Section 1: Activities of Daily Living

Bathing: Bed Bath

SUMMARY
This skill describes how to perform a complete or partial bed bath in the home setting.

ALERT
Do not allow a patient with cognitive impairment or decreased orientation to shower or bathe independently.

OVERVIEW
Skin functions as a barrier against harmful compounds and dehydration of the body. As the most superficial layer of the skin's epidermis, the stratum corneum encounters challenging environmental conditions on a daily basis; it is designed to retain barrier integrity and protect the deeper layers of the skin and internal organs.[9] The normal acidic coating of the stratum corneum, called the acid mantle, protects the skin from damage and reduces the growth of bacteria, fungi, and other potentially harmful microbes.

Bathing removes sweat, oil, dirt, and microorganisms from the patient's skin, stimulates circulation, and provides a refreshed and relaxed feeling. However, bathing disrupts the normal, protective, acidic pH of the skin, especially when alkaline soaps are used.

The type of bathing required depends on an assessment of the patient's physical capabilities and the degree of hygiene necessary. The skin should be cleansed once daily. Skin cleansing products that have a pH of 4 to 5 are most compatible with the acid mantle of healthy skin.[2]

Bathing provides an opportunity to assess the overall condition of the patient's skin, including its integrity, turgor, and color, and to detect abnormalities (e.g., petechiae, rash, bruising). The patient should be p**rotected from injury, including any caused by an excessive water temperature. This is especially important for older adult patients and for patients with reduced sensation, such as those who have diabetes, peripheral neuropathy, or spinal cord injury.**

These cautions help prevent skin breakdown and irritation during bathing:[5]
- Force and friction on the patient's skin should be avoided.

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- Massage of reddened areas should be avoided.
- Pressure over bony prominences, such as the heels, coccyx, and occiput, should be reduced.
- Environmental factors that lead to dry skin, such as extreme temperature and low humidity, should be minimized.
- The skin should be patted dry to avoid the friction from rubbing.

Patients who are incontinent of urine or stool require more frequent perineal care. Perineal care, which involves thorough cleansing of the patient's external genitalia and surrounding skin, should be performed during the bath. For a patient with an indwelling catheter, the urethral meatus should be cleansed daily with soap and water as part of overall patient hygiene.[8,9] Daily cleansing of the meatal surface is recommended for patients with an indwelling urinary catheter.[3,6] Antiseptic cleansers are not recommended for use with patients who have an indwelling urinary catheter because irritation of the urethral meatus may increase the risk of infection.[3]

The two categories of baths are cleansing and therapeutic.[9]

- Cleansing baths include the bed bath, tub bath, sponge bath at the sink, shower, and prepackaged disposable bed bath (Box 1). The type of cleansing bath depends on the patient's physical capabilities and the degree of hygiene required. When a patient is unable to perform personal care because of an illness or disability, the health care team member is responsible for assisting with bathing.
- Therapeutic baths may be ordered for a specific effect (e.g., soothing the skin or promoting healing). Types of therapeutic baths include:
    - *Sitz bath,* which cleanses and reduces pain and inflammation of the perineal and anal areas. A sitz bath is used for a patient who has undergone rectal or perineal surgery or childbirth or has local irritation from hemorrhoids or fissures. The patient sits in a special tub or basin.
    - *Medicated bath*, in which an over-the-counter, herbal, or practitioner-ordered ingredient is added to the bath to help relieve skin irritation and create an antibacterial and drying effect.

Various all-in-one disposable bath products that clean and protect the skin are available for use, eliminating the need for soap, water, and bath basins. The disposable bath contains several soft, nonwoven cotton cloths that are premoistened in a solution of no-rinse surfactant cleanser and emollient. The disposable bath offers an alternative to other bathing methods and may be appropriate because of ease of use, reduced bathing time, and patient comfort. A variety of disposable baths and no-rinse bathing products is available.

