act 1948 places a duty on the local authority to promote the welfare of people with disabilities.</p> <p>Section 45 of the Health Services and Public Health Act 1968 places a duty on the local authority to promote the welfare of old people.</p> <p>The Chronically Sick and Disabled Persons Act 1970 covers the provision of practical assistance in the home, works of adaptation of the home and the provision of meals.</p> <p>Section 13(1) of the Mental Health Act 1983 (amended 2007) places a duty on the local authority to make arrangements for an Approved Mental Health Professional to consider the case if they have reason to think that an application for admission to hospital or guardianship may be required.</p>

Question	Possible legal action if this is the case
Is the person protected under adult safeguarding procedures?	<p>Self neglect currently falls outside the definition of abuse that is used in the No Secrets guidance issued by the government in 2000ⁱⁱ.</p> <p>Some Safeguarding Adults Boards have chosen to include self neglect within its procedures. People may be treated differently depending on whether they are deemed to have capacity (see below).</p>
Are children likely to be at risk of significant harm?	<p>Section 44 of the Children Act 1989 provides for an Emergency Protection Order to remove a child or young person from immediate dangerⁱⁱⁱ.</p>
How does the Human Rights Act apply?	<p>Article 5 of the Human Rights Act protects the right to liberty and Article 8 to a private life free of interference by a public authority^{iv}.</p>
Is the home filthy, verminous or a health hazard to others?	<p>Environmental Health officers can take action^v to enforce improvements or cleanse and repair property under the Public Health Acts of 1936 and 1984 or demolish under the Housing Act 2004^{vi}. The destruction of vermin may be at the authority's expense, but other costs will be charged to the person.</p> <p>A tenant may be in breach of their tenancy contract, subject to eviction and consequently deemed to be intentionally homeless under the Homeless Persons Act 1977.</p>
Is the welfare of animals at risk?	<p>A number of people who neglect their self care and environment also keep a large number of pets that may be protected by the Animal Welfare Act 2006 and the RSPCA and the Police can act to protect animals^{vii}.</p>
Is the garden or open land causing a hazard?	<p>The Prevention of Damage by Pests Act 1949 requires steps to be taken to keep land clear of rats and mice.</p> <p>Section 92A of the Environmental Protection Act 1990 allows the local authority to serve a Litter Clearing Notice if the land which is open to the air is defaced by litter or refuse and is detrimental to the amenity of the locality.</p>

Question	Possible legal action if this is the case
<p>Are there signs of a mental health problem?</p>	<p>Refer to an Approved Mental Health Professional for assessment under Sections 2, 3 or guardianship, or to consider whether to move to a place of safety under Section 135 of the Mental Health Act 1983, as amended in 2007. Under section 135, the local authority can seek a warrant authorising a police officer to enter the premises and remove someone to a place of safety for the purpose of assessment if it is believed that the person is suffering from a mental disorder, is being ill treated or neglected, or, being unable to care for herself/himself, is living alone.</p>
<p>Does the person appear to lack mental capacity?</p>	<p>Follow the provisions of the Mental Capacity Act 2005, including the duty to consult the Attorney Health & Welfare and relatives if they are available and decide on best interests of the person.</p> <p>The Mental Capacity Act Code of Practice recommends that a professional mental capacity assessment is undertaken in relation to persons who self neglect.</p> <p>Consider Deprivation of Liberty Safeguards^{viii} and whether a court order is required, whether the person is in residential care, nursing or hospital care or in their own home.</p>
<p>Is the person refusing informal access to allow the condition of the home to be assessed?</p>	<p>Housing officers may apply for an access injunction in the case of tenant's properties by use of Part 8 of the Civil Procedure Rules^{ix}, with or without formal notification to the tenant. Entry may be forced where there is an emergency situation, such as a flood or gas leak.</p> <p>Section 17 of the Police and Criminal Evidence Act 1984 allows a constable to enter and search any premises for the purpose of saving life or limb or preventing serious damage to property.</p>

Question	Possible legal action if this is the case
<p>Does the person need to be forcibly removed from their home?</p>	<p>A 'proper officer' from the local authority (usually a medical practitioner from the public health department) may make a Section 47 application to the magistrate's court under the 1948 National Assistance Act if specific conditions are met^x.</p> <p>Under the Housing Act 1998 the court may evict a tenant if they are causing a nuisance to others. Consideration needs to be given to the person's rights under the Homelessness Act 2002.</p> <p>This can also be done under some of the other provisions set out in this table.</p> <p>Section 21 of the National Assistance Act 1948 places a duty on the local authority to provide residential accommodation to people aged over 18 years who are in need of care and attention which is not otherwise available to them.</p> <p>The Care Standards Act 2000 provides for the registration and inspection of residential homes, currently through the Care Quality Commission.</p>
<p>Is the person causing a nuisance to others?</p>	<p>Consider prosecution under the Antisocial Behaviour Act 2003 or the Clean Neighbourhoods and Environment Act 2005^{xi}. Both antisocial behaviour orders and antisocial behaviour injunctions create sanctions for non-compliance, including possible loss of tenancy.</p>
<p>Is the worker safe?</p>	<p>The Health and Safety at Work Act 1974 and employer's lone worker policies set limits on the conditions that staff should tolerate in gaining access and working with the person concerned, and what to do if safe access is not achieved.</p>



Appendix Two - Understanding Body Odour

Sweating.

