

Clinical Skills**Procedure for [please circle] healthcare students
Nursing ODP Midwifery****Title: Procedure for maintaining a patient’s hygiene needs (bed bathing)**

Definition:

Meeting a patient’s hygiene needs is an essential and integral aspect of nursing care and promotes physical and psychological well-being, enhances comfort and prevents infection. Ordinarily individuals are responsible for their own hygiene however illness, hospitalisation and institutionalisation will generally mean modifications to that individual’s hygiene practices. It is the nurses role to assist the patient to maintain their hygiene standards and where necessary teach the patient / family / carers how to adapt or develop hygiene practices. It is essential that nurses respect the individual’s preferences and take into account age, gender, cultural and spiritual requirements.

Virtual Learning Resource [s] [VLE] Links

Learning Outcomes:

By engaging with the resources in the students skills practice centre and virtual learning resources you will be able to:

- ❖ Explain the generic principles of hygiene practice.
- ❖ Understand the role of the nurse in maintaining personal hygiene

Preparation:

Practical Equipment / Environment (Box Number):

Clean Bowl of warm water, trolley to move filled bowl on, soap, the patient’s toiletries if they have them, disposable plastic apron, disposable gloves, disposable wipes, towels, clean bed linen, clean bed clothing, yellow clinical waste bag, linen skip.

Virtual Learning Resources

Healthcare professional:

- Ensure that your hands are clean
- Put on a clean plastic apron
- No special preparation is necessary unless required by the patients condition (e.g. MRSA)
- Gloves are **not** required unless dealing with body fluids.

RCN Publication: Good Practice in infection prevention & control: Guidance for nursing staff.

http://www.rcn.org.uk/resources/mrsa/downloads/Wipe_it_out-Good_practice_in_infection_prevention_and_control.pdf

No.	Procedure	Rationale	VLE Links
1.	<p>General Principles:</p> <ul style="list-style-type: none"> • Firstly establish what the patient's preferences are with regard to their hygiene, explain the procedure and gain their permission • Ensure that the ambient temperature of the bed area / room is appropriate and switch off fans / shut windows as appropriate to reduce drafts. • Ensure that any risk assessments with regard to moving and handling and infection control are complied with in accordance with Trust policy. 	<ul style="list-style-type: none"> • To ensure that any age / gender / cultural variations are accounted for and to ensure the patient's cooperation. Consent will be verbal and / or implied i.e. the patient will take their wash bag out of their locker. • To prevent the patient feeling cold and uncomfortable during their wash. • To ensure the patient's and nurse's safety. To prevent cross-infection and poor manual handling techniques. 	<p>Link to the Mary Seacole Centre. From top tool bar select the 'Centre for Nursing Practice', and then from the next tool bar select 'The MELTING Project'. Then select Essential Aspects of Care for more information on cultural issues related to personal Hygiene needs.</p> <p>www.maryseacole.com</p>
2.	<p>Preparation:</p> <ul style="list-style-type: none"> • Assess the patient's medical condition, how ill is s/he? How mobile? Will activity cause fatigue, breathlessness, pain? 	<ul style="list-style-type: none"> • To ensure that an appropriate level of assistance is provided for the patients' current levels of ability / mobility. 	

	<ul style="list-style-type: none"> • Assess whether the patient has any pain / discomfort and if necessary give them analgesia as prescribed prior to commencing their bed bath. • Consider the presence of intravenous lines, monitoring equipment, drainage bags and wounds. • Prepare the environment in which you are to work; remove any obstacles, gather everything that you need including clean night clothing and bed linen. Adjust the bed to an appropriate height. Use a trolley to transport a bowl of clean hot water to the bedside. • Ensure that bedside curtains are drawn or that an engaged sign is put on bathroom doors. • Wash your hands and put on a clean plastic apron. • Gloves are not necessary for the majority of the bed bath and should only be used if dealing with body fluids and when washing the genitals and peritoneum. 	<ul style="list-style-type: none"> • To ensure that the patient is comfortable & pain free and able to participate as much as their condition / illness / surgery allows. • To ensure that these are secured safely and will not be pulled out or damaged during the procedure. • To ensure that you have easy access to the patient in bed, have room to work and manoeuvre and are not stooping, stretching or twisting. Water is an unstable load and should not be carried. • To ensure privacy and dignity. • It is essential to wash your hands with soap and water to remove any transient organisms before and after any episode of patient care, (National Patients Safety Agency, 2004, ICNA, 1999) as hands are the most commonly implicated transmission route between patients. Hospital acquired infections cost the NHS 1 billion pounds and contribute to the death of an estimated 5,000 patients a year (Akid, 2001). 	<p>RCN Publication: Good Practice in infection prevention & control: Guidance for nursing staff.</p> <p>http://www.rcn.org.uk/resources/mrsa/downloads/Wipe_it_out-Good_practice_in_infection_prevention_and_control.pdf</p> <p>Link to National Resource for Infection Control (NRIC):</p> <p>http://www.nric.org.uk/IntegratedCRD.nsf/NRIC_Home1?OpenForm</p>
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2.	<p>Bed Bath Procedure: (with one nurse either side of the bed)</p> <ul style="list-style-type: none"> • Assist the patient to sit up in bed using correct moving & handling techniques or moving & handling equipment if required. • Loosen the bed clothing and remove the bedspread and top sheet, leaving a blanket to cover the patient. Bed Linen should be placed in the linen skip, which should be placed near the bed throughout the procedure. • Use the blanket to keep the patient covered at all times, apart from the area being washed. • Check the temperature of the water with the patient & adjust if required. • Remove spectacles and /or hearing aids as appropriate. • Check the patient's preferences with regard to 	<ul style="list-style-type: none"> • To enable the patient to assist where possible if their condition allows. • To keep the patient warm throughout the procedure. • To reduce the amount of dead skin cells, hair, dust and microorganisms dispersed from the linen into the environment. • To maintain privacy and dignity. To prevent undue cooling. • Ensure that the water is a comfortable temperature for the patient. • To enable cleaning of the face and ears • To ensure that the patient's own hygiene standards are 	