Skin care products containing chlorhexidine gluconate (CHG) effectively reduce the number of resident and transient organisms on the skin.[4] CHG decreases skin colonization of methicillin-resistant *Staphylococcus aureus;* however, it has minimal to no effect on *Clostridium difficile*.[7]

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EDUCATION

- Instruct the patient, family, and caregivers regarding the importance of hygiene.
- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Instruct the family or caregivers of a patient with decreased sensation to be cautious with warm bathwater. Instruct the family or caregivers to use the patient's unaffected extremity or a thermometer to test water temperature to avoid accidental scalding.
- Educate the patient, family, and caregivers on how to inspect surfaces between skinfolds for signs of irritation or breakdown.
- Explain the procedure and necessary precautions related to the patient's positioning or physical limitations to the patient, family, and caregivers.
- Encourage questions and answer them as they arise.

PROCEDURE

COMPLETE OR PARTIAL BED BATH

1. Perform hand hygiene before patient contact. Don appropriate personal protective equipment (PPE) based on patient's need for isolation precautions or risk of exposure to bodily fluids.
2. Introduce yourself to the patient, family, and caregivers.
3. Verify the correct patient using two identifiers.
4. Explain the procedure to the patient, family, and caregivers and ensure that the patient agrees to bathing.
5. Verify the practitioner's order and assess the patient for pain.
6. Assess the patient's tolerance for bathing and activity; also consider the patient's comfort level, cognitive ability, and musculoskeletal function. Assess the patient for shortness of breath.

   Rationale: Ascertaining whether the patient is experiencing fatigue or shortness of breath determines the patient's tolerance for bathing activities.

   Consider administering a partial bed bath for a patient who fatigues easily.

7. Assess the patient's visual status, ability to maintain a sitting position, hand grasp, and range of motion (ROM) of the extremities.
8. Assess the patient for medical devices and equipment (e.g., IV line, oxygen tubing, catheter). Follow the organization's practice on bathing with medical devices or equipment in place.
9. Ask about the patient's bathing preferences.

   a. Frequency and time of day

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b. Allergies or sensitivities to hygiene products
c. Preferred hygiene products
d. Desire to participate in the bath
e. Factors related to the patient's culture
f. Water temperature
g. Preference for type and length of partial bath

10. Ask if the patient has noticed problems related to the condition of skin or genitalia.
11. Before or during the bath, assess the patient's skin condition. Note the presence of dryness, which is indicated by flaking, redness, scaling, and cracking. Also note the presence of excessive moisture, inflammation, or pressure injuries.
12. Identify the patient's risk factors for skin impairment using an organization-approved pressure injury assessment tool (e.g., Braden scale).[9]

    a. Limited mobility (e.g., patients with paralysis, immobilized extremities, traction; patients who are weakened or disabled)
    b. Reduced sensation (e.g., paresthesia, circulatory insufficiency, neuropathies)
    c. Nutritional and hydration alterations
    d. Excessive moisture on the skin, particularly on skin surfaces that rub against each other (e.g., under breasts, perineal area)
    e. Vascular insufficiencies (e.g., diabetes mellitus)
    f. External devices applied to or around the skin (e.g., casts, braces, dressings, catheters, tubes)
    g. Fragile skin, especially in older adults
    h. Shear or friction (sliding down in bed)
    i. Incontinence (bowel or bladder)

13. Review specific precautions concerning the patient's movement or positioning.
14. Check the practitioner's order for a therapeutic bath, including the type of solution, length of time for the bath, and the body part to bathe, as applicable.
15. Prepare an area in a clean, convenient location and assemble the necessary supplies.
16. Perform hand hygiene and don gloves.
17. Offer the patient the opportunity to void in a bedpan or urinal.

    Rationale: Voiding may help the patient feel more comfortable and prevent interruptions during the bath.

18. Remove gloves, perform hand hygiene, and don clean gloves if assisting patient with a bedpan or urinal.
19. Adjust the room temperature and ventilation, and close doors and windows.
20. Assist the patient to a comfortable supine position, maintaining proper body alignment.

    Rationale: Bringing the patient toward the side aids access to the patient. A comfortable supine position helps maintain the patient's comfort throughout

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the procedure. Using proper body mechanics minimizes strain on the back muscles.