The term hyperhidrosis is sometimes used to describe excessive sweating. Several medical treatments are available including antibacterial bodywash that is available without prescription from a pharmacist, and assessment by a dermatologist who may be able to offer iontophoresis, Botox or surgery.

Washing, Shaving & Deodorants

Washing with soap and warm water removes bacteria from the skin that otherwise thrive on stale sweat and cause the smell. Hair, especially in the armpits and groin, provides a greater surface area for sweat to adhere to and gives bacteria a fertile breeding ground. Shaving and washing with soap and warm water reduces body odour, helped by regular use of deodorants or antiperspirants.

Clothing and laundry

Loose fitting clothes allow odours to evaporate, but all clothing traps some odour, and artificial fibres are the worst. Armpit shields are available that absorb excessive sweat. Problems are minimised if fresh clothes are worn every day, clothing is washed at as high a temperature as possible, and then dried as quickly as possible as bacteria can survive in damp clothing.

Footcare, socks and shoes

Dirty and long toenails and patches of dead skin will encourage the growth of bacteria and fungi which can lead to odour and athlete's foot. Shoes and socks that are made of synthetic materials make the problem worse, especially if the same pair are worn every day.

Diet and exercise

Curry, garlic or strong spices, alcohol and substance misuse can increase sweating. Some people take supplements such as garlic which may also cause body odour and bad breath. People who are overweight sweat more, as do people who eat a lot of red meat.

Body changes and illness

Puberty, pregnancy and menopause causes excess sweating from time to time and menopause can also cause temporary loss of smell. Medical conditions such as diabetes, thyroid disease, carcinoid syndrome, heart disease, respiratory failure, gout, hyperthyroidism, tuberculosis, HIV and malaria, some types of cancer such as Hodgkin's disease, neurological disorders, such as Parkinson's disease, and sexually transmitted diseases can cause excessive sweating or body odour. There may be a link between certain neurological problems and the behaviours that lead to self neglect.

Continence

Incontinence may be a temporary problem linked with a particular illness or disorder, such as prostate cancer, a response to a specific phase of life, such as childbirth or the menopause, urinary infections, or a lifelong difficulty. It can lead to very serious problems with odour and increased risk of infection. General practitioners or specialist continence management nurses will be able to offer advice on treatment and management. Some medications such as antibiotics can cause diarrhoea or vomiting.

Stress

Stress can increase the amount of sweat the body produces, and excessive sweating can make people feel self conscious and anxious about how they will be perceived by others. However, not everyone who sweats a lot is experiencing stress, although the sweating may lead to social embarrassment.

Medication

Some medicines may increase sweating or increase the smelliness of sweat. The following is not a complete list, and advice from a doctor or pharmacist should be sought before drawing conclusions. However, increased sweating has been noted from the following medicines: Anticholinesterases such as Donepezil (Aricept), Bupropion

hydrochloride (Zyban), Clomipramine hydrochloride (Anafranil), Duloxetine hydrochloride (Cymbalta), Escitalopram oxalate (Cipralext), Fluoxetine hydrochloride (Prozac), Leuprorelin acetate (Prostap), Omega-3-acid ethyl esters (Omacor), Paroxetine hydrochloride (Seroxat), Sertraline hydrochloride (Lustral), Topiramate (Topamax), and Venlafaxine hydrochloride (Effexor)

Genetics

Many people who sweat excessively have a close family member who also has the condition. Trimethylaminuria is a rare genetic disorder that causes the sweat and breath to smell like rotten fish.

Oral Health

Inflamed gums, tooth decay, ill-fitting dentures and more serious problems such as mouth cancer can cause halitosis or bad breath. Smoking, alcoholic or carbonated drinks and sugary food are well understood to damage oral health. In addition, some medications, such as many used in the treatment of mental health problems, can dry the mouth and cause difficulties with chewing and swallowing and so make toothbrushing painful, thus increasing the risk of oral health problems.

Sense of smell

The sense of smell can be impaired in two ways – the threshold at which a smell is detected (anosmia) and the ability to judge its quality (agnosia). These can occur through damage to nerves, fever, nasal obstruction, smoking, habituation to odours, the drying effects of medication and cognitive issues that affect how the brain processes information from the nose. Some people with negative symptoms of schizophrenia have been found to be unable to detect any smells at all, and this was not a consequence of smoking or medication.



