Applying a Warm Compress or Soak

Purpose

The purposes of this procedure are to ease the body of pain caused by inflammation and congestion, to aid in the treatment of the resident's condition, to promote drainage in infections, to improve circulation and to apply heat to an area.

Preparation

1. Verify that there is a physician's order for this procedure.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.

General Guidelines

1. Be sure that the resident is in a safe and comfortable position to prevent falls and/or accidents.
2. Avoid spilling warm water on the resident, bed and the floor.
3. Check the resident's skin often for redness or discoloration.
4. Should you observe any of the above conditions, cease the treatment, cover the resident and summon the Staff/Charge Nurse at once.
5. Listen to the resident's complaints. Report them to the Staff/Charge Nurse.
6. Should you have reason to believe that the resident is being burned from the application, cease the procedure, cover the resident, and summon the Staff/Charge Nurse.
7. Unless otherwise instructed, do not apply a warm compress to a resident who is a diabetic or has circulatory impairments.

Equipment and Supplies

The following equipment and supplies will be necessary when applying a **warm soak**:

1. Soak basin (arm or foot, as indicated);
2. Pitcher of warm water (105°F);
3. Bath thermometer;
4. Bath towel;
5. Bath blanket;
6. Bed protector (disposable or plastic); and
7. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

The following equipment and supplies will be necessary when applying a **warm compress**:

1. Basin;
2. Compress (towel, wash cloth, or gauze pad);
3. Pitcher of warm water (115°F);
4. Bath thermometer;
5. Bath towel;
6. Bath blanket;
7. Bed protector (disposable or plastic); and
8. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

1. Wash your hands thoroughly before beginning the procedure.
2. Assist the resident into a safe, comfortable position.

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Steps in the Procedure (continued)

3. **If applying a warm soak**:
   a. Position the soak basin so that the limb can rest easily in the solution.
   b. Place the bed protector under the part of the body that will be treated with the warm application. (**Note**: If using a plastic sheet or pad, keep the plastic from touching the resident's skin.)
   c. Fill the water pitcher with warm water (105°F).
   d. Fill the soak basin until it is one-half full of warm water.
   e. Gradually place the resident's arm or leg into the warm solution.
   f. Change the water as often as necessary to keep it warm. Pour used water down the commode. Flush the commode.
   g. When changing soak water, remove the limb being treated. Wrap it in a towel to keep it warm.
   h. Unless otherwise instructed, check the skin of the limb being soaked every five (5) minutes. (**Note**: If the skin appears to be reddened or discolored, cease the treatment. Cover the area with a towel. Summon the Staff/Charge Nurse.)
   i. Should the resident become weak or complain of being cold, cease the treatment, cover the resident with a blanket and summon the Staff/Charge Nurse.
   j. Unless otherwise instructed, soak the limb for twenty (20) minutes.
4. If applying a warm compress:
   a. Expose the area to be treated. Avoid unnecessary exposure.
   b. Place the bed protector under the part of the body that will be treated with the warm application. (**Note**: If using a plastic sheet or pad, keep the plastic from touching the resident's skin.)
   c. Fill the pitcher with warm water (115°F). Check the water temperature with the bath thermometer.
   d. Pour the water into the basin.
   e. Dip the compress (towel, wash cloth, or gauze pad) into the water and wring it out thoroughly.
   f. Gently apply the compress to the area to be treated. Avoid spilling water on the resident.
   g. Wrap the entire area with the bath towel.
   h. Wrap the plastic sheet around the towel and compress. (**Note**: Keep the plastic from touching the resident's skin.)
   i. If the resident complains of being cold or chilled, cease the procedure, cover the resident with a blanket, and summon the Staff/Charge Nurse.
   j. Change the compress as often as necessary to keep the application warm.
   k. Unless otherwise instructed, check the skin under the application every five (5) minutes. (**Note**: If the skin appears red, remove the compress. Cover the area with a towel. Summon the Staff/Charge Nurse.)
   l. Unless otherwise instructed apply the warm compress for twenty (20) minutes.
5. After the treatment has been completed, pat the area dry with a towel. Do not rub the skin.
6. Reposition the bed covers. Make the resident comfortable.
7. Place the call light within easy reach of the resident.
8. Discard soiled towels and linen into the soiled laundry container. Red bag as necessary.
9. Discard all disposables into designated containers.
10. Pour liquids down the commode. Flush the commode.
11. Wash and rinse the basin. If stored in the resident's room, store in the proper place.
12. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them they may now enter the room.

Wash and dry your hands thoroughly.

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Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that the procedure was performed.
2. The name and title of the individual(s) who performed the procedure.
3. The type of treatment administered (soak or compress).
4. The condition of the resident's skin.
5. If and how the resident participated in the procedure.
6. All assessment data obtained during the procedure.
7. How the resident tolerated the procedure.
8. If the resident refused the procedure, the reason(s) why and the intervention taken.
9. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the care.
2. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (RAPs)	J(2); I(1)(l); M(5)(i)
Survey Tag Numbers	n/a
Related Documents	
Risk of Exposure	Blood–Body Fluids–Infectious Diseases
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____