21. Observe the patient's ROM during bathing.
22. Place a bath towel over the patient. Have the patient hold the top of the bath towel. Remove the top sheet from under the bath towel without exposing the patient. Place soiled linen in a designated laundry hamper or basket.

    Do not allow the linen to contact the health care team member's clothes. Do not place soiled linens on the floor.

23. Remove the patient's clothing using the towel to cover exposed areas of the body.
24. If an extremity is injured or has reduced mobility, undress the unaffected side first.

    Rationale: Undressing the unaffected side first allows easier manipulation of the gown over the body part with reduced ROM.

25. Fill the basin two-thirds full with warm water. Check the water temperature with a thermometer, when available; bring the basin to the bedside and have the patient test for temperature tolerance with the fingers.

    Rationale: Warm water promotes comfort, relaxes muscles, and prevents unnecessary chilling. Testing the water temperature prevents accidental burns.

    A safe water temperature for bathing is 37.8°C (100°F).[1]

26. Place a bath towel under the patient's head. Place a second bath towel over the patient's chest.
27. Wash the patient's face.

    a. Washing a conscious patient's face:

        i. Form a mitt with a washcloth. Immerse the washcloth in the water and wring thoroughly.

            Rationale: A mitt retains water and heat better than a loosely held washcloth. Forming a mitt avoids cold edges that can brush against the patient and prevents splashing.

        ii. Wash the patient's eyes with plain, warm water. Use a clean area of the washcloth for each eye and bathe from the inner to the outer canthus. Soak any crusts on the eyelid with a damp cloth until moist before attempting removal. Dry around the eyes gently and thoroughly.

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Rationale: Using plain, warm water avoids irritating the eyes. Using a separate section of the mitt reduces infection transmission. Bathing the eye gently from the inner to the outer canthus prevents contaminants from entering the nasolacrimal duct.

iii. Ask if the patient prefers to use soap on the face. Wash, rinse, and dry the forehead, cheeks, nose, neck, and ears. Ask a male patient if he wants to be shaved.

Rationale: Soap tends to dry the face, which is exposed to air more than other body parts. Some patients may prefer to use plain water on their face.

b. Washing an unconscious patient's face:

i. Cleanse the eyelids with a washcloth from the inner to the outer canthus using plain, warm water.

Rationale: Patients who are unconscious have lost the normal protective corneal reflex of blinking, increasing the risk of corneal drying, abrasions, and eye infection.

ii. Instill eye drops or ointment, if appropriate, per the practitioner's order.
iii. In the absence of a blink reflex, keep the eyelids closed. Close the eye gently, using the back of the fingertip before placing an eye patch or shield.

Rationale: When the blink reflex is absent, the eye loses its protective mechanism. Keeping the eyelids closed maintains eye moisture and prevents injury.

28. Wash the patient's upper extremities and trunk. Change bath water when moving from one body part to the next.

a. Remove the bath towel from the arm closest to the health care team member. Place the bath towel lengthwise under the arm.
b. Raise and support the arm above the patient's head (if possible) to wash the axilla using long, firm strokes from distal to proximal (fingers to axilla).

Rationale: Long, firm strokes promote venous return.

c. Rinse and dry the axilla thoroughly. Apply deodorant or powder to the underarms as needed and per the patient's preference.

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Rationale: Moving the arm exposes the axilla and exercises the joint's normal ROM.

d. Move to the other side of the bed and repeat the process to bathe the other arm.
e. Cover the patient's chest with a bath towel and fold it down to the umbilicus. Bathe the chest using long, firm strokes. Take special care with the skin under a female patient's breasts, lifting each breast upward, if necessary, using the back of the hand. Rinse and dry well.

Rationale: Secretions and dirt collect easily in tight skinfolds. The skin under the breasts is vulnerable to excoriation if not kept clean and dry.

29. Wash the patient's hands and nails.

a. Fold a bath towel in half and lay it on the bed beside the patient. Place a basin on the towel.
b. Immerse the patient's hand in the water and allow the hand to soak (if appropriate) before cleansing the fingernails.

