The underlying principles and procedure for bed bathing patients

Supporting patients to maintain their hygiene needs while they are in hospital is a fundamental aspect of nursing care, yet there is very little evidence to support practice (Coyer et al, 2011). Personal hygiene includes care of the:

- Hair;
- Skin;
- Nails;
- Mouth, eyes, ears and nose;
- Perineal areas (Dougherty and Lister, 2015);
- Facial shaving (Ette and Gretton, 2019).

Hygiene and skin care should be considered as one entity, as both have a potential impact on skin health and on patients’ comfort and wellbeing.

Factors that have a negative effect on skin health include:

- Excessive washing, particularly if harsh products are used;
- Lack of hygiene, causing build-up of potential pathogens and increasing infection risk (Cowdell et al, 2014).

Box 1 lists other factors.

Helping patients to wash and dress is frequently delegated to junior staff, but time spent attending to a patient’s hygiene needs is a valuable opportunity for nurses to carry out a holistic assessment (Dougherty and Lister, 2015; Burns and Day, 2012). It also allows time to address any concerns patients have and provides a valuable opportunity to assess the condition of their skin.

Patients will have their own values and practices relating to hygiene, which nurses need to consider when planning care. For example, some patients may bathe in the evening as it helps them settle for the night, while others may prefer to shower in the morning. Nurses should also discuss with patients any religious and cultural issues relating to personal care (Dougherty and Lister, 2015). For example, ideally, Muslim patients should be cared for by a nurse of the same gender (Rassoool, 2015), and Hindus may wish to wash before prayer (Dougherty and Lister, 2015).

As part of routine hygiene care, some patients may require urethral catheter care, mouth and denture care, footcare and eye care. These procedures are not covered in depth in this article.

Bed bathing a patient

Bed bathing is not as effective as showering or bathing and should only be undertaken when there is no alternative (Dougherty and Lister, 2015). If a bed bath is required, it is important to offer patients the opportunity to participate in their own care, which helps to maintain their independence, self-esteem and dignity.

Selecting appropriate equipment

Plastic wash bowls were routinely used in hospitals for bed bathing but they can easily become contaminated with microorganisms responsible for healthcare-acquired infections (Marchaim et al, 2012). As such, single-use disposable bowls are now commonly used.

All patient should have their own toiletries or be supplied with single-patient use items until their own toiletries can be brought into hospital.

Soap can alter skin pH, leading to dryness and skin breakdown, so it is suggested that skin-cleansing emollient creams should be used (Cowdell et al, 2014). These should be prescribed for individual patients, and a spoon or spatula should be used to decant the product into a disposable pot to prevent contamination; emollients in tubes or pump containers reduce this risk. New supplies should be prescribed following treatment for a skin infection (Lawton, 2016).

Reusable washcloths should be avoided as they can harbour bacteria. This is particularly important in patients who are immunocompromised or critically ill, or those whose skin integrity is compromised, for example, patients with burns (Dougherty and Lister, 2015).

A relatively new development is prepackaged cloths for bed bathing (commonly known as the bag bath), which do not require water. A systematic review comparing bag baths with traditional bed baths concluded that ‘washing’ without water may be an alternative to the traditional bed bath, although more research is required (Groven et al, 2017).

Box 1. Factors that negatively affect skin health

- Poor nutrition and hydration
- Advancing age
- Incontinence
- Medical interventions, such as radiotherapy and chemotherapy
- Concurrent or underlying skin conditions
- Surgical interventions, wounds and drains
- Poor mobility

Source: Dougherty and Lister (2015)
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Box 2. General principles of bed bathing
- Keep the patient warm at all times
- Position a linen skip near the patient and dispose of used linen immediately to reduce dispersal of microorganisms and dead skin cells into the environment
- Only expose the area of the body being washed (Fig 1)
- Change water if it becomes dirty or cold and always after washing the genitalia and sacrum
- Change wash cloths if they become soiled and after washing the genitalia and sacrumal area
- Check skin for pressure damage
- Avoid contaminating dressings and drains with water
- Pat the skin dry to reduce the risk of friction damage
- Separate skin folds, and wash and pat them dry
- Use the correct manual handling procedures and equipment to avoid injury to yourself and the patient
- If the patient is unconscious, remember to talk them through what you are doing; nurses should not talk over the patient

Source: Ersser et al (2005); Dougherty and Lister (2015)

Glove use
The World Health Organization (2009) stated that non-sterile gloves are not required routinely for washing and dressing patients. Nurses need to assess individual patients for risk of exposure to blood and body fluids (Royal College of Nursing, 2018) and be aware of local policies for glove use.

