

## ORIGINAL ARTICLE

# Bed bath with soap and water or disposable wet wipes: Patients' experiences and preferences

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## Abstract

**Aims and objectives:** To gain an in-depth understanding of patients' preferences regarding two bed bath methods: soap and water and disposable wet wipes.

**Background:** Bed baths allow hospitalised, bedridden patients to stay clean and fresh. They serve a number of purposes: health promotion, social propriety and pure pleasure. Traditionally, soap and water have been used for personal hygiene, but in recent years soap and water have increasingly been replaced by the use of disposable wet wipes.

**Design:** A qualitative study with a hermeneutical-phenomenological approach was chosen to explore and understand patients' experiences of bed bath methods.

**Methods:** Semi-structured, individual, in-depth interviews with 16 bedridden patients from three wards were conducted. The software program NVIVO was used to structure the transcribed interviews and assist in the initial data analysis. The data were analysed and interpreted within a phenomenological-hermeneutical framework. COREQ guidelines were used in the preparation of this paper (See Supporting information Appendix S1).

**Results:** Four overall themes were identified: "Creating a sense of cleanliness," "Preferences and concerns in different situations," "Cleanliness of hands and face" and "Clinical decision-making about bed bath method."

**Conclusions:** Overall, patients' bed bath preference was for soap and water, but disposable wet wipes were considered a convenient alternative and preferred in certain circumstances, for example, when a patient had pain or diarrhoea. Shared decision-making regarding bed bath method is recommended. Hands and face had specific requirements.

**Relevance to clinical practice:** Nursing staff should be aware that bedridden patients have varying preferences, and it is important to incorporate the patients' preferences in the development of standards, health policies and clinical guidelines for bed bath practices.

## KEYWORDS

bedridden, disposable wipes, hermeneutic, patient experience, personal hygiene, phenomenology, qualitative interviews

## 1 | INTRODUCTION

Nursing staff provides bed baths for hospitalised, bedridden patients to maintain personal hygiene. Bed baths serve a number of purposes: health promotion, social propriety and pure pleasure (Lentz, 2003; Möller & Magalhães, 2015; Shoonhoven et al., 2014). Furthermore, bed baths are regarded as necessary procedures to improve patients' quality of life, social acceptance and well-being (Ahluwalia, Gill, Baker, & Fried, 2010; Downey & Lloyd, 2008; Lentz, 2003; Sheppard, 2000).

Traditional bed baths with soap and water (SAW) are now increasingly replaced with bed baths using disposable wet wipes (DWW) (Groven, Zwakhalen, Odekerken-Schröder, Joosten, & Hamers, 2017; Ogai et al., 2017; Shoonhoven et al., 2014). The prepacked and heated DWW was introduced in nursing practice in 1994 in the USA (Skewes, 1994). A report showed that 71% of bed baths used SAW use and 12% DWW without disinfectants (Coyer, O'sullivan, & Cadman, 2011).

The increased use of DWW for bed baths in Denmark during the past 10–15 years follows the international tendency (Hørdam et al., 2017; Nøddeskou, Hemmingsen, & Hørdam, 2014).

In Danish hospital wards, bed baths are provided to approximately 15% of somatic patients (Nøddeskou et al., 2014). Estimated by number of hospitalised patients' and bed days, this corresponds to approximately 600,000 bed baths per year provided annually to hospitalised patients (Statbank Denmark, 2017).

## 2 | BACKGROUND

The provision of hygiene care to patients is a core nursing task (Groven et al., 2017) and is offered on almost all hospital wards (Collins & Hampton, 2003a, 2003b; Sheppard, 2000; Shoonhoven et al., 2014). Bathing has been regarded as a ritualistic pleasure and, in recent times, a necessary therapeutic daily procedure (Sheppard, 2000). In addition, personal hygiene is considered one of our basic needs (Orem, 2001). Bed baths allow bedridden patients to stay clean and fresh. The primary goals of bathing are to maintain hygiene, and to leave patients feeling refreshed, and comfortable. There are other benefits as bathing can remove sweat, oil, dirt and microbes from the skin, decrease body odour and stimulate circulation. In addition, bathing may also reduce the risk of infections (Lentz, 2003; Sheppard, 2000; Skewes, 1994). It has been reported that up to 10% of all admitted Danish patients will get a nosocomial infection (Central Enhed for Infektionshygiejne, 2018). Nosocomial infections are associated with higher mortality rates and represent an economic burden on the healthcare system (Stone, Braccia, & Larson, 2005). Other benefits include the ability to induce comfort, relaxation and reduce pyrexia. In addition, bathing allows nursing staff to assess the patient's skin for integrity and pressure sores (Coyer et al., 2011).

