

Giving a bed bath

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Assisting patients in meeting their personal hygiene needs is a fundamental aspect of nursing care. It is essential to maintain patients' privacy and dignity at all times (DoH, 2010a). This task provides an excellent opportunity to perform a full assessment of your patient's skin integrity, including any wounds and pressure areas (DoH, 2010a). You can also assess the patient's ability to carry out simple instructions, and his or her ability to move within the bed. To promote independence, encourage the patient, to the best of his or her ability, to participate in the wash. Always take individual needs, culture and gender into consideration. The carer can initiate conversation with the patient; however, if the patient is not willing to talk, the carer must respect this stance. If the patient needs full assistance, two carers may need to be involved. In this case, personal conversations should not take place "over the patient" (DoH, 2010b). Deal with any interruptions in a professional manner, ensuring that you maintain the patient's dignity at all times.

Maintain standard precautions at all times (NICE, 2012; DoH, 2010b). It is normally only necessary to wear gloves when washing the genitals and sacral area, or when handling contaminated bed linen. Gloves should be worn at all times, however, if the patient has areas of broken skin or a known or suspected infection (such as meticillin-resistant *Staphylococcus aureus* or MRSA), or if the health care professional has broken skin on his or her hands.

Encourage the patient and/or relatives to bring in toiletries from home (DoH, 2010a). Relatives may wish to assist with or advise on the care of the patient so it may appropriate to include them, subject to the patient's consent. Obtain fresh water at any time during the procedure if it becomes cold or dirty, and after washing the genitals, buttocks and anal region. The exact order of the different parts of this procedure can vary, so follow local policy.

Explain the procedure and obtain the patient's consent



Introduce yourself and obtain consent for the procedure. Decontaminate your hands and put on a disposable apron. Clear the patient's table or other available space and prepare the equipment. Check the temperature of the warm water yourself and, if possible, ask the patient to check it. Adjust the bed to a suitable height before beginning.

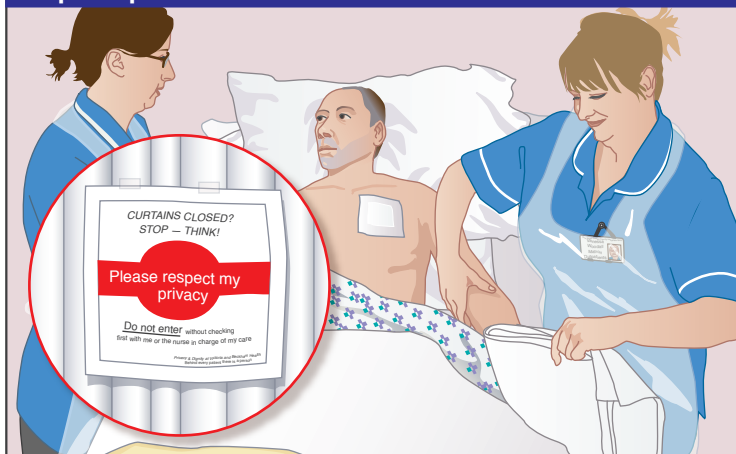


Disposable cloths provide an hygienic method for washing patients; bacteria will multiply in the wet, warm environment offered by cloth flannels. Use fresh flannels for washing the face, the torso, the genitals and the back. To prolong the use of the water, avoid putting soapy and dirty flannels back in the bowl.

Do not undertake or attempt any procedure unless you are, or have supervision from, a properly trained, experienced and competent person. Always first explain the procedure to the patient and obtain his/her consent, in line with the policies of your employer or educational institution

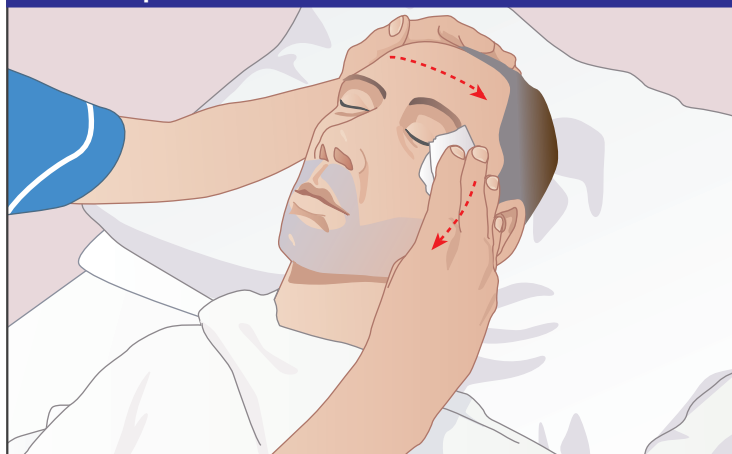
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Help the patient to undress



Ensure the patient's privacy and dignity by drawing curtains, closing the door and/or putting up a "Do Not Disturb" sign, if available (see inset). You may need to shut the windows to prevent the patient from getting cold. Help with removal of clothing and cover the patient with towels up to the shoulders. Have an additional towel available for drying.