Do not soak the fingers of a patient with diabetes mellitus or other vascular disease; this can lead to maceration and increase the risk for infection.

c. Remove the basin and dry the hand well. Repeat the process for the other hand.

Rationale: Soaking softens cuticles and calluses, loosens debris beneath the nails, and enhances the feeling of cleanliness.

30. Check the temperature of the bathwater and change the water. Bathwater should be changed when moving from one body part to the next.

Rationale: Warm water maintains the patient's comfort.

31. Wash the patient's abdomen.

a. Place one or two bath towels, as needed, lengthwise over the chest and abdomen. Fold the towels down to just above the pubic region.
b. Bathe, rinse, and dry the abdomen, paying special attention to the umbilicus and skinfolds of the abdomen and groin. Keep the abdomen covered between washing and rinsing.
c. Dry well.

Rationale: Moisture and sediment that collect in the skinfolds predispose the skin to maceration.

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32. Change the bathwater, being mindful of water temperature.
33. Wash the patient's lower extremities.

    a. Cover the chest and abdomen with the top of the bath towel. Expose the near leg by folding the towel toward the midline. Ensure that the other leg and the perineum are draped.

    b. Wash the leg using long, firm strokes from the ankle to the knee and then from the knee to the thigh. Assess the condition of the extremities.

        Rationale: Using long, firm strokes promotes circulation and venous return.

    c. Cleanse the foot and between the toes.

        Do not file or cut toenails.

    d. Dry the toes and feet completely. Remove and discard the towel.

        Rationale: Moisture between the toes can predispose the skin to maceration and breakdown.

    e. Move to the opposite side of the bed and repeat the process for the other leg and foot.
    f. Apply a moisturizing lotion or an emollient to both feet. When finished, cover the patient with a bath towel.

34. Change the bath water before perineal care. Be mindful of water temperature.
35. Provide perineal care while the patient is in the supine position.

        Perform perineal care during the daily bath and after each episode of urine or fecal incontinence.

    a. Cleanse around the penis. For a female patient, cleanse the outer and inner labia from front to back. Cleanse, rinse, and dry the area thoroughly.

        Rationale: Cleansing from front to back helps to avoid contamination of the meatus.

    b. If fecal material is present, enclose it in a fold of underpad or toilet tissue and remove it with disposable wipes. Use additional wipes to remove any remaining fecal material.

36. Change the bath water after perineal care. Be mindful of water temperature.

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37. Wash the patient's back.

    a. Assist the patient to a prone or side-lying position, using safe patient-handling techniques (as applicable). Place a bath towel lengthwise along the patient's side.

    b. If fecal material is present, enclose it in a fold of the underpad or toilet tissue and remove it with disposable wipes. Use additional wipes to remove any remaining fecal material.
    c. Keep the patient draped by sliding the bath towel over the shoulders and thighs during bathing. Wash, rinse, and dry the patient's back from the neck to the buttocks with long, firm strokes.
    d. Use a clean washcloth mitt for cleansing the buttocks and anus to prevent contamination of the bathwater.
    e. Cleanse the buttocks and anus, washing from front to back. Cleanse, rinse, and dry the area thoroughly. Pay special attention to the folds of the buttocks and anus. If needed, place a clean absorbent pad under the patient's buttocks.

38. Place the soiled linen in a linen hamper or basket.
39. Remove gloves, perform hand hygiene, and don clean gloves.
40. Give a back rub if the patient desires.

    Do not massage any reddened areas on the patient's skin because pressure contributes to the development of pressure injuries. Reddened, nonblanchable areas, especially over bony prominences, may indicate localized injury to the skin or underlying tissue.

41. Assist the patient to a supine or sitting position and help with additional grooming as needed.
42. Remove gloves, perform hand hygiene, and don clean gloves.
43. Assist the patient with a clean gown, pajamas or other clothing, dressing the affected side first.
44. Check the function and position of devices (e.g., indwelling catheters, nasogastric tubes, IV tubes, braces).
45. Replace the top bed linen by pulling the sheet and bedspread from the foot of the bed to cover the patient before removing the bath towel.
46. Replace any personal possessions.
47. Remove gloves, perform hand hygiene, and don clean gloves.
48. Clean and dry the basin; then turn it upside down to store and reduce contamination; replace bathing equipment.