Bathing with SAW can have a direct impact on the epidermis, by posing a number of threats to the integrity and barrier function

### What does this paper contribute to the wider global clinical community?

- This paper provides insights into and deeper knowledge about hospitalised, bedridden patients' preferences for bed bath methods.
- The general preference was for soap and water, but disposable wipes were considered convenient and were preferred in certain circumstances.
- The results can enhance nursing staff's focus on the inclusion of patients' experiences and preferences in nursing care

of the skin. Soap can affect the resident flora and natural lipids and can change skin acidity. Furthermore, it may interfere with the water-holding capacity of the skin and can have a thinning effect on the outermost layers of epidermis and the stratum corneum (Collins & Hampton, 2003a; Massa, 2010; Voegeli, 2008). The use of SAW and subsequent drying with a towel can have a disruptive effect on the skin barrier and tentative evidence shows that a high frequency of bed baths with SAW is associated with an increased risk of skin damage (Voegeli, 2008). It is necessary to remove excess body secretions, but preferably without drying out the skin. Intact skin serves a vital role in maintaining the body's first line of defence against invading microbes (Collins & Hampton, 2003a). Dry skin is also prone to cracks, which could lead to infections and pressure sores (Beeckman et al., 2010; Hampton, 2011). Basins for water used for bed bathing can be a reservoir for bacteria, if not properly cleaned after use, and may be a source of cross-contamination between patients (Greaves, 1985; Johnson, Lineweaver, & Maze, 2009; Marchaim et al., 2012). Furthermore, rubbing the skin during bathing may release skin flora into the basin, which may become a source of cross-contamination between different areas of the patient's body.

DWW may offer many advantages for patients, including a lower risk for cross-contamination, because of limited contact with different body parts, and avoidance of having to use a basin (Collins & Hampton, 2003a; Lentz, 2003; Wright, 1996).

DWW may also leave the patient's skin soft and better moisturised (Sheppard, 2000; Skewes, 1994; Wright, 1996). Furthermore, compared to SAW, DWW seem to enhance the skin barrier function, reduce the risk of skin impairment, reduce dermatitis and pressure ulcers (Beeckman, Verhaeghe, Defloor, Shoonhoven, & Vanderwee, 2011; Hodgkinson & Nay, 2005; Kron-Chalupa, Benda, & Williams, 2006; Lentz, 2003; Massa, 2010; Shoonhoven et al., 2014). However, in an experimental setup, no significant differences in skin physiology were found between washing with SAW and DWW (Ogai et al., 2017).

Additionally there are studies, which support the idea that DWW are easy to use and a valuable alternative to SAW (Groven et al., 2017; Hørdam et al., 2017; Nøddeskou et al., 2014, 2018;

Sheppard, 2000; Shoonhoven et al., 2014; Wright, 1996). A Dutch study even showed that some patients would prefer to exchange washing with SAW for washing with DWW on a permanent basis (Shoonhoven et al., 2014). DWW might help support independence and studies have described that patients like the fact that each wipe only comes in contact with one part of the body (Skewes, 1994; Wright, 1996).

A cluster randomized study (Shoonhoven et al., 2014) of 500 nursing homes residents showed that most of the residents felt refreshed and clean after washing without water. Secondary analysis of the same data found that patients also seemed to receive a more thorough bathing with DWW compared with SAW (Achterberg et al., 2016).

Furthermore, the use of DWW seems to reduce staff time and save costs (Collins & Hampton, 2003a; Larson et al., 2004; Lentz, 2003; Nøddeskou et al., 2014, 2018).

Despite the increasing use of DWW, no in-depth qualitative studies that explored the patient's experiences regarding the two bed bath methods has been identified. The patients' perspective from quantitative studies may not nuance the patients' individual perspective (Groven et al., 2017; Hancock, Bowman, & Prater, 2000; Hørdam et al., 2017; Nøddeskou et al., 2014, 2018; Sheppard, 2000; Skewes, 1994).

