



## Complete Summary

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### GUIDELINE TITLE

Bathing persons with dementia.

### BIBLIOGRAPHIC SOURCE(S)

Thiru-Chelvam B. Bathing persons with dementia. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2004. 37 p. [22 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Gerontological Nursing Interventions Research Center (University of Iowa), Research Development and Dissemination Core. Bathing persons with dementia. Iowa City (IA): University of Iowa; 1998 Apr. 17 p. (Research-based protocol; no. 1998).

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Dementia

### GUIDELINE CATEGORY

Management

### CLINICAL SPECIALTY

Geriatrics  
Neurology  
Nursing  
Psychiatry

### **INTENDED USERS**

Advanced Practice Nurses  
Nurses

### **GUIDELINE OBJECTIVE(S)**

To provide guidelines for nurses who are planning and/or directing care and the direct caregiver of persons with dementia, to enhance the therapeutic effects of the bathing process and to provide the person with an environment and bathing options which meet their needs and add to their quality of life

### **TARGET POPULATION**

Patients with chronic dementing illness

### **INTERVENTIONS AND PRACTICES CONSIDERED**

1. Patient assessment including interviewing the patient's family and obtaining previous bathing preferences
2. Determining level of assistance the individual will require using cognitive/functional status tools, such as the Mini Mental State Examination (MMSE), Test for Severe Impairment (TSI), and the Clock Drawing Test, and direct observation
3. Establishing bathing methods using results of the above tests and discussing current preferences with patient/family
4. Documenting the established method of bathing for caregivers to follow

### **MAJOR OUTCOMES CONSIDERED**

- Frequency and severity of negative bathing episodes
- Therapeutic effects of bathing experience

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The guideline developer performed literature searches using the following sources: Medline, Cumulative Index to the Nursing and Allied Health Literature (CINAHL).

#### **NUMBER OF SOURCE DOCUMENTS**

Not stated

#### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

#### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

The grading schema used to make recommendations in this evidence-based practice protocol is:

- A. Evidence from well-designed meta-analysis
- B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention, or treatment)
- C. Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results
- D. Evidence from expert opinion or multiple case reports

#### **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review

#### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

#### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

#### **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Not stated

#### **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

#### **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Clinical Validation-Trial Implementation Period  
External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

This protocol was reviewed by experts knowledgeable of research on bathing persons with dementia and development of guidelines. The reviewers suggest additional evidence for selected actions, inclusion of additional practice recommendations, and changes in the protocol presentation to enhance its clinical utility.

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

The grades of evidence (A-D) are defined at the end of the "Major Recommendations".

#### **Assessment**

When a person with dementia enters a care facility, the initial interviews between the care staff and the family are very important in establishing a successful path of appropriate care. Knowledge of the individual's history of bathing practices and preferences would help in determining the time of day (morning or later in the day) and the type of bathing process (tub, shower or bed bath) to be used initially for that person.

The use of simple tests to determine levels of cognitive status would also assist staff in determining where the person is in their disease process and therefore gain an understanding of the individual's ability to participate in, or even accept, the bathing process. There are many tools available. Some can be performed by nurses and others would need the input of other professionals. An Occupational Therapist is a good resource when looking at cognitive and functional status testing.

Some samples of tests are:

- MMSE - the Mini Mental State Examination (Folstein) measures cognition.
- TSI - Test for Severe Impairment (Cohen) measures cognitive function.
- The Clock Drawing Test (Shulman) measures cognition and cognitive change over time.

Behavior monitoring can be achieved through observing and recording the person's response in certain situations and using the patient record for a historical perspective on behaviors.

If the bathing method established is accepted by the individual it should be documented so that other caregivers will follow the same routine. If unaccepted, then further exploration into other methods would be necessary until a bathing process is found which is accepted by the individual. Again, documentation will ensure that the accepted practice is continued by other caregivers (See Appendix A: "Bathing Option Decision Tree" in the original guideline document).