Wash the patient's face



Ask the patient if he or she wants soap on the face. Encourage the patient to assist with any aspect, if this is possible. Wet the cloth thoroughly and then wring it out to prevent water dripping over the patient. Clean around the eyes first, then the forehead, cheeks, ears, nose, jaw and neck. If you used soap on the face, rinse well.

Dry the patient's face



Pat dry with a towel. Confirm with the patient that his or her face feels dry. If the skin remains wet or moist, the patient may start to feel cold, his or her skin may become sore and microorganisms may start to grow. Ask the patient if he or she would like face cream applied (if available).

Change the water



Change the water as appropriate to ensure it remains clean and warm. Dispose of used water in the slop hopper, not a clinical hand wash basin. Arrange the bed linen to cover the patient from the waist down, placing a towel over the torso to maintain dignity.

Wash the patient's arms



Place a clean towel under the patient's arm that is nearest to you, and wash the hand, arm and axilla with soap and water (inset). Dispose of used cloths in a rubbish bag to prevent contamination of the water. Make sure that you rinse off all the soap. Take care around cannulae and associated dressings.

Dry the arms



Use the towel to dry the arm. Move to the other side of the bed (raise and lower the bed rails as required, if the patient needs these) and repeat the procedure on the other arm.

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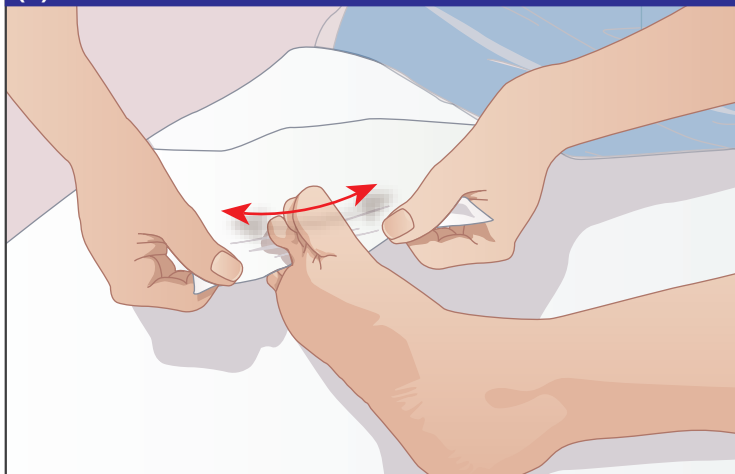
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Wash the patient's torso

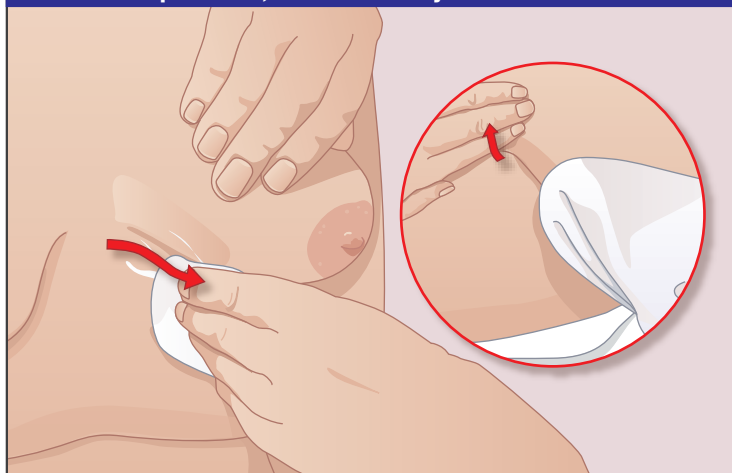
Wash the torso with soap. Take care not to wet any dressings or dislodge drains or central lines.