Thus, the objective of this study was, through in-depth qualitative interviews, to explore and nuance hospitalised, bedridden patients' experiences of, satisfaction with and preferences for either SAW or DWW bed baths.

### 3 | METHOD

We conducted a qualitative interview study based on a hermeneutical-phenomenological approach to analyse and interpreting patients' experiences of bed baths with SAW and DWW. Hermeneutic phenomenology is a qualitative research methodology which can be used to understand how individuals experience a common phenomenon (Zahavi, 2003) and is suitable to describe an unexplored phenomenon (Kvale & Brinkmann, 2009; Patton, 2002). The approach was used in the formulation of the research questions, to develop a semi-structured interview guide, the probing questions used during the interviews and in the first step of the analysis. The interviews were intended to create an understanding of a phenomenon from the interviewed person's perspective, to unfold the meaning and importance of their experiences with the intention of setting aside the interviewer's preconceptions (Kvale & Brinkmann, 2009; Patton, 2002). Semi-structured, individual, in-depth interviews allow the interviewer to delve deeply into personal experiences and are widely used to co-create meanings with interviewees, and to reconstruct their perceptions and experiences related to healthcare (DiCicco-Bloom & Crabtree, 2006). COREQ guidelines were used in the preparation of this paper (Tong, Sainsbury, & Craig, 2007) (See Supporting information Appendix S1).

#### 3.1 | Setting and data collection

The inclusion criteria were bedridden patients who were able to speak and understand Danish fluently, were able to understand oral and written information and, able to sign a written consent form. All participants should have experienced bed baths with DWW for a minimum of 2 days in a hospital and have previous experiences of bed baths with SAW. In this study, a bed bath was defined as staff washing the patient's body in bed (Downey & Lloyd, 2008; Shoonhoven et al., 2014). Eligible patients were identified according to the inclusion criteria by the nurse who cared for them during day shifts.

Prior to participation oral acceptance from the patients to hear more about the study was obtained by their nurse. Next, the first author offered potential participants oral and written information about the study. The readability of the written patient information and consent documents was assessed using the Gunning fog index to ensure that the readability level matched the average educational level (Hamnes, van Eijk-Hustings, & Primdahl, 2016).

To ensure heterogeneity in patient characteristics, the aim was to apply a sampling strategy with maximum variation (Patton, 2002). Specified characteristics of potential participants were used in a matrix for participant inclusion, to allow for the selection of a variety of participants (Wacherhausen, 1996). The characteristics included sex, age, occupational background, cohabitation status, ward, length of admission, diagnosis, bariatric information, skin issues, stoma and information regarding use of urinary catheter and diaper. In this study, bariatric information was noted if the nursing staff assessed that the patient required bariatric equipment.

A semi-structured interview guide was developed. The interview guide contained thematic dimensions related to the research question, for example, bed bath with DWW, and a dynamic dimension, expressed in everyday language, for example, "Can you describe how you were washed this morning?" (Kvale & Brinkmann, 2009). The interview guide was developed based on the interviewer's previous experience, conceptual and theoretical knowledge and familiarity with the topic (Larson et al., 2004; Pedersen, Delmar, Falkmer, & Grønkjær, 2015; Sheppard, 2000). The questions were kept brief and easy to understand. Academic concepts were avoided to promote a positive interaction, to optimise conversation flow and to encourage the participants to talk about their experiences (Kvale & Brinkmann, 2009). All interviews were planned to last maximum 1 hr and were digitally recorded and transcribed verbatim by the interviewer. The interviews were conducted in separate consultation rooms in the ward or at the bedside and by the first author across all interviews. The length of each interview was noted.

Participants were included until no new information appeared in three consecutive interviews, in order to achieve data saturation (Francis et al., 2010; Patton, 2002).

#### 3.2 | Data analysis

The transcribed interview became the basis for the analysis and a hermeneutic interpretation (Gadamer, 2004). NVivo version: 11.4.3

was used to structure the data, ensure a systematic analysis, help reinforce completeness and allow flexibility in the analytical process (DiCicco-Bloom & Crabtree, 2006). Through an initial inductive analysis, themes regarding the specific phenomenon were developed (Kvale & Brinkmann, 2009).

A five-step coding method was employed (Kvale & Brinkmann, 2009).