    Do not use the washbasin as a storage container for supplies.[8]

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49. Continue to monitor the patient's skin condition and risk for injury. Pay attention to areas that were soiled, reddened, flaking, scaling, or cracking and areas that showed early signs of breakdown. Use an organization-approved skin assessment tool.
50. Assess pain, treat if necessary, and reassess.
51. Discard or store supplies, remove PPE, and perform hand hygiene.
52. Document the procedure in the patient's record.

DISPOSABLE BED BATH

1. Perform hand hygiene before patient contact. Don appropriate personal protective equipment (PPE) based on patient's need for isolation precautions or risk of exposure to bodily fluids.
2. Introduce yourself to the patient, family, and caregivers.
3. Verify the correct patient using two identifiers.
4. Explain the procedure to the patient, family, and caregivers and ensure that the patient agrees to bathing.
5. Verify the practitioner's order and assess the patient for pain.
6. Assess the patient's tolerance for bathing and activity; also consider the patient's comfort level, cognitive ability, and musculoskeletal function. Assess the patient for shortness of breath.

   Rationale: Ascertaining whether the patient is experiencing fatigue or shortness of breath determines the patient's tolerance of bathing activities.

   Consider administering a partial bed bath for a patient who fatigues easily.

7. Assess the patient's visual status, ability to sit without support, hand grasp, and ROM of the extremities.
   1. Assess the patient for medical devices and equipment (e.g., IV line, oxygen tubing, catheter).
   2. Ask about the patient's bathing preferences.

   a. Frequency and time of day
   b. Allergies or sensitivities to hygiene products
   c. Preferred hygiene products
   d. Desire to participate in the bath
   e. Factors related to the patient's culture
   f. Water temperature
   g. Preference for type and length of partial bath

8. Ask if the patient has noticed problems related to the condition of skin or genitalia.

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9. Before or during the bath, assess the patient's skin condition. Note the presence of dryness, which is indicated by flaking, redness, scaling, and cracking; also note the presence of excessive moisture, inflammation, or pressure injuries.
10. Identify the patient's risk factors for skin impairment using an organization-approved pressure injury tool (e.g., Braden scale).[9]

    a. Limited mobility (e.g., patients with paralysis, immobilized extremities, traction; patients who are weakened or disabled)
    b. Reduced sensation (e.g., paresthesia, circulatory insufficiency, neuropathies)
    c. Nutritional and hydration alterations
    d. Excessive moisture on the skin, particularly on skin surfaces that rub against each other (e.g., under breasts, perineal area)
    e. Vascular insufficiencies (e.g., diabetes mellitus)
    f. External devices applied to or around the skin (e.g., casts, braces, restraints, dressings, catheters, tubes)
    g. Fragile skin, especially in older adults
    h. Shear or friction (sliding down in bed)
    i. Incontinence (bowel or bladder)

11. Review specific precautions concerning the patient's movement or positioning.
12. Check the practitioner's order for a therapeutic bath, including the type of solution, length of time for the bath, and the body part to bathe, as applicable.
13. Prepare an area in a clean, convenient location and assemble the necessary supplies.
14. Perform hand hygiene and don gloves.
15. Offer the patient the opportunity to void in a bedpan or urinal.

    Rationale: Voiding may help the patient feel more comfortable and prevent interruptions during the bath.

16. Remove gloves, perform hand hygiene, and don clean gloves if assisting the patient with a bedpan or urinal.
17. Adjust the room temperature and ventilation, and close doors and windows.
18. Assist the patient to a comfortable supine position, maintaining proper body alignment.

    Rationale: Bringing the patient toward the side aids access to the patient. A comfortable supine position helps maintain the patient's comfort throughout the procedure. Using proper body mechanics minimizes strain on the back muscles.

19. Warm a cleansing package per the manufacturer's instructions.

    Rationale: The cleansing pack contains several premoistened towels. Many products can be used at room temperature, but warming towels may provide additional patient comfort.

