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Bed bathing patients in hospital

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Summary

There are a number of circumstances that may affect an individual's ability to maintain personal hygiene. Hospitalised patients, and in particular those who are bedridden, may become dependent on nursing staff to carry out their hygiene needs. Assisting patients to maintain personal hygiene is a fundamental aspect of nursing care. However, it is a task often delegated to junior or newly qualified staff. This article focuses on the principles of bed bathing patients in hospital, correct procedure and the importance of maintaining patient dignity and respect in clinical practice.

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THE HEALTHCARE Commission (2007) reported that up to 30% of complaints about care in NHS hospital trusts related to dignity and respect, as well as other aspects of essential personal care. Examples included:

- Patients left in soiled bedding and clothing.
- Personal hygiene needs not being met, for example, no regular baths or showers.
- Hair and nail care not always being provided.
- Bedside curtains and room doors not being closed properly.
- Staff entering rooms without knocking or waiting for permission to enter.

It is important to ensure that essential hygiene needs are met, such as bed bathing, and that nursing procedures are correct and in line with local policies and guidelines to prevent the spread of infection and promote dignity and respect for all patients.

Young (1991) described cleanliness as a basic human right, not a luxury. Personal hygiene is the physical act of cleansing the body to ensure that the skin, hair and nails are maintained in an optimum condition (Department of Health (DH) 2003). Assisting a patient to maintain his or her personal hygiene needs contributes to the comfort, safety, wellbeing and dignity of the individual and helps to prevent the spread of infection. Patients should receive the level of assistance that they require to meet their individual personal hygiene needs (DH 2001a), which will vary between individuals and cultures. The nurse should demonstrate sensitivity and competency to be able to deal with the bodies and bodily functions of individual patients and differences in cultural practices to ensure that hygiene needs are met (Castledine 2005).

Bed bathing

Bed bathing can help to maintain the hygiene needs of patients who are bedridden as a result of acute illness or chronic debilitation. Although a bed bath is not the most effective way of washing patients, and wherever possible patients should be encouraged and supported to shower or bathe to promote independence (Baker *et al* 1999), it may be the only way to meet the hygiene needs of, for example, the unconscious patient (Waugh 2007).

Cultural awareness and personal preferences

Before undertaking a bed bath, or any aspect of hygiene care, the nurse should acknowledge the patient's preferences. The nurse should not impose his or her own standards of cleanliness on the patient or even assume that these will be the same as the patient's. Personal preferences might

include what toiletries the patient uses, for example, or whether the patient would normally use soap on his or her face. Other preferences for care may relate to the patient's cultural or religious beliefs.

Keesing (1981) referred to culture as shared ideas, rules and meanings. Culture underpins the way that human beings live and the way that they express themselves. Nurses should ensure that they have an understanding of patients' various religious and cultural needs. Cultural understanding is particularly important in the sensitive and highly personal area of bed bathing and, if requested, all attempts should be made for the bed bath to be performed by someone of the same gender. For example, Muslims and Hindus generally prefer to wash in running water, therefore patients should be given the option of showering where possible (Holland and Hogg 2001). When nursing a Muslim patient, especially of the opposite gender, direct skin-to-skin contact should be avoided, as this may distress the individual (Ethnicity Online 2003). It is important that the nurse views the patient as an individual with different health needs, beliefs and behaviours, while acknowledging religious and cultural practices to maintain patient dignity and wellbeing.

Privacy and dignity Privacy and dignity are paramount when assisting a patient with his or her hygiene needs. Bed bathing is a personal and intrusive procedure, and the patient may feel embarrassed or even frustrated relying on someone else to meet his or her intimate needs.

Basic methods of maintaining privacy and dignity include:

- Covering patients with a sheet or towel while they are being washed so that no part of the body is left exposed.
- Taking care to ensure that any curtains around bed areas are closed properly and that there are no gaps through which other people can see.
- Trying to prevent other people, staff or visitors from entering the room during bed bathing.

It is important that all members of staff respect patient privacy and dignity. If the curtains surrounding a bed are closed or the door to the patient's room is closed, staff should ask if they can enter before doing so, either by knocking on the door or asking the person behind the curtain.

Assessment Bed bathing provides the nurse with an opportunity to assess the patient's activities of living. Valuable insight can be gained regarding the independence or dependence of the patient, including mobility, hygiene, dressing and continence needs. The nurse can use this contact with the patient to find out about his or her nutritional status, sleeping patterns and pain experiences. Communication will enable the patient to discuss any issues or concerns regarding the care plan or treatment regimen. The nurse is also ideally placed to assess the patient's skin and pressure areas as well as the risk of pressure ulcer development. During bed bathing the nurse can also observe for any non-verbal cues, such as grimacing or frowning, which may suggest that the patient is experiencing pain or discomfort.