The management of behavior associated with bathing starts with assessing why the negative behavior occurs. Monitoring what happens at the onset to the end of the bathing process and each step in between will give the caregiver helpful clues into preventing what could become a catastrophic situation.

In assessing the factors which may trigger a negative response, caregivers can consider environmental stimuli as well. Institutional bathing rooms do not, for the most part, present familiar memories for the individual as they are a long way from representing a residential or homelike atmosphere (See "Environmental Considerations" section below).

Caregiver approach is perhaps the one area that can have the most impact on the individual's response to the bathing process. A caregiver attuned to assessing the individual's response to each action and having the flexibility and understanding to deflect escalating negative responses will allow the individual to remain in control and the bathing process to remain therapeutic (See "Caregiver Approach" below).

### **Description of the Practice**

Although bathing is done mainly for personal hygiene and infection control, pleasure derived through relaxation, sensory stimulation, and a feeling of well-being should also be accompanying goals (See Appendix B: "Personal Hygiene Standards" in the original guideline document). Success in meeting these goals is achieved one step at a time.

The following considerations before beginning the bath will set the stage for success:

- Speaking in terms of "personal hygiene" rather than "bathing" when establishing care plans refocuses the goal to that of addressing cleanliness and odor (Sloane et al., 1995) (*Evidence Grade = D*).
- When bathing is seen as a treatment it carries the same compelling necessity as a medication order. Caregivers feel pressured to carry out the order with little discretion. (Corber, Siberfeld, & Feldman, 1998; Schindel Martin, 1998) (*Evidence Grade = D*). As a result, the bathing process may continue on a regular basis without either the resident or the caregiver achieving a positive experience.
- Nursing practice rituals such as bathing need to be rethought in terms of who really benefits from this activity. The need to put the individual's needs first and adjust nursing care to them via individualized approaches cannot be over

- emphasized (Farrell Miller, 1997; Schindel Martin, 1998) (*Evidence Grade = D*).
- Only by listening to and carefully observing the individual and by speaking with family members can the individual's expectations and perceptions of bathing be appreciated (Sloane et al., 1995) (*Evidence Grade = D*).
  - By interviewing the family members and discovering the past personal habits of each individual, the nurse has a framework for how to approach the individual in terms of which bathing methods are acceptable for each person. For example, the caregiver should not expect that an elderly woman who always bathed at the sink would respond favorably to a tub or shower bath (See Appendix A: "Bathing Option Decision Tree" in the original guideline document) (Dunn, Thiru-Chelvam, & Beck, 2002) (*Evidence Grade = C*).
  - Individualized bathing care plans should be developed from the perspective of the person to be bathed, including goals for the bath, outcomes to achieve, and background information which may provide extra help in achieving the goals (Hoeffler et al., 1997; Winslow and Jacobson, 1997) (*Evidence Grade = D*).
  - Goals can be developed in relation to identifying the specific function the bath is to serve, the frequency needed, and what form can be used to achieve that function (Hoeffler et al., 1997) (*Evidence Grade = C*).
  - In considering form, look beyond a tub or shower to include the possibility of a bed bath. In a recent study, bed bath variations resulted in 49.8% lower frequency of agitated behaviors and less discomfort than tub or shower. The bed bath also showed reduction in behaviors regardless of degree of cognition and physical mobility (Dunn, Thiru-Chelvam, & Beck, 2002) (*Evidence Grade = C*). (See Appendix D: "Procedure for Thermal Bathing Method" in the original guideline document).