The first step was to read all interview transcriptions in order to achieve an overall sense of the interviews. The second step was an open initial coding, where natural meaning units, as expressed by the participants, were identified. The third step was a thematic description of the initial natural meaning units, as they were understood by the interviewer. During a second reading, new units and concepts, which were not previously captured, were added to the themes.

Through an axial reading of the interviews, the fourth step was to link the initial themes between the transcripts. The fifth and final step was to condense the initial themes into more overall themes (Kvale & Brinkmann, 2009).

The hermeneutic approach (Gadamer, 2004) formed the descriptions from the analysis and addressed the identified overall themes in three interpretational contexts described as self-understanding, critical common sense understanding and theoretical understanding (Kvale & Brinkmann, 2009). Self-understanding expresses the participant's experience in the transcribed interviews as rephrased and condensed statements. In the critical common sense understanding, the interpretation goes beyond the rephrased and condensed themes while remaining within the context of common sense. This context provided a wider understanding, including general knowledge, which amplified and enriched the condensed statements (Kvale & Brinkmann, 2009).

Some of the patients' self-understanding and critical common sense understanding are presented as findings in the results section.

Interpretation in the third context, "theoretical understanding" goes beyond the participants' experiences of bed baths. The findings are discussed with relevant literature in the Discussion section.

### 3.3 | Ethical considerations

This study followed the recommendations given in the Ethical guidelines for nursing research in the Nordic countries, published by the Northern Nurses' Federation (Vård I Norden, 2003). Furthermore, the study followed guidelines developed by the World Medical Association and implemented by the National Ethics Committee (World Medical Association, 2001). The local Scientific Ethics Committee found that formal ethical registration and approval were not required (The Local scientific Ethics Committee of Southern Denmark, 2011). The head physicians in the three participating clinics approved the study and formal permission to store the data was obtained by the Danish Data Protection Agency (Danish Data Protection Agency, 2015) (J.No.18/35356). Written consent to participate was obtained.

## 4 | RESULTS

Sixteen in-depth, individual, semi-structured interviews were conducted, from October 2016–May 2017, with bedridden patients in three different wards at one Danish hospital. Five men and eleven women, with a mean age of 67 (range from 43–81) were included. Participants characteristics are summarised in Table 1. Two participants who met the inclusion criteria declined participation.

The interviews were conducted during admission. The mean length of stay before participation was 8 days (range: 2–35 days). The interviews lasted between 17–41 min (mean: 23 min). Seven of the participants had a cohabitant status and nine were single. Ten were retired, but five of these still had a link to their work. Three of the patients were assessed as bariatric patients' by the nursing staff.

In general, the participants reported that when they were at home, taking a shower was the overall preferred method for personal hygiene, and the participants normally took a shower almost every day. This information was expressed in an unsolicited manner by the patients. Cleanliness was considered absolute necessary and personal hygiene was essential for well-being and self-esteem. Furthermore, many were concerned about odour and expressed that it was extremely important to smell nice. Otherwise, they would feel disgusting and be ashamed.

The analysis derived at four essential themes: "Creating a sense of cleanliness," "Preferences in different situations," "Cleanliness of hands and face" and "Clinical decision-making about bed bath." The participants are referred to by a numbering (P1–P16).

### 4.1 | Creating a sense of cleanliness

The participants strongly expressed a general preference for the use of SAW for personal hygiene, if given a choice. They highlighted and reaffirmed a belief that the use of SAW made them feel cleaner and fresher than the use of DWW, but they did not know if this was actually true that SAW did clean better. SAW was described as the type of bath that removes bacteria, dirt and sweat from the skin much

**TABLE 1** Characteristics of the participants

Patient characteristic matrix	
Ward	Surgical 8 Medical 4 Emergency 4
Occupational background	Health professional 5 Communication 2 Vocational 9
Diagnosis	Infection 4 Chronic diseases 7 Elucidation 5
Other variables	Stoma 5 Diaper 10 Urinary catheter 9

more effectively than DWW. They characterised the effect of SAW as being “really washed,” and one participant noted that if SAW were left out, it would be unhygienic. SAW helps you feel “really” clean and some participants believed that SAW removed more dirt and was more thorough and hygienic than DWW. The following participants discussed reasons for their preferences for SAW.