Communication The provision of hygiene care offers an opportunity for the nurse to communicate with the patient and assess the individual's physical and psychological state, detecting potential anxieties and fears (Wilson 1986). Meaningful conversation enables the nurse to provide a supportive dialogue and discuss any sensitive and difficult issues that may arise. Discussion, observation, explanation and evaluation during this time can inform realistic care planning, with individualised, achievable goals (Baker *et al* 1999).

It is important that the nurse engages in appropriate conversation with the patient. If two nurses are present during bed bathing the patient should not be excluded. The discussion of personal issues between nurses and talking over the patient should be avoided. Many patients appreciate the opportunity to participate in small talk with the nurse to reduce embarrassment. Language used when conversing with the patient or describing nursing terms and anatomy should be kept simple. For example, a patient might not understand what the nurse means when asking: 'Can I wash your sacral area?' Complex language and terminology should be adapted to meet the needs of the patient and ensure that he or she understands the procedure. If a patient requires language or signing support, he or she should be offered the services of an interpreter, communication aids or identified support systems to ensure effective communication takes place.

Consent The registered nurse must obtain consent from the patient before providing treatment or care (Nursing and Midwifery Council (NMC) 2004). All professionals should understand the laws and local policy pertaining to consent. *The NMC Code of Professional Conduct* (NMC 2004) and the *Good Practice in Consent Implementation Guide* (DH 2001b) provide guidance for nurses on gaining consent. To ensure consent, the nurse explains all aspects of care to the patient before any procedure is performed. It is important to remember that even if the patient gives his or her verbal consent to a

bed bath before it is carried out, the patient can withdraw this consent at any time or may choose not to consent to a particular part of his or her body being washed by the nurse.

Delegating Bed bathing is often seen as a 'mundane' nursing task. Castledine (2005) suggested that some aspects of nursing care were viewed as unattractive because they involved unpleasant, repetitive and harder physical work. Delegating the task of bed bathing to a junior member of the team or a healthcare assistant may result in the nurse in charge of the patient's care missing vital information and the opportunity to enhance the nurse-patient relationship.

It is important that the nurse recognises his or her personal accountability for the care that is provided, but also for delegating that care to an appropriate person (NMC 2004). The nurse should ensure that details of care delivered are documented in an accurate and timely fashion. This includes documenting any occasions when a patient may have refused care or treatment.

Risk assessment It is essential to ensure that any relevant risk assessments have been carried out before performing a bed bath. The nurse accountable for delegating a bed bath must also ensure that any risks have been communicated to colleagues to maintain their health and safety as well as that of the patient. Risk assessments might include moving and handling, pressure area, falls and infection control. The nurse should always follow local policies and procedures in the reduction of risk.

Bed bathing procedure

NHS trusts may choose to develop guidelines for undertaking a bed bath or they may adopt one of the guidelines or procedures published in the nursing literature. Some organisations advocate following the procedure outlined in *The Royal Marsden Hospital Manual of Clinical Nursing Procedures* (Allen *et al* 2004). Other comprehensive procedures have been illustrated by Baker *et al* (1999) and Pegram *et al* (2007). There is generally a lack of research on the topic of bed bathing and further evidence is required to identify best clinical practice and improve patient care.

Equipment Before carrying out a bed bath the nurse should ensure that he or she has all of the necessary equipment to hand. The nurse should never leave the patient exposed or at risk during the procedure to obtain missing equipment. Equipment required for a bed bath should include:

- Disposable apron, gloves and yellow clinical waste bag.
- Sliding sheet or hoist, if required.
- Flannel or wash cloth, preferably disposable, or wipes.
- Clean linen and laundry skip.
- At least two sets of washbowls and towels.
- Toiletries such as soap, shampoo, conditioner and deodorant.
- Toothbrush and toothpaste or mouth care pack.
- Brush or comb.
- Shaving equipment.
- Cleanser or moisturiser.
- Incontinence pad, if needed.
- Clean nightclothes.

Table 1 provides an example of a procedure that could be used when carrying out a bed bath.

Special considerations There are a number of areas that require special attention during bed bathing to maintain the patient's health and comfort. If the patient has frail or dehydrated skin, wounds or pressure ulcers, or any areas which are reddened, the nurse should take extra care while washing these areas, to ensure that further damage to the skin does not occur. Patients may have intravenous (IV) or arterial devices *in situ*, a wound or chest drain or a wound dressing. The nurse should take care when washing around these devices to reduce the risk of infection and prevent any drains or IV catheters from being dislodged. Consideration should also be given to patients who may experience pain or discomfort on movement, for example, following surgery. The nurse should ensure that any unnecessary movement is minimised and consider the use of analgesics before carrying out a bed bath. Extra care must be taken with patients who are haemodynamically unstable, for example, have abnormal cardiac function.