### **Why Reactions Occur**

- Bathing involves multiple stressors, and persons with dementia have a decreased threshold for tolerating stress in their environment (Kovach & Meyer-Arnold, 1997; Schindel Martin, 1998) (*Evidence Grade = D*).
- Being undressed and washed by a stranger may be a humiliating, frightening, and potentially traumatic experience (Corber, Siberfeld & Feldman, 1998; Schindel Martin, 1998) (*Evidence Grade = D*).
- Showering an individual with dementia was the activity of daily living most likely to provoke patient-to-staff physical aggression (Farrell Miller, 1997) (*Evidence Grade = C*).
- Disruptive behaviors are normal responses to (Corber, Siberfeld, & Feldman, 1998; Hoeffler et al., 1997; Kovach and Meyer-Arnold 1997; Sloane et al., 1995; Winslow and Jacobson, 1997). (*Evidence Grade = D*):
  - Perceived threats
  - Unfamiliar activities
  - The presence of strangers
  - Unpleasant sensations - cold, pain
  - Fear of catching cold
  - Feeling confused, dominated, insulted
  - Misinterpretation as a sexual assault
  - Impaired ability to recognize staff as being helpful, not harmful
  - Unwanted touch or invasion of personal space
  - Frustration from declining abilities

- Anticipation of pain
- Perceived loss of control
- Lack of attention to personal needs

### **Caregiver Approach**

Many caregivers possess intuitive skills with which to assist in understanding and caring for persons with dementia. There are, however, many skills that can be learned by staff motivated to providing quality care to all individuals who may require assistance in performing activities of daily living.

- Shifting the caregiver's perspective from task focused to person focused is one way to change the psychosocial environment under which successful bathing process can occur (Hoeffler et al., 1997; Schindel, 1998) (*Evidence Grade = C*).
- Understanding the individual and their behavior is crucial for staff to be able to provide safe care and prevent aggression (Farrell Miller, 1997; Hoeffler et al., 1997) (*Evidence Grade = C*).
- Knowledgeable caregivers will preserve the dignity of the individual by (Farrell Miller, 1997; Kovach & Meyer-Arnold, 1997; Sloane et al, 1995) (*Evidence Grade = D*):
  - Giving choices
  - Knowing personal preferences (i.e., time, day, type of bath)
  - Allowing for privacy
  - Providing same gender caregiver if possible
  - Keeping directions simple, one step, to reduce the amount of stimuli
  - Adjusting their schedule to the individual
  - Giving adequate time for the bath so the person does not feel hurried
  - Encouraging use of the person's abilities whenever possible
- Knowledgeable caregivers need to display the following skills (Sloane et al., 1995; Schindel Martin, 1998) (*Evidence Grade = D*):
  - Patience
  - Flexibility
  - Sensitivity
  - Gentleness
  - Creativity
  - A genuine interest in older persons

### **Preparation for the Bath**

Time spent preparing both the individual and the environment for the bathing process could have a very positive effect on the final outcome (See Appendix C: "Helpful Communication Techniques" in the original guideline document).

- Create a list of reasons the caregivers can use to explain to the individual why they should bathe. For example, the following are a few "approach" techniques to use in gaining the person's cooperation:
  - Preparing for the day
  - A special occasion
  - To get ready for a meal--breakfast, lunch
  - They have worked hard and need to "freshen up"

(Dougherty & Long, 2003; Schindel Martin, 1998). (*Evidence Grade = D*).