Then I would take soap and water... I just think that it's the best, but why, I don't know... again I think that I am cleaner. (P7)

I feel that I am cleaner that way (with SAW), I mean, bacteria have to be removed as much as possible ... because, in any case, you cannot go around being crusty. (P12)

The participants also discussed social reasons for their beliefs and that bathing with SAW was a part of growing up, traditions in childhood and habits. Because of that, they did not question the assumption that bathing with SAW removed dirt, bacteria and provide a feeling of cleanliness. However, it was difficult for the participants to explain and find the right words for their beliefs.

It's a cleaning process – I mean, you get oil off your skin. Maybe it's mostly in your mind, I don't know – it's just that you've always done it like that. It's a tradition you could say. (P 5)

## 4.2 | Preferences and concerns in different situations

Several advantages of using DWW were expressed, which included independence and self-care for bedridden or disabled. Participants described the quality of the wipes and how fast and easy they were to use. The wipes were characterised as big, soft, moist and pleasant, compared to a washing cloth used with SAW.

I think they (DWW) are soft and they are moist and they are not so big, you can do it yourself, I'm so plagued with rheumatism all over, so I can, like, I can hardly move this arm anymore – but I just think they are so good – they work so well for me. The first time they opened one up and I had to use it myself ... then I thought, no it's moist, and it's not that big and so soft, and that, I could sort of notice that I felt washed. I think I could really feel that. (P15)

It was convenient and faster to use the wipes if they had pain or diarrhoea, because it would take a longer time to bathe with SAW and it required multiple actions. One had to wash with soap, rinse with water and dry all parts of the body with a towel. In contrast to this, DWW required only one action.

Yes, yesterday I was washed with soap and water, and I think that it was actually very uncomfortable. I had so much pain and she keep saying that I should do it myself and I just couldn't and then she came up with the solution soap and water – you simply cannot dry off like you can with the (DWW) – and it should be dried and it should ... there you would want her to use DWW. (P4)

Washing with DWW was described as a way to freshen up, but if the participants were visibly dirty with sweat, dirt and emanated an odour, they did not feel they were clean or smelled clean after using the wipes. Some participants even expressed very clearly that they did not like to be washed with DWW.

I think they (DWW) are great for freshening up – like now, for example, let's say you have just come from surgery and you wake up and you need to be refreshed a little before bedtime on your forearms – I think they are quite good – but I don't like to be washed with them. (P10)

Other participants discussed the difference between “freshening up” and being “really washed.” They described their concerns and doubts about cleanliness. Being washed with DWW was definitely preferred to no bathing, but was judged to be the second choice, after SAW.

Yes that's it, and if you just have to freshen up or that, they're fine. Well, it (soap) doesn't wash you any better, but I think it's like I haven't been washed (with DWW), I don't think so – I don't feel that with the wipes. It's better than nothing, of course – so you are freshened up. (P 8)

In contrast, other participants felt clean and appreciated the advantages by using DWW as an alternative washing method.

No, I actually think I feel pretty clean (with DWW). (P9)

You feel you're clean and, really, I don't have anything against it. (P 12)

Other concerns about DWW were expressed. Some of the participants described that it was as if the DWW left a layer on the skin, which they expressed as “oily or a film.” After using DWW for several consecutive days, they also described that the skin turned dry and scaly. In addition, other participants described redness, skin irritation and itchiness of the skin, which were linked to recent skin problems, such as eczema or flaking skin.

It's as if the skin can't really get air, or... But, I just think there's just, like, a film, over it. (P 11)

Bed baths with DWW did not necessarily include subsequent drying off with a towel. Participants described the moist feeling left on the skin after a bath with DWW. It took time to dry and they expressed having the sensation of moist skin for a long time, compared to the use of SAW. Some did not like to have wet skin for long time, and in addition, this was associated with feelings of not being clean.

I think, like those wipes, (the skin) is not dry straight away, but with soap and water, if you use a towel, you know ... (the skin) it's like it's damp. (P16)

However, other participants expressed great satisfaction with DWW, including benefits to skin integrity, softness and the fact that they did not need to apply lotion after washing.

The skin is also dry (after using soap) and then you have to use body lotion ... and I don't think you feel that with the wipes, it's not at all the same, it's (the skin) softer. (P 4)

Both preheated and cold DWW had some advantages for those who had experienced them. Preheated DWW were considered to be very nice, especially if the participants were cold in bed. Other participants appreciated the coolness because it was comfortable on their warm skin, if it was hot from fever or if they felt sweaty.