The use of disposable flannels or wash cloths is recommended. This reduces the risk of fabric wash cloths becoming colonised with micro-organisms from warm and moist body areas, such as the axillae, genitals, groin, buttocks and anal area, when they are left to dry and are later reused to wash another part of the body. Soiled and infected linen must be disposed of as per local trust policy. Disposable gloves and aprons should be used as specified in the trust's policies and procedures, for example, to prevent cross-contamination of patients with *Clostridium difficile*. The nurse should ensure that universal precautions are maintained when carrying out a bed bath, particularly when washing a patient's genitals. It is not necessary, however, to wear gloves for

the whole procedure and the nurse should use his or her clinical judgement when deciding to do so, and an explanation should be offered to the patient.

The wash water should be changed whenever it becomes dirty, cold or too soapy, and should always be changed after washing the genitals, buttocks and anal area. The temperature of the water must be checked by the nurse before washing the patient to ensure that it is not too hot or too cold; this should be in accordance with the patient's preference and local or national guidance relating to health and safety.

Within the *Essence of Care* hygiene benchmark patients are expected to supply their own toiletries and single-use toiletries should be provided until patients can supply their own (DH 2003). It may be necessary for the nurse to ask the patient's family or friends to bring the patient's toiletries into hospital. Communal toiletries should not be used or shared between patients, as this increases the risk of cross-contamination.

Special consideration should be given to the eyes and mouth. They have been mentioned in brief as these are standalone procedures. It is recommended that the nurse reads additional

TABLE 1

Procedure guidelines for bed bathing a patient

Action	Rationale
The patient's plan of care should be consulted before carrying out a bed bath. This should include an assessment of the patient's needs and preferences and should address religious and cultural beliefs.	To plan care and ensure patient comfort and safety during the procedure. To promote the patient's dignity and uphold his or her human rights.
Before each step of the bed bath the patient's independence and level of participation should be assessed. Where possible, the patient should be encouraged and enabled to carry out his or her own personal hygiene needs with the nurse assisting as required.	To negotiate involvement by the patient and so promote independence.
During each step of the procedure the nurse should ensure that correct manual handling techniques and/or equipment are used.	To reduce the risk of the patient or nurse sustaining a manual handling injury.
Hearing aids or spectacles should be cleaned.	To ensure the prosthesis is in good working order and free from debris and contaminants.
The procedure should be explained to the patient.	To ensure that the patient understands the procedure and gives his or her consent.
The patient should be given the option of using the urinal, bedpan or commode.	To reduce any disruption to the procedure and prevent any discomfort.
All equipment required should be collected before the procedure.	To minimise time spent away from the patient during the procedure.
The environment should be prepared. The area around the bed should be kept private and draught free. Curtains and/or doors should be closed.	To maintain a safe environment and promote privacy and dignity.
A washbowl should be filled with warm water. The patient should be asked to confirm the temperature of the water (if able).	To maintain the safety and comfort of the patient.
Hands should be washed. Disposable gloves and aprons should be worn according to local guidelines.	To minimise the risk of cross-contamination in the clinical environment.
The patient should be assisted with the removal of clothing. The patient should be covered with a bath towel or sheet before folding back the bedclothes.	To maintain the patient's modesty and sustain body temperature.
The patient should be asked whether he or she uses soap on the face. The face, neck and ears should be washed, rinsed and dried.	To promote cleanliness and ensure that patient preferences are acknowledged.
The top half of the body, including the hands, arms, axillae and torso, should be washed and rinsed. It is important to ensure that the area under the breasts is washed and dried thoroughly. Areas of the body that are not being washed should remain covered. Care should be taken not to wet drains, dressings and/or intravenous devices. Toiletries should be applied as required.	To promote patient wellbeing and cleanliness and reduce the risk of cross-contamination.
The water should be changed and disposable gloves should be worn. The patient should be informed that the area around the genitalia is going to be washed. Verbal consent from the patient should be obtained or the patient should be asked to wash the area, if possible.	To reduce the risk of cross-contamination and to maintain patient comfort and dignity.