	<p>using soap on the face and also check if they have a preferred face cloth for their face.</p> <ul style="list-style-type: none"> • Place a towel over the patient's chest and shoulders to prevent splashes. Rinse and wring out the facecloth and gently wash the face, rinse away soap or cleanser if used and dry gently. If the patient is able ask them to wash and dry their face. • Replace spectacles and / or hearing aids as appropriate. • Ask the patient, or assist them to remove their upper clothing, ensuring that you keep them covered with the blanket. If hospital clothing is worn this should go straight into the linen skip. If it is the patient's own place neatly in their locker. • The arm furthest away from the nurse with the washbowl should be washed first. The nurse on that side should place a towel under the patient's arm to prevent wetting the bed linen. The nurse with the washbowl should pass a wet washcloth to the nurse on the side to be washed – she will wash & rinse the fingers, hand, wrist & arm (including the under arm) 	<p>adhered to.</p> <ul style="list-style-type: none"> • To maintain privacy & dignity, to keep the patient warm and to prevent the blanket getting wet. • To ensure that the patient can see / hear in order to participate with their hygiene. • To reduce the amount of dead skin cells, hair, dust and microorganisms dispersed from the clothing into the environment. To allow access to the upper arms and torso for the next stage in the bed bath. • By starting at the point furthest from the nurse with the washbowl this ensures that areas that have been washed and dried will not be dripped on and made wet as the bed bath continues. • To ensure that the skin is not damaged by rubbing and to prevent discomfort from 	
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	<p>Pat gently dry.</p> <ul style="list-style-type: none"> • Whilst washing the arm pressure points such as the elbow can be checked for pressure damage. • Place the towel on the patient's chest and turn down the blanket that is beneath it so that only the towel covers the patient's upper body. Wash and rinse the patient's torso (with female patients it is important to ensure that the area beneath the breast is washed and dried thoroughly) Pat dry gently. • Cover the upper body with the blanket and proceed to wash, rinse and dry the arm closest to the nurse with the washbowl. • At this point if the patient is able to sit forward easily, without discomfort and without support you can wash, rinse and dry the patient's back. Clean night clothing can then be replaced on the upper body. • The water can be replaced at any time during the procedure if it gets cold, soapy or dirty. • Ensure that the patient's upper body is covered and that they feel warm enough. • Uncover the leg furthest from the nurse with the washbowl; 	<p>chaffing.</p> <ul style="list-style-type: none"> • To prevent the occurrence of pressure ulcers. • To maintain privacy & dignity. To prevent the bed linen getting wet. • Take note of any redness, soreness, rashes, bruises, lumps or bumps. • To maintain privacy, dignity & warmth. • CAUTION: This can only be undertaken if the patient is able to support themselves. If it requires either or both nurses to support the patient upright then back injury may occur! (You must be aware of the patient's moving and handling requirements prior to commencing a bed bath) • To ensure the patient's comfort and prevent undue cooling. • By starting at the point furthest 	
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<p>place a towel under the leg. The nurse on that side of the bed should wash and rinse the toes, feet (check if the patient is ticklish first), ankles and legs (up to the top of the thigh) Pat dry gently. Check the heel for any signs of pressure damage. Remove the towel and cover the leg up with the blanket.</p> <ul style="list-style-type: none"> • Uncover the leg nearest to the nurse with the washbowl; place a towel under the leg then wash and rinse the toes, feet (check if the patient is ticklish first), ankles and legs (up to the top of the thigh) Pat dry gently. Check the heel for any signs of pressure damage. Remove the towel and cover the leg up with the blanket. • Prior to washing the genitalia check if the patient would prefer to wash this area. Use disposable wipes. If the patient is unable to assist don a pair of disposable gloves, gently wash and dry the area gently. Dispose of the wipes and gloves into a yellow clinical waste bag. Decontaminate the hands using an alcohol-based gel. Change the water. • In order to wash the patient's 	<p>from the nurse with the washbowl this ensures that areas that have been washed and dried will not be dripped on and made wet as the bed bath continues.</p> <ul style="list-style-type: none"> • An important aspect of bed bathing the patient is the opportunity it presents to check the patient's skin condition and pressure areas for signs of damage. • Gloves should be worn and disposable wipes used to prevent cross-infection. Water must be changed after washing the genitalia to prevent cross-infection. 	
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<p>back (if not washed earlier due to poor mobility) and bottom, the patient should be laid flat and asked to roll using the correct moving & handling technique and equipment as required.</p> <ul style="list-style-type: none"> • Place a towel under the patient's back and wash, rinse and gently pat dry the back. Take care to note the pressure areas of the shoulder blades, spine, sacrum and buttocks. • Put on a pair of disposable gloves and using disposable wipes wash the patient's bottom, rinse and pat gently dry. Dispose of the wipes and gloves into a yellow clinical waste bag. Decontaminate the hands using an alcohol-based gel. • Cover the patient with the blanket and keep them on their side whilst you replace the bottom sheet with a fresh sheet using correct moving & handling techniques. • Assist the patient into a comfortable position using the correct moving & handling technique. • Assist the patient with the application of deodorant, body spray or talcum powder, as they prefer. • Assist the patient with putting 	<ul style="list-style-type: none"> • To ensure that the patient is moved safely, minimizing risk of injury to both the patient and nurses. (The patients moving & handling care plan should be adhered to). • To prevent soreness and chaffing. To prevent the development of pressure ulcers. • Gloves should be worn and disposable wipes used to prevent cross-infection. • To maintain privacy & dignity and to prevent undue cooling. • To prevent harm to the patient and nursing staff through unsafe practice. • To ensure comfort. • To maintain the patient's own hygiene standards. 	
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	<p>on clean nightclothes.</p> <ul style="list-style-type: none"> • Replace the top sheet with a clean sheet, blanket and bedspread • Assist the patient with hair care, oral care and / or shaving as required (clean hot water will be need for a wet shave) 	<ul style="list-style-type: none"> • To maintain dignity and the patients own personal care standards. • To maintain the patients own personal care standards and dignity. 	
3.	<p>Post Procedure:</p> <ul style="list-style-type: none"> • Ensure that the patient is comfortable, has the call bell to hand and any other items that they might require within reach. Readjust the bed to a safe lower level. • Tidy away all the equipment used. The patient's own soap should be rinsed, dried and stored in an open soap dish. Washcloths should also be rinsed and rung dry and hung on the towel rail of the patient's locker. The wash bowel should be thoroughly cleaned, dried and stored according to local policy. • Remove and dispose of the plastic apron and wash your hands. • Document the care that has been given in the patient's notes. 	<ul style="list-style-type: none"> • To ensure patient comfort. • To minimise the risk of falls. • To minimise bacterial growth in damp soap and wash bowls. • To ensure a clear, clutter free bed space. • To comply with Infection Control Policies. • To ensure that nursing notes are current and contemporaneous. 	