It was really lovely. I don't know if they heat them in the microwave ... It was great – I didn't realize that it could be done ... (P 3)

#### 4.3 | Cleanliness of hands and face

All participants who mentioned the face and hands pointed out that their needs and preferences for these two body parts were different from the rest of the body. They described the need to use SAW as extremely important when it came to the hands. They wanted their hands to be "really clean," because hands touch everything in the environment and are used to put food into the mouth. Furthermore, the participants expressed that the use of SAW helped them feel "really" clean.

Yes, I don't know, it could be that it's the habit, again – I don't know, I feel I'm cleaner when I stand and rub myself with soap, and ... It's important, because you are putting things in your mouth, aren't you, and it (the hands) has to be clean, so, yes that's an important factor. (P 12)

Soap and water is number one, yes ... you can't explain it... I don't know, it (SAW) might be cleaner – I don't know ... more comes off, and it's cleaner than with wipes, to get them (my hands) clean and it's more hygienic too... (P13)

Furthermore, the participants pointed out the need to wash their hands with SAW at least once a day and always after using the toilet.

No, I want to go and wash my hands at the sink once a day. (P 8)

In addition, other participants expressed concerns about the use of DWW for handwashing. The expressed film was also left on the hands and described by one participant as "clammy."

Yes, and I feel as well that there is a sort of a film after (using the DWW) ... a layer – on the fingers, again it's that soap, that doesn't get washed off, you know... (P10)

Some of the participants did not like their face to be washed with DWW because the skin felt strange afterwards. The feeling in the face was described as "tight" and that it felt like it needed to be moisturised after washing. They also pointed out that facial skin is different to the rest of the body. They did not want soap in their face, either, and preferred water only or other personal cleaning agents, such as oil or cleansing fluid.

Yes, I also tried them (DWW) ... I don't like them on my face. (P 3)

But I've been washed with them (DWW). I feel it on my face today ... It's as if the skin needs to get, like, moisture. (P4)

I don't use soap on my face ... I use cleansing cream. (P5)

In contrast, other participants did not mind using DWW on their face and said it was good enough and that you felt freshened up. They stated that they felt that something was done to feel fresh and washed.

It's fine – the only thing is, when washing your face ... just like, you know, when you're on a plane you get those wipes ... they're refreshing ... but they ensure you're at least, you feel at least that you've done something. (P 4)

#### 4.4 | Clinical decision-making about bed bath method

Some participants expressed that the opportunity to have a bed bath and to maintain personal hygiene was more important to them than whether it was performed with SAW or DWW.

I don't really have an opinion on that – when you are sick it doesn't matter a damn, so it's all the same – just as long as you are washed. (P 1)



In contrast, other participants discussed concerns about the clinical decision regarding the type of bath, in relation to the actual situation and condition of the individual patient. They expressed the importance and complexity in the choice of bathing method, depending on whether they were bedridden, had pain, the length of stay and how it fitted the situation. Some of the participants even discussed economic issues, and which method they believed was most cost-effective. The participants also pointed out that it was faster for the staff to use DWW.

So, it was the wet wipes – the other is too hard to use. I think if they (the patients) are out in the bathroom, it's going to be soap and water. It depends on the situation, of course. (P12)

Participants expressed that the decision regarding type of bath should be taken by the nursing staff and should be related to the workload and clustering of other care activities on the ward. They expressed strong acceptance of the nursing staff's decisions and that the nursing staff did it in their own way and decided what they found suitable in the situation. The participants were not always offered a choice. Some participants did not want to be asked at all, because they did not think it was possible to choose SAW while they were bedridden. Other participants discussed whether the nursing staff should ask at all, because the patients experienced bustle on the ward, while other participants would like the nursing staff to ask for their bed bath preferences before their daily hygiene routine, if possible.