TABLE 1

Procedure guidelines for bed bathing a patient (continued)

A separate flannel or wipe should be used to wash around the genitalia. The area should be dried. Gloves should be removed and disposed of in line with hospital policy. Hands should be decontaminated. When washing this area, it is important to remember that female patients must be washed from the front to the back. Male patients should draw back the foreskin, if uncircumcised, when washing the penis. If the patient has a urinary catheter appropriate catheter hygiene should be carried out.	To promote good meatal hygiene and reduce the risk of cross-contamination.
Change the water and towel.	To reduce the risk of cross-contamination.
The legs and feet should be washed and dried. All areas that are not being washed should remain covered. The need for possible podiatry referral should be assessed.	To promote cleanliness and ensure that privacy is maintained.
The patient should be assisted to roll onto his or her side. The patient's back should be washed, rinsed and dried. Disposable gloves should be worn and a disposable flannel or wipe should be used to wash and dry the sacral area, observing pressure areas. Gloves should be removed and disposed of in line with hospital policy. Hands should be decontaminated.	To maintain the safety of the patient and ensure safe manual handling, and to reduce the risk of cross-contamination.
Clothes should be replaced. If the patient is to remain in bed, the bottom sheet should be changed while the patient is being turned. A minimum of two nurses should be present during the procedure.	To promote patient comfort and modesty. To maintain the safety of the patient and ensure safe manual handling.
The top bedclothes should be remade. Dispose of soiled bedclothes in line with hospital policy.	To reduce the risk of cross-contamination.
The patient should be assisted with facial shaving or application of make up, if required.	To promote a positive body image.
The patient's teeth and mouth should be cleaned using a toothbrush and toothpaste or sponge sticks. Dentures should be removed, cleaned and replaced.	To promote good oral hygiene.
The patient's hair should be brushed or combed as desired.	To promote a positive body image and enhance patient comfort.
The patient should be assisted to sit or lie in the desired position.	To reduce the risk of pressure ulcer development and enhance patient comfort.
Equipment should be removed from the bedside. The patient's possessions should be put back in their appropriate place. The locker, bedside table and call bell should be placed within reach.	To maintain a safe environment and promote patient safety.
Hands should be washed and any clinical waste should be disposed of in line with hospital policy.	To reduce the risk of cross-contamination.
Care provided should be documented.	To provide recorded documentation of care to aid communication with other members of the multiprofessional team.

(Adapted from Baker *et al* 1999, Allen *et al* 2004, Pegram *et al* 2007)

information on the appropriate procedures available for eye and mouth care.

Benchmarking care

The NHS Plan (DH 2000) reinforced the importance of getting the basics of nursing care right, while improving the patient experience. *Essence of Care* provided a clinical benchmarking tool to enable practitioners to adopt a patient-focused and structured approach to establish and share best practice (DH 2001a). Benchmarks relating to hygiene, self-care and privacy and dignity are particularly important when meeting the needs of patients during the task of bed bathing. However, communication, continence, bladder and bowel care, nutrition, pressure ulcer care, record keeping, safety, promoting health and the environment are also important considerations when reviewing and identifying best practice and developing action plans to improve patient care relating to hygiene. Nurses should familiarise themselves with the *Essence of Care* benchmarks (DH 2003) to ensure that care is patient focused and based on best practice (Table 2).

Conclusion

Personal cleanliness is important to promote wellbeing. Hospitalised patients should be assisted to maintain personal hygiene to promote comfort, dignity and prevent the spread of infection. Bed bathing should be carried out with competency and sensitivity to the patient's individual preferences and cultural and religious needs. The procedure for bed bathing should follow local guidelines and policies to ensure that care is safe, patient focused and based on best practice **NS**

TABLE 2

Benchmarks for personal and oral hygiene

Factor	Benchmark for best practice
Individual assessment of personal and oral hygiene needs.	All patients are assessed to identify the advice and/or care required to maintain and promote individualised personal and oral hygiene.
Care for personal and oral hygiene negotiated and planned based on assessment.	Planned care is negotiated with patients and/or carers and is based on assessment of individual needs.
Environment within which oral and personal hygiene needs are met.	Patients have access to an environment that is safe and acceptable to the individual.
Provision of toiletries for own personal use.	Patients are expected to supply their own toiletries but single-use toiletries are provided until they can do so.
Providing assistance with personal and oral hygiene when required.	Patients have access to the level of assistance that they require to meet individual personal and oral hygiene needs.
Information and education to support patients in meeting personal and oral hygiene needs, particularly if these are changing or are having to be met in unfamiliar surroundings.	Patients and/or carers are provided with information and education to meet the patient's individual personal and oral hygiene needs.
Evaluation and reassessment of personal and oral hygiene needs and how effectively these are being met.	Care is continually evaluated, reassessed and the care plan renegotiated with the patient.
(Department of Health 2003)	

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