- Use persuasion, not coercion. Do not pressure the person. This will increase agitation. Allow the person to remain in control (Sloane et al., 1995; Schindel Martin, 1998) (*Evidence Grade = D*).
- If undressing in either the bedroom or the bathroom and resistance occurs, give the person a reason to remove their clothes (e.g., laundry day today) (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- Ensure privacy by closing the door and not undressing until absolutely necessary (Mickus et al., 2002) (*Evidence Grade = C*).
- Avoid a series of distasteful tasks in succession. If undressing agitates, bathe in the morning when one only needs to remove pajamas or nightgown, or undress only a little at a time, such as keeping the shirt on while washing the legs, covering the lower body when removing trousers (Sloane et al., 1995; Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- Always try to minimize the time the person is unclothed (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- How the person is transported to the bathing area is also important. A negative response here will set the tone for the rest of the bathing process. If transporting in a shower chair is uncomfortable, use a wheelchair or, if able, allow to walk. Make sure the patient is kept warm and well covered on the way to the bathing area. (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- Be sure the bathing area is prepared before the individual arrives. Keep everything warm, including the room, water, towels, and blankets (Dougherty & Long, 2003; Schindel Martin, 1998; Winslow & Jacobson, 1997) (*Evidence Grade = D*).
- If the sound of running water causes agitation, fill the tub before the person enters the room. (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- The person's perceptions are always valid--cold is cold, pain is pain. Stay attuned to responses and validate their experiences (Sloane et al., 1995; Schindel Martin, 1998) (*Evidence Grade = D*).
- Help the individual understand by
  - Reminding
  - Redirecting
  - Making eye contact
  - Using comforting words, touch
  - Negotiating/Offering rewards

(Corber, Siberfeld, & Feldman, 1998; Farrell Miller, 1997) (*Evidence Grade = D*).

- If it is determined that bathing causes or increases pain, appropriate medications to control that pain should be given 30 to 40 minutes before the bath begins (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- Stretch and stimulation of muscles can trigger a response often interpreted by the caregiver as resistance. Slow and steady movement can sometimes overcome this problem (Schindel Martin, 1998) (*Evidence Grade = D*).
- Try bubble bath or colored water for those who may fear water or cannot visualize water in the tub (Hall & Buckwalter, 1995) (*Evidence Grade = D*).

## **The Bath**

Whether it is performed in a tub, a shower, at a sink, or in bed, there are a number of principles and guidelines to follow in each situation for the process to be pleasant and therapeutic.

- Literature indicates that rushed, task orientated behavior by the caregiver was associated with agitated behavior by the individual. Avoid rushing. Use persuasion and allow the person to feel they are in control. Encourage participation whenever possible (Schindel Martin, 1998; Winslow & Jacobson, 1997) (*Evidence Grade = D*).
- Speaking in a low pleasant voice, giving information before and all through the bathing process is a strategy that can help to keep the person calm and in control. Give repeated reassurance that the person is safe and not alone (Mickus et al., 2002) (*Evidence Grade = C*).
- Calm behaviors from the individual have been shown to be the result of engaged verbal communication from the caregiver (Kovach & Meyer-Arnold, 1997) (*Evidence Grade = C*). If agitation occurs, use distraction, bring up a pleasant topic (Mickus et al., 2002) (*Evidence Grade = C*) or use other distraction such as music, singing, holding an object, or eating (Dougherty & Long, 2003) (*Evidence Grade = D*).
- Involve the individuals by having them feel the temperature of the water before getting into the tub or shower (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- Focus on an awareness of how the person is responding, including if the timing of the bath was appropriate (Mickus, et al., 2002) (*Evidence Grade = C*). Concentrate on the person's feelings and reactions. Pay attention and don't converse with others, listen to the radio or daydream (Sloane, et al., 1995) (*Evidence Grade = D*). In addition, watch for warning signs. Stay alert to nonverbal behaviors such as facial expressions, mood, or raising fists (Dunn, Thiru-Chelvam, & Beck, 2002; Farrell Miller, 1997) (*Evidence Grade = C*). If agitation escalates, modify the plan and give a partial bath or delay hygiene altogether. There is always tomorrow (Kovach & Meyer-Arnold, 1997) (*Evidence Grade = C*). Always acknowledge the person's request to stop (Schindel Martin, 1998) (*Evidence Grade = D*).
- Use "rescuing" if necessary to reduce agitation. A negative response to one caregiver can be "solved" by the second caregiver. However, two people should not bathe different parts of the person. Keep stimulation singular and focused. (Kovach & Meyer-Arnold, 1997) (*Evidence Grade = C*).
- Resistance may be due to anxiety, trouble initiating or coordinating movements or both, fear of falling, or physical pain. When moving into tub or shower, break the steps into small simple directions. Accompany verbal prompting with touch--a gentle pressure on the leg that should move first or behind the knees to sit (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
- Recognize and validate expressions of pain. Pain could be due to arthritis or other physical problems (Winslow & Jacobson, 1997) (*Evidence Grade = D*). Painful feet should be handled gently and tender areas of the body patted dry, not rubbed. A thin towel or Q-tip can be used to dry between toes (Hall & Buckwalter, 1995) (*Evidence Grade = D*). When pain cannot be successfully treated to withstand movement into the tub or shower, the person should be bathed in bed (Hall & Buckwalter, 1995) (*Evidence Grade = D*). (See Appendices D and E, "Procedure for Thermal Bathing Method" and "Towel or Bed Baths" in the original guideline document).
- If washing the hair during the bath creates a negative response, try some alternatives. Use a soapy washcloth and tilt the head back, always keeping