Dry then cover the torso

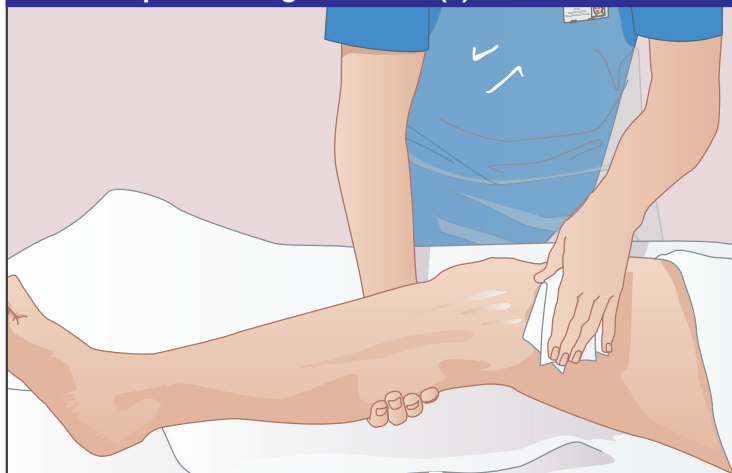
Dry the patient's torso thoroughly and ask the patient if the torso feels dry. Apply toiletries, such as deoderant, if requested. Cover the torso with a dry towel, to maintain the patient's dignity and retain warmth.

(b)

Clean gently between the patient's toes and dry with the towel. Move to the other side of the bed and repeat on the other leg.

For female patients, wash and dry under the breasts

In women, if they are unable to lift their own breasts, gently lift the breasts and clean underneath then dry thoroughly.

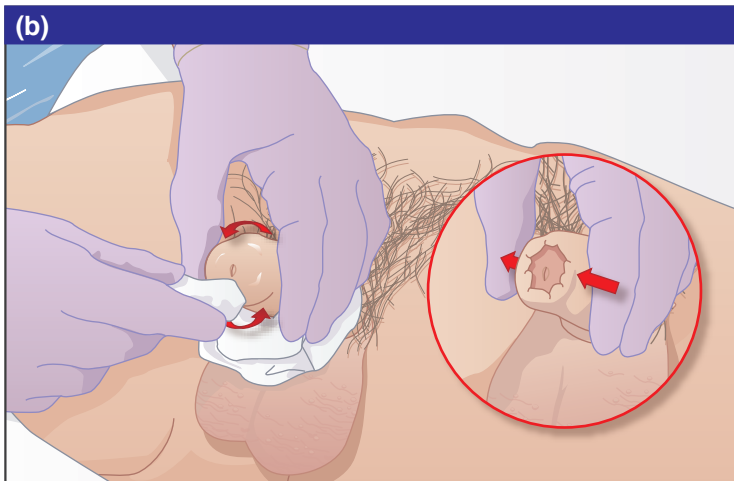
Wash the patient's legs and feet: (a)

Fold the covers up from the feet to expose the patient's legs, keeping the genitals covered. Place a towel under the leg nearest to you and wash the leg and foot with soap. Rinse well.

Wash the patient's genitalia : (a)

Change the water if required and put on disposable gloves. Tell the patient that you intend to wash the genitalia; obtain his or her consent. Use only disposable cloths on the genitalia. Ask the patient if he or she can wash this area him/herself. If a catheter is present, carry out appropriate catheter care (see clinicalskills.net procedure on "Catheter care").

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In an uncircumcised male patient, the foreskin should be gently retracted to allow washing. If the patient is unable to perform this, you must obtain his consent. Gently return the foreskin after washing to prevent swelling and discomfort. When clean and dry, cover the patient's genitals. Dispose of gloves into a clinical waste bag. Decontaminate hands and obtain fresh water.

Changing the sheets: (a) Roll back old sheet



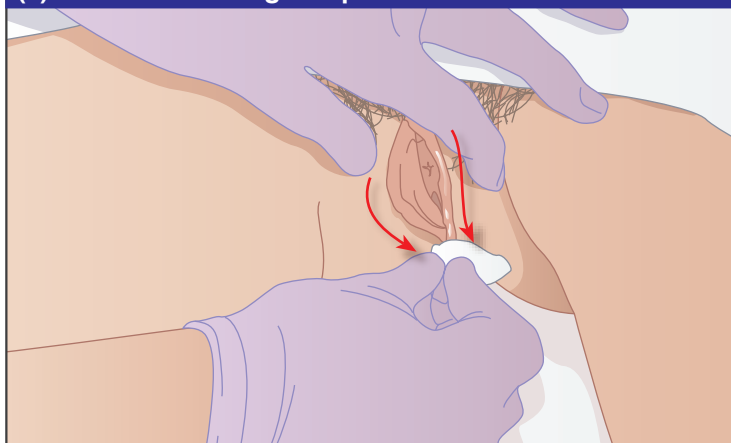
Follow local manual handling policies; you may need to use a slide sheet to reposition the patient. With two carers as shown, and where available, check that the bed is at a suitable height for both carers. The patient needs to roll onto his or her side, with the carer facing the patient offering support. The carer on the other side rolls the current sheet into the centre of the bed.