No (I don't want to be asked) and it's also easier for the staff (pointing to the DWW). So, I assume they use (SAW) when I can sit up ... and when I'm in bed, they use a wet wipe. (P4)

When you are lying in bed, you can't use soap and water. (P9)

Yes, I think so – you should be allowed to choose for yourself. (P10)

No they just wash me ... no, it's all the same, I take it as it comes ... I'm very satisfied with that. (P7)

It doesn't matter, they have their own ways – they just do whatever works for them. (P 1)

## 5 | DISCUSSION

This study aimed to gain an in-depth understanding about patients' preferences regarding two types of bed bath, the use of SAW and DWW. The participants strongly preferred SAW for personal hygiene, a preference that they stated was linked to traditions held

since childhood. However, this finding cannot be taken in isolation, because many of the same participants also described washing with DWW as a chance to freshen up and that this type of washing was convenient and preferred in specific situations. They expressed that the face and hands needed special attention and that neither soap nor DWW belonged on the face. While some thought it was acceptable to use DWW on the face, and handwashing was overwhelming linked to SAW. Despite these findings, many participants also pointed out that the type of bath was less important than the overall need to be washed. Furthermore, the participants expressed different attitudes regarding their bed bath preferences, which reflected the individual value they placed on personal hygiene during admission.

Another important advantage related to DWW was that they promote independence, as patients could wash themselves despite their disabilities, and thus they were convenient and could be used independently of the nursing staff's priorities on the ward.

Nearly, all the participants showered almost every day at home and the findings in this study illuminated that taking a shower was the overall preferred method of maintaining personal hygiene. This is in the line with another study, which showed that 90% of adults take a shower minimum twice a week (Sheppard, 2000). All participants compared their experiences of the two types of bed baths with taking a shower, and they would definitely choose a shower during admission, if it was possible.

Other studies also reported that patients were more significantly positive and satisfied after showers, compared with after bed baths, and that a bed bath is not experienced as being equal to a shower (Hancock et al., 2000; Lopes, Nogueira-Martins, & de Barros, 2013).

The participants described washing as a mandatory daily necessity, which had an impact on integrity, self-image, personality and well-being. This is consistent with other studies, in which bathing is described as an important and meaningful activity. It is a means to becoming clean, it is related to notions of well-being and virtue (Ahluwalia et al., 2010; Downey & Lloyd, 2008) and it is considered important for the self-image (Massa, 2010). The importance of bathing is instilled during childhood, and sociocultural factors, such as cultural beliefs and family practices, influence hygienic care (Collins & Hampton, 2003b). Furthermore, it seems that, in Western societies, there is a stigma attached to uncleanness and odour and there is a social expectation that one bathe (Ahluwalia et al., 2010). This could explain why the participants expressed that they felt ashamed and disgusting because of odour, if they did not wash every day during admission.

Overall, the participants did not always experience cleanliness after washing with DWW, and they described DWW as leaving a layer on the skin. The consequences for the patients could be an uncomfortable feeling of not being clean in the same way as they were used to, and especially if they used DWW several days in a row. This has also been elaborated by others, including that most people can become distressed if they cannot keep as clean as they are used to, and running water is generally believed to be the most effective cleansing agent (Collins & Hampton, 2003a). Contrary to

our findings, other studies have found that the patients felt clean using DWW (Kron-Chalupa et al., 2006; Sheppard, 2000) and would trade SAW for DWW (Groven et al., 2017; Shoonhoven et al., 2014).

Participants in our study preferred SAW, and in general, they considered that this method really leaves one clean. This is in line with a recent study, which also found that patients tend to prefer SAW (Nøddeskou et al., 2018). In addition, participants in our study specifically wanted SAW for handwashing. This has not been identified in other studies.

Contrary to these findings, some quantitative studies concluded that DWW was predominantly preferred by the patients (Kron-Chalupa et al., 2006; Nøddeskou et al., 2014; Sheppard, 2000; Shoonhoven et al., 2014).

Some participants in the current study discussed DWW as a fast and easy type of bath, which can be less burdensome if they had pain or diarrhoea and was considered to be a convenient way to freshen up. Other studies support that DWW for bed bath is time-saving, easy and less distressing for the patients, compared to the use of SAW (Hørdam et al., 2017; Kron-Chalupa et al., 2006; Lentz, 2003; Nøddeskou et al., 2014; Sheppard, 2000).

The nursing staff did not always ask for patients' preferences regarding bed bath method and the majority of the participants felt that the nursing staff should make the decision about the type of bath. The decision should follow their workload and other care activities.

This is in accordance with a review, which concluded that the important stakeholder with regard to the clinical decision is the nursing staff, and that they often decide the type of bath without shared decision-making with the patients (Groven et al., 2017).

The findings in our study indicate that many patients accept this, as they see that the nursing staff are busy, and that it is faster to use DWW.