- the soap out of the eyes. Wet hair can be very cold. Try washing hair last and cover immediately with a towel. Hair can also be done at a separate time with an inflatable basin in bed or non-rinse shampoos which are rubbed in and towel dried (Hall & Buckwalter, 1995) (*Evidence Grade = D*). A visit to the beauty parlor can elicit pleasant memories for some elderly ladies (Sloane et al., 1995) (*Evidence Grade = D*).
- To reduce the incidence of screaming, try reducing the stimulation, such as one caregiver instead of several, move slowly, and minimize glare and noise. Try calm music; pleasing aroma, food, conversation or song, neck or shoulder massage are also useful (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
  - Aggressive behaviors such as hitting punching and shoving can often be prevented if the early signs of agitation are observed and the caregiver backs off for a few minutes until the person calms. If it appears the person will become violent call the person's name sternly and give immediate verbal feedback to stop. Gentle restraint such as holding a hand firmly may be necessary (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
  - If an individual grabs at objects or people, distraction is often an effective technique. Give an object to hold, a towel or bath toy. Grabbing during transfer usually indicates a fear of falling. Constant reassurance is necessary. Guide the person's hand to the grab bar or edge of tub (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
  - Individuals who are at risk for biting should have dentures removed if this is possible. Caregivers need to be aware of the person's mouth and keep a distance. If biting occurs during a transfer, caregiver could wear a jacket. Offer something to keep in the mouth. Gum, cookies or other food works, or try having them sing (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
  - Toilet the person before the bath so that accidents of incontinence do not create a problem. If bowel incontinence does occur, remove the person, clean the area, and resume bathing (Hall & Buckwalter, 1995) (*Evidence Grade = D*).
  - If there is a compelling health concern and the person is agitated, use several staff to restrict movement gently but firmly while one person provides constant reassurance and emotional support. Keep eye contact and use soothing speech. Wash only what is necessary and keep actions very brief (Schindel Martin, 1998; Sloane et al., 1995) (*Evidence Grade = D*).

### **After the Bath**

The process of bathing a person with dementia is many faceted. There are multiple issues going on at any one time and many considerations for the caregiver to pay attention to.

- Sometimes it is impossible to eliminate all negative behaviors. Sometimes a reduction is only what can be achieved. No solution works all the time. The caregiver needs to reevaluate moment to moment (Sloane et al., 1995) (*Evidence Grade = D*).
- When bathing is stressful, discussion and evaluation are required at report and care planning sessions. The health care team should "brainstorm" to explore every avenue for possible solutions to problems encountered while bathing (Schindel Martin, 1998) (*Evidence Grade = D*) (See Appendix A in the original guideline document).

Remember to celebrate small successes and share every little intervention with the team. It may mean the difference between the next caregiver providing a pleasant event or eliciting a catastrophic reaction from the individual.

### **Environmental Considerations**

In attempting to manage negative behaviors associated with the bathing process, the actual room in which this activity occurs plays a major role in the outcome and plan of interventions.