(c) Wash the patient's back



Wash the patient's back with soap, rinse and dry.

(c) Place towel alongside patient



On female patients, you must likewise obtain consent before washing the genitals. Offer the patient the option of washing this area herself if possible. It is essential to clean women's genitalia from front to back, to reduce the risk of infection. When clean and dry, cover the patient's genitals. Dispose of gloves into a clinical waste bag. Decontaminate your hands and obtain fresh water.

(b) Place towel alongside patient



Make sure that the patient's front remains covered, to maintain dignity and prevent the patient from getting cold. Place a towel on the bed by the patient's back as shown.

(d) Seek consent to wash the sacral area



Ask the patient's consent to wash the sacral area. Put on gloves and wash the buttocks/sacral area. Rinse off all the soap and dry gently but thoroughly. Remove gloves and dispose of them; decontaminate your hands. (If bed sheet is soiled, keep gloves on).

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(e) Inspect the skin

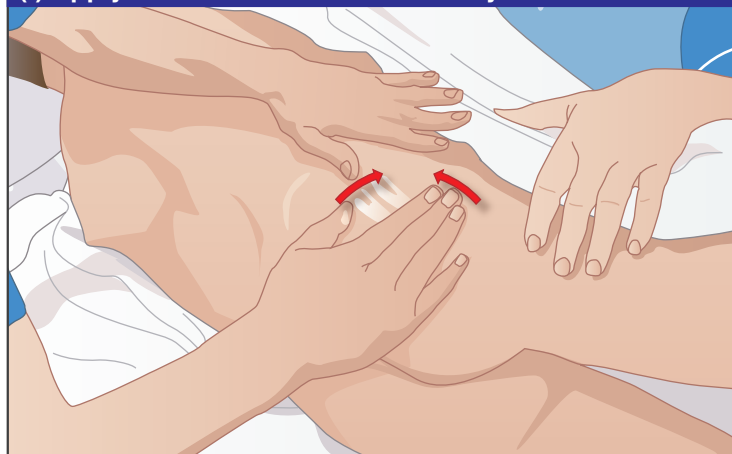
While the patient is on his or her side, carry out an inspection for pressure area damage, paying particular attention to bony prominences such as heels, sacrum, hips, elbows, shoulders and the back of the head. Inspect the skin, looking for changes in colour, especially redness that does not go away when pressed with fingers. Consider how the skin feels: observe its temperature, how firm it is and whether it feels wet or dry (NICE, 2014).

(g) Continue with changing the sheet

Remove the towel from behind the patient and cover the current sheet with an incontinence sheet, if the bed sheet is wet.

(i) Place the clean sheet on the bed

Place the clean sheet alongside the patient. Tuck in the clean sheet and place the rolled section close to the patient's back.

(f) Apply a barrier cream as necessary

If you observe any pressure damage, report this to the nurse looking after the patient and consider the appropriate application of barrier creams and pressure-relieving strategies. If redness on the skin does not go away when you press the skin with your fingers, then the nursing team must implement pressure-relieving preventive strategies, including 2-hourly checks and changes of position (NICE, 2014).

(h) Roll up the clean sheet

Roll up the new sheet, either on your own or with your colleague, making sure that it does not come into contact with the floor.

(j) Roll the patient onto the clean sheet

Ask the patient to roll onto his or her other side; give the patient appropriate support. Complete the inspection of his/her skin. Explain that there is a slight bump in the bed caused by the rolled sheet. Remove the old sheet and dispose of it in the appropriate linen bag, wearing gloves if the sheet is soiled. Dispose of the incontinence sheet in a clinical waste bag.