Post Procedure:	VLE Links
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Equipment / Environment:

1. Clean the equipment following the manufacturers guidelines and Trust Policy
2. Replace the equipment storing it appropriately and in its designated area
3. Remove your apron and clean your hands before dealing with further patients.

Healthcare Professional:

- Ensure that all care episodes are recorded appropriately and information is passed onto the patient's medical team.

Branch / Speciality Applications: short scenarios / links to existing VLE resources

Whatever your branch you should communicate with your patient through out the procedure. Use language appropriate to your patient's age and abilities; be aware of verbal and non-verbal cues.

Adult:

Be aware that changes in the patient's body image due to a mastectomy, amputation or stoma for instance may make it difficult for the patient to look at that area of their body.

Child:

In general parents or carers will be involved in assisting a child with their hygiene needs. For a baby bath see the baby bath procedure.

Learning Disability:

Moving and handling can be a big issue and you may need specially adapted bathing aids for your client group. You may need to educate and use health promotion in order to encourage personal hygiene. You may have to also use behavioural strategies with patients that refuse to wash.

Mental Health:

Mental Health problems may result in a lack of interest in personal hygiene and a degree of self-neglect. You may have to use behavioural strategies with patients that refuse to wash.

VLE Links

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References:	
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accessed 28/05/08	
Procedure Originator[s]	Kirsty Wedgbury.
Procedure Reviewers[s]	
Date:	30/04/09
Version:	Version 2
Supersedes:	N/A
Proposed review date:	
Reviewed by:	
Date:	
Signature:	

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