In older facilities the challenge is to make the bathing room a place that does not contribute to negative behaviors by alarming the individual who may interpret a large, sterile, cavernous room as threatening. How often do these rooms become the resting place of used or unused lifts, commodes, wheelchairs, linen hampers, and boxes of supplies or boxes of personal items waiting for disposal? With a little creativity and planning even an older facility can have a home-like, pleasing environment for the person being bathed as well as for the person giving the bath.

Because of the frailties and physical limitations of individuals requiring care, the tubs and accompanying bathing equipment required for facilities does not resemble anything the person would remember from their past. However, much can be done so that this equipment does not become the focal point of the room.

The following considerations can be used as a starting point in making any bathing room both functional and visually pleasing.

- Try to find another location for extra supplies/equipment, which find their way into the space, or, if unable to relocate, hide it behind a screen or colorful curtain. Add extra cupboards if the area is large enough (Schindel Martin, 1998) (*Evidence Grade = D*). A shelving unit with baskets for personal toiletries or bathing supplies is pleasing to the eye and adds interest and organization to the area (Brawley, 2002) (*Evidence Grade = D*).
- Look at the room from the other person's point of view. What is the first thing they see when entering the room? What do they see when they enter or leave the tub? the shower? Here's where creativity takes over. Hang colorful posters or prints where they would get noticed. Shelves with items such as decorative bottles, shells, or ceramic fish are easy to install and do not need to be expensive. Add colorful towels hanging on decorative rods (Calkins, 2002) (*Evidence grade = D*). (Sew in place if there is a possibility that someone may use them by mistake). Paint a large mural or ivy on the walls accented with hanging baskets of greenery or flowers (Calkins, 2002; Furrow, 1996) (*Evidence Grade = D*).
- Lighting is important. It needs to be sufficient enough for the caregiver but also subdued enough not to startle the person being bathed. Lights shining off ceramic tiles cause a glare that is distressing to the person with dementia. Cove lighting is good for this area as it reflects toward the ceiling, or try wall sconces (Calkins, 2002) (*Evidence Grade = D*). Either way, have lights on dimmer switches so that it can be adjusted to the individual need (Calkins, 2002; Furrow, 1996) (*Evidence Grade = D*).
- The hard surfaces of tiled walls and floors cause echoes and can make any noise overwhelming. This is why it is important to limit the number of people

- coming in and out of the bathing area by removing excess equipment. Fabric will absorb sound. Use it generously for curtaining off bathing and showering areas and any windows in the room (Brawley, 2002; Calkins, 2002) (*Evidence Grade = D*). Vinyl wallpaper in pretty patterns will also absorb sound and create visual interest. Add it to the top half of the area around the tub and surrounding walls. Water resistant acoustic panels can also cover walls as well as ceilings and can be made as decorative as desired (Brawley, 2002; Calkins, 2002) (*Evidence Grade = D*).
- Eliminate offensive smells by making sure that soiled clothing is removed immediately. Clean hampers and floors where odor may linger with disinfectants regularly and thoroughly. Some odors can be masked by the use of scented sprays or electronic dispensers (Calkins, 2002) (*Evidence Grade = D*).
  - Flooring needs to be examined from the aspects of cold and safety when wet. Floors should have a high coefficient of friction to be considered safe. Washable non-slip rugs are considerations if one is stepping out of tub or shower (Calkins, 2002) (*Evidence Grade = D*).
  - Commercial towel warmers come in a variety of sizes. When choosing the appropriate size, consider needing a good supply if a number of baths are done in succession. Also consider if there is a need to have the larger bath blankets warming as well (Brawley, 2002; Furrow, 1996) (*Evidence Grade = D*).
  - Stable grab bars are of prime importance where individuals who require assistance are moving into tub or shower. It is important that they be very visible and strategically placed for safety (Brawley, 2002; Calkins, 2002) (*Evidence Grade = D*).
  - Wet skin feels cold and therefore the room needs to be maintained at a higher temperature than other areas the individual may frequent. Some bathing rooms, because of the manner in which the facility was constructed may not have separate controls for adjusting the heat. A heat lamp on a timer or radiant heat panels can usually be permanently mounted to any room to supply an extra source of heat (Brawley, 2002; Calkins, 2002; Furrow, 1996) (*Evidence Grade = D*).
  - Hand held showers are easier to control and more versatile than wall mounted. They can usually be attached to a bracket to use in the traditional way if the person is more independent (Brawley, 2002) (*Evidence Grade = D*).
  - A seating area with a vanity can also be both a focal point and a "finishing" spot. A table with a makeup mirror can be set up off the bathing area and will add to the hominess of the room as well as serve to help individuals complete their appearance after the bath (Brawley, 2002) (*Evidence Grade = D*).
  - Tubs come in a wide variety of types in relation to their specific functions. Side entry, end entry, and those requiring specialized lifts are all available with a range of other functions such as water capacity, pre-fill features, manual versus digital controls, disinfecting systems, sitting or recumbent styles, and whirlpool systems. How the individual with dementia enters the tub is the most important considerations when choosing a tub. Those systems where the person has to be raised a considerable height showed to cause the largest degree of negative behaviors (Namazi & Johnson, 1996) (*Evidence Grade = C*).