Appendix Three - Examples

Example One

Fred lives independently in a bedsit, has serious mental health issues, chooses to be isolated and neglects his hygiene and environment. His cooking stove was very greasy and he was storing two year's worth of daily newspapers, but informal conversation led to no change. A routine visit to Fred's block from the Fire Prevention Officer provided the breakthrough. The Fire Officer explained that grease and large stores of paper were fire hazards to all the other tenants. Fred accepted this and permitted a cleaner to start visiting regularly to deal with the stove and remove old newspapers. The support worker's informal advice was not enough, but the firm but compassionate advice of the uniformed expert made a difference.

Example Two.

Charlie lived alone and was referred to the mental health team for support. He was aware of the unpleasant smell of his accommodation and would always open windows when the support worker visited. He lived on sandwiches rather than hot cooked food; refused to attend any social events and had a fear of chemicals in shampoo and soap, which made him very reluctant to wash himself or his clothes. After two years of contact, but no real progress, Charlie stopped answering the door and the phone. The support worker passed these concerns to the Social Worker who became more actively involved and managed to gain entry to Charlie's home. By this time, Charlie had lost a lot of weight, his mental state had drastically deteriorated, and there was little sign that he was able to care for himself, so he was detained in hospital under the Mental Health Act. After six months in hospital he moved to supported accommodation, where he is settled and well supported. He recently showed off his new clothes to the support worker saying "They are great"!

Example Three

Bill, a middle aged man, lived alone, did not eat properly but did visit the local shop to get sandwiches, pies and 60 cigarettes a day. It took nearly a year for Adam, his support

worker, to persuade Bill to open the door. When Adam did get into the house he found it was disorganised and filthy, with boxes of unused medication strewn around. Bill would wear one lot of clothes until they needed throwing away. The team decided to admit Bill to hospital because of his physical and mental health state and from there he moved into residential care. Bill now looks better, takes his medication and is cared for. Bill's quality of life is better and his family are happier although he has lost independence.

Example Four

George lived on the streets for 30 years and was generally filthy, but gradually started to call into a day centre for a cup of tea. The staff there were respectful and worked at George's pace. They would leave some clean clothes out for him, and, after several years, he started to get changed in the toilets. He was then encouraged to have a shower from time to time and, several years after the connection began, staff took him out to buy a new suit of clothes, of which George was very proud, as he owned very few possessions of any kind.

During a short stay in the psychiatric unit, his belongings were spoilt and his personal space invaded. His new clothes were stuffed into a plastic bag as if they were rags, and a worker accompanied him into the shower room and told George he was now "very smart" and would "have the ladies after him". George was offended by these actions and words, and withdrew his cooperation.

Example Five

Bob is smartly dressed but "smells a mile away ". He is generally very cheerful, has schizophrenia and lives on his own. After wondering how to broach the subject of body odour, Harry suggested that Bob might like to visit someone who needed some company. Harry asked Bob to put on his best clothes and maybe have a shave. Bob followed Harry's advice, smelt less strongly and the visit was a success. Bob started visiting on a regular basis.

Next, Harry suggested that Bob might like to join a trip that the team were organising, but he would need to have a shower beforehand as he would be sitting next to people on the minibus. The trip was another success and Harry discovered something new about Bob – that he had a fear of water, and this was the reason that he wasn't washing.

Example Six

Sue misuses drugs and the deterioration of her physical appearance caused the team concern. It took over a year for Pat, her support worker, to build up trust and gain entry to Sue's home. She found that Sue had not used the heating system for over a year and the gas was not connected. Sue did not seem to be aware of the squalid state of her surroundings. The psychiatric medication had been making her feel unwell and she had not been eating satisfactorily or looking after her hygiene and grooming. Pat worked with housing colleagues to arrange for Sue to move out so the flat could be cleaned up and she was then able to return. With improved living conditions and support to continue with medication she made progress.

Example Seven

John, aged 30, was using a personal budget to help with cooking and cleaning, and was referred to a mental health support worker as he rarely went out and had become isolated. The worker supported him to go down the stairs, one at a time, until, after two years; he managed all five flights to the street and went outside briefly. The team then withdrew support as they generally did not work with anyone for more than two years and John showed insufficient evidence of progress and co-operation. His leg muscles gradually wasted away and he lost the ability to walk, and began to use a bucket as a toilet. He continued to manage his personal budget and cancel appointments, thus demonstrating his mental capacity.