There may be different values and preferences according to the type of bath between the patients and the nursing staff. In a descriptive study of bed bath practices, nurses report that other factors such as no policy, lack of knowledge and workload affect their decisions (El-Soussi & Asfour, 2016). Because of this, the patients who want to have influence on the choice of bed bath method should be given the opportunity to choose bed bath as a shared decision, where special concerns such as pain (Möller & Magalhães, 2015), and requirements for hands and face can be taken into consideration. This is supported by the Danish home care study, which found that patients want to have the choice of type of bath (Hørdam et al., 2017).

## 5.1 | Methodological strengths and limitations

Sixteen participants were included in this study. The recommended sample size in qualitative research is between 6–12 interviews (Onwuegbuzie & Leech, 2007; Patton, 2002), but according to Patton, there are no rules for sample size in a qualitative enquiry.

We aimed to achieve data saturation (Francis et al., 2010), indicated by three consecutive interviews in which no new additional

information appeared. This was evident after 16 interviews and contributed to validation of the final sample size.

In small studies, heterogeneity can be a problem. Maximum variation was aimed for, because it can turn that weakness into a strength, by capturing in-depth, detailed information simultaneously with emerging patterns across cases (Patton, 2002). The inclusion from three different wards contributed to the heterogeneity, as did the other chosen variables. Fluent Danish as inclusion criteria might exclude ethnic minorities whose opinions could be vastly different.

Although the interviews were conducted during the patients' present admission, their experiences might be mixed with experiences from other admissions and private use of SAW and DWW. This study was related to a specific brand of DWW, which was used on all the wards at the hospital. Other brands may feel different, because of different ingredients and textures of the wipes. The included patients could have experience of different brands of DWW and may not be able to separate their experiences.

In addition, nursing staff will probably have different experiences of, attitudes towards, and preferences relating to DWW, which can influence how they perform the two types of bed bath and thus have an impact on the patients' experiences.

A patient's planned discharge and length of stay could also influence their experiences. One might be more indifferent to the type of bath and whether one is involved in the decision, if discharged was planned the day after the interview, or if the patient was hospitalised for a long time. On the other hand, the patients could be more negative towards DWW if they did not know their discharge date and thereby did not know how soon they would be able to take a shower or bath at home with SAW.

Given that the interviews were conducted on the wards and that the interviewer's uniform was similar to those worn by the nursing staff, the participants might have been reluctant to express all of their opinions. The patients could feel caught in a loyalty dilemma, together with the fact that they were asked about nursing care on which they were dependent. This could have influenced the participants' opinions—although the interviewer's independent status on the ward was pointed out at the beginning of all the interviews. The interviewer's female nursing background and previous work with intimate hygiene from a philosophical perspective may have influenced the findings, and other researchers may analyse and interpret the data differently.

## 6 | CONCLUSION

Personal hygiene was an unavoidable task during admission, and maintaining personal hygiene was linked to traditions held since childhood. Shower would be the patients' first choice if not bedridden.

In general, the preference for bed bath type was the use of SAW, but DWW was considered to be a convenient and preferred method in specific situations, for example when the patient was in pain, suffering from diarrhoea or if the patients wanted to freshen



up or get washed quickly and easily. Washing the face was special and pure water was preferred. Contrary to this, the patients felt that the hands needed to be washed by the use of SAW and at least once a day.

Nursing staff should incorporate patients' preferences of shared decision regarding choice of bed bath method when possible and if the patients want this.

The findings addresses some of the patients' experiences but indicate a need for additional research about nurses' preferences, which could also include studies of other bed bath methods and a cost-effectiveness comparison of the two types of bed bath.

## 7 | RELEVANCE TO CLINICAL PRACTICE

The findings should remind nursing staff to acknowledge and include patients' experiences and preferences in shared decisions about the appropriate type of bed bath for hospitalised, bedridden patients. The findings are relevant for the future development of guidelines for clinical nursing.

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### CONFLICTS OF INTEREST

None.

### AUTHOR CONTRIBUTION

PLV gathered all the data in the study and takes full responsibility for the integrity of the data and the accuracy of the initial data analysis. PLV, CSJ, JS, MC and JP contributed to the study design, analysis, interpretation and drafting the manuscript, revision, review and final approval of the manuscript.

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## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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