**Definitions:**

## **Evidence Grading**

- A. Evidence from well-designed meta-analysis
- B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention, or treatment)
- C. Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results
- D. Evidence from expert opinion or multiple case reports

## **CLINICAL ALGORITHM(S)**

An algorithm is provided in the original guideline document for Bathing Option Decision Tree.

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **REFERENCES SUPPORTING THE RECOMMENDATIONS**

[References open in a new window](#)

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

- Decreased frequency and severity of negative bathing episodes in patients with chronic dementing illness
- Enhanced therapeutic effects of bathing (e.g., personal hygiene; pleasure derived through relaxation, sensory stimulation; a feeling of well-being)

### **POTENTIAL HARMS**

Not stated

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

This evidence-based practice is a general guideline. Patient care continues to require individualization based on patient needs and requests.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The "Evaluation of Process and Outcomes" section and the appendices of the original document contain a complete description of implementation strategies.

### IMPLEMENTATION TOOLS

Audit Criteria/Indicators  
Chart Documentation/Checklists/Forms  
Clinical Algorithm  
Resources  
Staff Training/Competency Material

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Thiru-Chelvam B. Bathing persons with dementia. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2004. 37 p. [22 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1996 (revised 2004)

### GUIDELINE DEVELOPER(S)

University of Iowa Gerontological Nursing Interventions Research Center,  
Research Translation and Dissemination Core - Academic Institution

### **SOURCE(S) OF FUNDING**

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### **GUIDELINE COMMITTEE**

Not stated

### **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Authors:* Brenda Thiru-Chelvam, RN

*Series Editor:* Marita G. Titler, PhD, RN, FAAN

### **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

### **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Gerontological Nursing Interventions Research Center (University of Iowa), Research Development and Dissemination Core. Bathing persons with dementia. Iowa City (IA): University of Iowa; 1998 Apr. 17 p. (Research-based protocol; no. 1998).

### **GUIDELINE AVAILABILITY**

Electronic copies: Not available at this time.

Print copies: Available from the University of Iowa Gerontological Nursing Interventions Research Center, Department of Nursing-RDDC, 4118 Westlawn, Iowa City, IA 52242-1100. For more information, please see the [University of Iowa Gerontological Nursing Interventions Research Center Web site](#).

### **AVAILABILITY OF COMPANION DOCUMENTS**

The original guideline document and its appendices include a variety of implementation tools, including outcome and process indicators, staff competency material, and other forms.

### **PATIENT RESOURCES**

None available

## **NGC STATUS**

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