Example Eight

Steve is a young man experiencing depression and social isolation. A switch of worker helped unlock some progress. The new worker, Jack, chose a determinedly cheerful and happy approach and this slowly worked to gain Steve's confidence. After a year, Jack felt able to suggest that Steve's poor personal hygiene might be a reason he had few friends or invitations to social gatherings. Jack knew another person at a similar life stage, who used the service and was lonely. With consent, he arranged for them to meet one another for coffee. In preparation, Jack asked Steve to wash his hair before the meeting, and Steve did so and asked Jack to trim his hair and beard. The meeting was a great success, they now people meet regularly, and Steve's personal hygiene has improved. A sympathetic barber has been found to keep Steve's hair trimmed.



Appendix Four – Assessment Tools

One or more of the following measures might assist staff in assessment: Mini-Mental State Examination and cognitive screening, Geriatric Depression Scale, Wolf-Klein Clock Drawing Test, Kohlman Evaluation of Living Skills, Instrumental Activities of Daily Living, Activities of Daily Living, Alcohol Misuse Assessment, Nutrition Assessment, Duke Social Support Index, Environmental Cleanliness and Clutter Scale (ECCS), Self Neglect Severity Scale, and the Impact of Squalor Checklist. MacMillan and Shaw introduced a rating scale that has been incorporated into a wider measure used to assess for severe domestic squalor in New South Wales. The hygiene part of the scale is shown below:

	0	1	2	3
SKIN	Neat and clean	Mildly or slightly dirty	Moderately dirty, flaking or greasy skin	Filthy, peeling skin, old dry flaking skin, exposed sores, infestation
HAIR	Neat and clean	Mildly dirty: untidy, uncut uncombed	Moderately dirty: greasy, overgrown, uncombed	Filthy: overgrown, extremely dirty, matted, infested
FINGER NAILS	Neat and clean	Mildly dirty, ragged	Moderately dirty: nails poorly kept, long, dirty, nicotine stained	Filthy: grossly overgrown, ground in dirt, very nicotine stained
CLOTHING	Neat and clean	Mildly dirty or untidy: unironed and dirty	Moderately dirty: some stains, mildly malodorous	Filthy: many stains and badly needing washing, may have cigarette burns, excrement, very malodorous

Whilst this is only a part of a scale that was designed to consider severe domestic squalor and collect data on a whole population, the descriptions of severity may help individual

practitioners communicate clearly with their colleagues and demonstrate the severity of the person's neglect of their personal hygiene.



Appendix Five – Reading List

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Smith V (2007) *Clean: a history of personal hygiene and purity* Oxford: Oxford University Press.

Snowdon J & Halliday G (2009) How and when to intervene in cases of severe domestic squalor *International Psychogeriatrics* 21:6:996-1002.

ⁱ Disability (such as a mental health problem) must not be the sole reason for actions against nuisance or hazard, but rather the behaviour that causes the nuisance or hazard This point was established in the House of Lords (LB Lewisham vs Malcolm (2008) UKHL43).

ⁱⁱ Department of Health and the Home Office (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*.

ⁱⁱⁱ http://www.cafcass.gov.uk/the_law_about_children/care.aspx accessed 26 March 2011.

^{iv} “Everyone has the right to respect for his private and family life, his home and his correspondence and there shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

^v Sections 83 to 85 of the UK Public Health Act 1936 requires Environmental Health officers to intervene (and, if necessary to override the person refusal to cooperate) if a dwelling is ‘filthy, unwholesome and verminous’, with evidence of filth, usually faecal matter, and rodent or insect infestation. They can obtain a warrant to gain admission to

assess, impose enforcement notices, cleanse or destroy property in the house or on open land.

^{vi} Section 83 of the Public Health Act 1936 allows the use of gas to destroy vermin, section 84 requires cleaning or destruction of filthy or verminous clothing and furnishings, and section 85 to compulsorily cleanse verminous persons. As most or all cleansing stations have now closed, the task usually now falls to a reluctant NHS. The Housing Act 2004 allows the local authority to demolish a house that is a severe hazard.

^{vii} <http://www.rspca.org.uk/in-action/changingthelaw/whatwechanged/animalwelfareact> accessed 26 March 2011.

^{viii} The Mental Capacity Act Deprivation of Liberty Safeguards (formerly known as the Bournewood Safeguards) were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007 and came into force on 1 April 2009.

^{ix} http://www.justice.gov.uk/civil/prorules_fin/ accessed 26 March 2011.

^x Section 47 of the National Assistance Act 1948 sets out the local authority's duty to remove a person from insanitary conditions if this is in their best interest and they are unable to devote proper care and attention to their self care due to chronic disease, age, infirmity or incapacity. Section 1 of the National Assistance Amendment Act 1951 adds the power to act in an emergency.

^{xi} The Antisocial Behaviour Act 2003 and the Clean Neighbourhoods and Environment Act 2005 allow a wide range of behaviours to be treated as offences.