Evidence suggests that patients may prefer nurses to wear gloves to provide intimate care (Loveday et al, 2014a), for example, washing genitalia. When gloves are required they must be single-use and be disposed of in accordance with local policy (Loveday et al, 2014b).

Undertaking a bed bath
Box 2 outlines the general principles of bed bathing.

Equipment needed
- Disposable apron
- Clean bed linen and clothes
- Two bath towels
- Wash cloths
- Patient toiletries
- Comb/brush
- Equipment for oral and denture care
- Disposable wash bowls
- Linen skip
- Non-sterile gloves if personal protective equipment is required or for intimate care.

The procedure
1. Review the patient’s care plan for hygiene needs. Ensure that someone will be available to help you during the procedure.
2. Decontaminate your hands.
3. Discuss the procedure with the patient, ask about their usual hygiene routine and gain informed consent for a bed bath.
4. Check whether the patient has any pain. Administer analgesia if necessary and ensure it has taken effect before starting the bed bath. This will help to relieve any pain associated with moving the patient during the procedure.
5. Ensure the patient’s privacy and check the environment is warm and draught free.
6. Check whether the patient wishes to empty their bowel or bladder before starting the bathing procedure.
7. Assemble your equipment and ensure everything is to hand to minimise the amount of time the patient is exposed. Ensure the bed is at the correct working height.
8. Decontaminate your hands and put on an apron.
9. Fill a disposable bowl with warm water and ask the patient to check the temperature is comfortable.
10. If the patient is wearing a watch, hearing aid or glasses, remove them.
11. Place a towel under the patient’s chin and cleanse the patients eyes according to local policy. Wash the face, neck and ears, checking whether the patient likes soap on their face (Fig 1a).
12. Clean hearing aids and glasses if worn, and return them to the patient to facilitate communication during the procedure.
13. Help the patient to remove their upper clothes and use a sheet to cover the patient. Only expose the part of the body that is being washed.
14. Starting with the arm farthest away, wash and dry the upper body, including the arms, hands, axilla and torso. Moving across the body in this way ensures the patient is clean and dry by the end of the procedure (Dougherty and Lister, 2015) (Fig 1b). Always wash down the body, for example from axilla to hands.
15. Ask the patient if they would like to soak their hands in water (Fig 1c).
16. Remove clothing from the lower body, then wash and dry the legs and feet, starting with the leg farthest away and working from the top of the leg to the foot. Check feet for any problems such as calluses and dry skin.
17. Change the water and wash cloth and, if required, apply non-sterile gloves before washing the patient’s genitalia.
18. If appropriate, ask the patient if they wish to wash their own genitalia, or gain consent to continue with the procedure. Female patients should be washed from front to back to reduce the risk of urinary tract infection (Fig 1d). The foreskin in uncircumcised men should be drawn back and the skin underneath should be washed.
19. Dispose of water – and gloves if used.
20. Decontaminate your hands and fill a disposable bowl with warm water, checking the temperature again with the patient.
21. With help from a colleague (who has decontaminated their hands and put on an apron), roll the patient onto one side using appropriate equipment. Assess if gloves are required for washing the sacrum. Using a clean wash cloth and towel, wash and dry the back then the sacral area, moving from top to bottom (Fig 1e).
22. Roll the patient back and both you and your colleague decontaminate your hands.
23. Change the lower sheet according to local procedures.
24. Help the patient to get dressed.
25. Check the patient’s fingernails and toenails, and offer nail care if it is required.
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26. Help the patient to clean their teeth and/or dentures, or assist them with mouth care following local procedures.

27. Comb or brush the patient’s hair. Offer to help male patients with shaving if this is part of their normal routine.

28. Finish making the bed and ensure the patient is warm and comfortable with a call bell and a drink (if allowed). Ensure that their belongings are within reach.

29. Remove and dispose of aprons and decontaminate your hands.

30. Record the care that has been undertaken, along with any abnormal finding(s), and ensure you update the patient’s care plan. Contact the tissue viability specialist if you have any concerns about the patient’s skin.

References


Professional responsibilities

This procedure should be undertaken only after approved training, supervised practice and competency assessment, and carried out in accordance with local policies and protocols.