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20. Observe the patient's ROM during bathing.
21. Place a bath towel over the patient. Have the patient hold the top of the bath towel. Remove the top sheet from under the bath towel without exposing the patient. Place soiled linen in a designated laundry hamper or basket.

    Do not allow the linen to contact the health care team member's clothes. Do not place soiled linens on the floor.

22. Remove the patient's clothing using the towel to cover exposed areas of the body per the same order as for a complete or partial bed bath.
23. Use a single premoistened towel for each general body part cleansed, using the same order of cleansing as for a complete or partial bed bath.

    Use an extra cleansing pack, washcloths, soap and water, and towels as needed for excessive soiling (e.g., in the perineal region).

24. Allow the skin to air dry.
25. Apply body lotion or emollient to the skin and topical moisturizing agents to dry, flaky, reddened, or scaling areas.

    Rationale: Dry skin results in reduced pliability and cracking. Moisturizers help prevent skin breakdown.

26. Remove gloves, perform hand hygiene, and don clean gloves.
27. Give a back rub if the patient desires.

    Do not massage any reddened areas on the patient's skin because pressure contributes to the development of pressure injuries. Reddened nonblanchable areas, especially over bony prominences, may indicate localized injury to the skin or underlying tissue.

28. Assist the patient to a supine or sitting position and help with grooming as needed.
29. Remove gloves, perform hand hygiene, and don clean gloves.
30. Assist the patient with a clean gown, pajamas or other clothing, dressing the affected side first.
31. Check the function and position of devices (e.g., indwelling catheters, feeding tubes, IV tubes, braces).
32. Replace any personal possessions.
33. Continue to monitor the patient's skin condition and risk of impairment. Pay attention to areas that were soiled, reddened, flaking, scaling, or cracking and areas that showed early signs of breakdown. Use an organization-approved assessment tool.
34. Assess pain, treat if necessary, and reassess.
35. Discard or store supplies, remove PPE, and perform hand hygiene.

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36. Document the procedure in the patient's record.

ILLUSTRATIONS

BOX 1 TYPES OF BATHS

- **Complete bed bath:** Bath administered to totally dependent patient in bed.

- **Partial bed bath:** Bed bath that consists of bathing only body parts that would cause discomfort if left unbathed, such as the hands, face, axilla, and perineal area. Partial bath also includes washing the back and providing a back rub. Dependent patients in need of partial hygiene or self-sufficient bedridden patients who are unable to reach all body parts receive a partial bed bath.
- **Sponge bath at the sink:** Involves bathing from a bath basin or sink with patient sitting in a chair. Patient is able to perform a part of the bath independently. A health care team member helps with hard-to-reach areas.
- **Tub bath:** Involves immersion in a tub of water that allows more thorough washing and rinsing than a bed bath. Patients may require team member's help. Some agencies have tubs equipped with lifting devices that facilitate the positioning of dependent patients in the tub.
- **Shower:** Patient sits or stands under a continuous stream of water. The shower provides more thorough cleansing than a bed bath but can be tiring.
- **Disposable bed bath/travel bath:** The bag bath contains several soft, nonwoven cotton cloths that are premoistened in a solution of no-rinse surfactant cleaner and emollient. The bag bath offers an alternative because of the ease of use, reduced bathing time, and patient comfort (Meiner and Yaeger 2019).

(From Perry, A.G. and others [Eds.]. [2022]. *Clinical nursing skills & techniques* [10th ed.]. St. Louis: Elsevier.)

SUPPLIES

Ensure that all necessary supplies and durable medical equipment are available.

- Patient's own pajamas or gown
- Bath towels
- Disposable bed bath or cleansing pack
- Disposable wipes (as needed)
- PPE (Gloves and other PPE as needed)
- Bar or liquid soap, or antimicrobial cleansing agent, as indicated
- Laundry bag
- Toilet tissue or hygiene wipes

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- Toiletry items (deodorant, lotion)
- Protection for equipment, casts, or catheters
- Washbasin
- Washcloths
- Eye patch/shield and nonallergenic tape (for unconscious patient)

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ADDITIONAL READINGS

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