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(k) Pull the clean sheet through

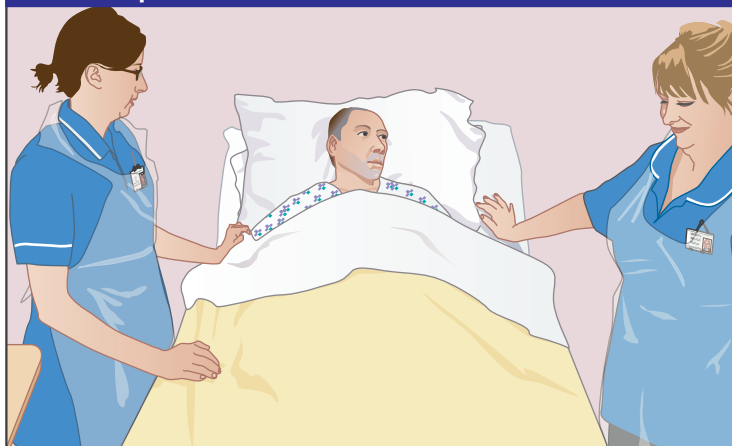
Pull through the clean sheet and tuck it in under the mattress. Assist the patient to roll into the supine position. Ensure that the underwear and nightclothes that the patient was wearing previously is sent for laundering or left for his/her relatives to take home.

Clear away equipment

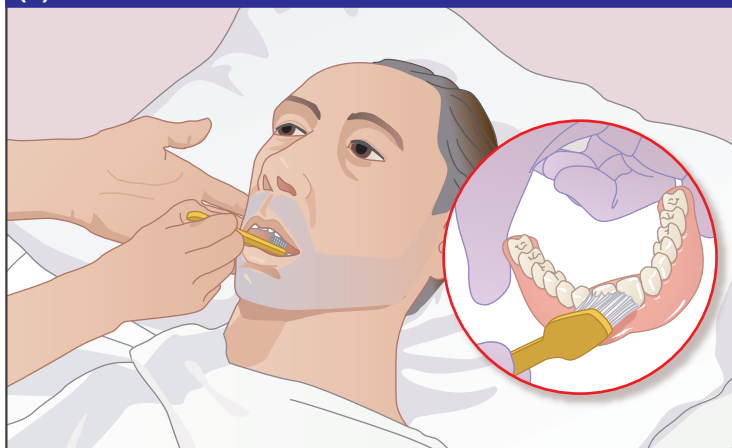
Clear away the used-water bowl; if it is nondisposable, clean and dry it. Store it with the patient: bowls should be allocated to individual patients and not all stored in the sluice. Wipe down the patient's table. Decontaminate hands; if the patient wears dentures and you are going to clean these, keep the apron on, otherwise remove it.

Comb the patient's hair

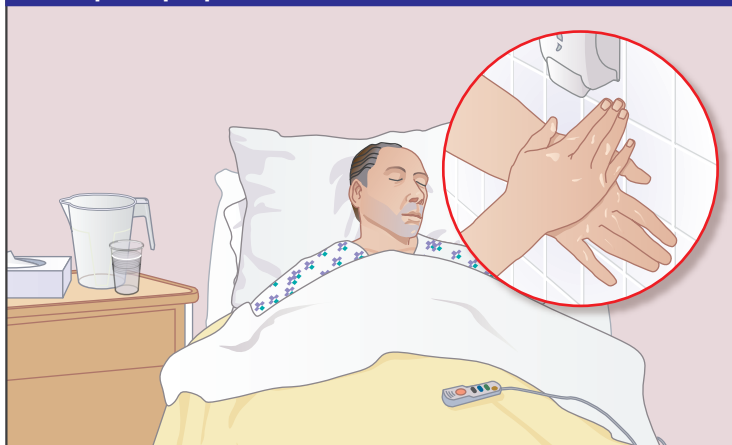
Encourage the patient to comb/brush his or her hair and discuss how he or she styles it. Assist patients who are unable to brush their own hair and style the hair as appropriate. Men may want to have a shave. (See also clinicalskills.net procedures on "Washing a patient's hair in bed" and "Facial shaving".)

Make the patient comfortable

Put a clean case on the pillow. Assist the patient into clean bed clothes and/or clean underwear as appropriate, and make him or her comfortable. Adjust the position of pillows and the bed head if the patient requests. Place clean sheet and blankets over the top of the patient and finish making the bed.

(b)

Brush the patient's teeth, using a toothbrush and toothpaste. (See also clinicalskills.net procedure on "Mouth care".) If the patient is wearing dentures, apply gloves and remove the dentures. Clean them with a toothbrush and toothpaste (see inset); rinse well, then replace them. Offer the patient clean water to rinse the mouth after cleaning his or her teeth; the patient can spit into the disposable bowl. Dispose of gloves.

Bed space preparation

Replace the patient's belongings on the table and put all personal hygiene items away in the patient's locker. Make sure the call bell is within the patient's reach. Decontaminate hands. Document the care given in the patient's notes.