Worcestershire Acute Hospitals NHS Trust

# Guidelines for the Care of the Skin in Relation to Tissue Viability

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

## Introduction

This guideline outlines the recommendations to assess and manage skin care in relation to Tissue Viability for people in all age groups.

## This guideline is for use by the following staff groups:

All clinical staff within Trust

### Lead Clinician(s)

Claire Hughes — Lead Tissue Viability Nurse

Approved by Fundamentals of Care Committee on: 19th August 2025

Review Date: 19th August 2028

This is the most current document and is to be used until a revised version is available

### Key amendments to this guideline

| Date | Amendment | Approved By: |
|---|---|---|
| August 2017 | Document extended for 6 months as per TMC paper approved 22nd July 2015 | TMC |
| December 2017 | Sentence added in at the request of the Coroner | |
| December 2017 | Document extended for 3 months as per TLG recommendation | TLG |
| March 2018 | Document extended for 3 months as approved by TLG | TLG |
| June 2018 | Document extended for 3 months as per TLG recommendation | TLG |
| April 2019 | Document extended for 6 months whilst review process is completed | Lisa Hill |
| March 2020 | Document extended for 3 months whilst review is completed | Lisa Hill |
| June 2020 | Document extended for 6 months during COVID period | |
| 22nd Jan 2021 | Document extended for 6 months whilst thorough review takes place | Lisa Hill |
| January 2023 | Document extended for 6 months whilst review process is completed | Claire Hughes |
| Jan 25 | Document extended for 3 months | Claire Hughes/Alison Robinson |
| August 2025 | Document reviewed and approved at Fundamentals of Care Committee | Fundamentals of Care Committee |

## CONTENTS

## 1. Introduction

The skin is the largest organ of the body and accounts for 15% of body weight (Wingerd, 2013 cited by Wounds UK 2018). The primary function of healthy skin is to act as a barrier against chemical, physical and mechanical hazards, and invasion from micro-organisms and allergens (Proksch et al, 2008 cited by wounds UK 2018).
The skin consists of three main layers: the epidermis, the dermis and the subcutaneous layer (Figure 1).

■ The epidermis is the outermost layer of the skin, which provides a waterproof barrier
■ The dermis is beneath the epidermis. It has a rich blood supply and contains tough connective tissue, hair follicles, sweat glands and sensory nerve endings
■ The deeper subcutaneous tissue (hypodermis) is made of fat and connective tissue

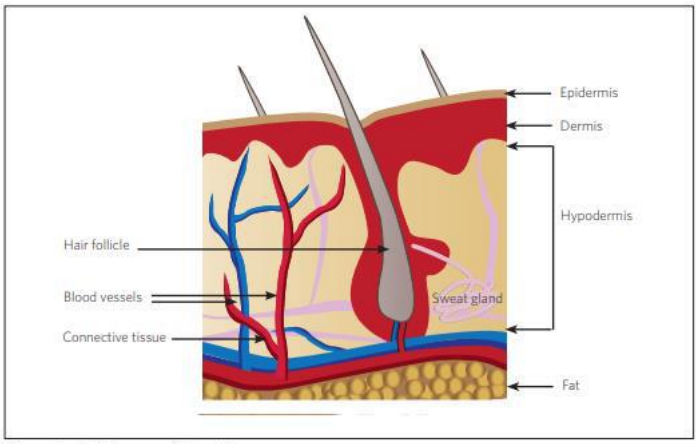



Figure 1: Main layers of the skin

Wounds UK (2018) Best Practice Statement Maintaining skin integrity. London: Wounds UK. Available to download from: www.wounds-uk.com

### Combined, these three layers of tissue perform the following functions:

■ **Protection**: the skin acts as a protective barrier, preventing damage to internal tissues from trauma, ultraviolet (UV) light, temperature, toxins and pathogens and allergens (Butcher and White, 2005 cited by Wounds uk 2018).
■ **Barrier to infection**: part of this function consists of the physical barrier of intact skin; the other is the presence of sebum, natural antibiotic chemicals in the epidermis (antimicrobial peptides) and a well-preserved surface acidic environment (Günnewicht and Dunford, 2004 cited by Wounds uk 2018).
■ **Sensory perception**: nerve endings within the skin respond to painful stimuli. Other sensory modalities, such as temperature, vibration, touch and itch are also important
■ **Temperature regulation**: the rich blood supply can serve as a 'heat dump' to enable body cooling, along with eccrine sweat roles. Similarly, surface vascular plexus can be restricted to conserve heat; hairs also play a role here, standing on end in the cold. The subcutaneous fat also acts as a heat source, as well as heat insulation (Timmons, 2006 cited by Wounds uk 2018).
■ **Production of vitamin D in response to sunlight**: this is important in bone development (Butcher and White, 2005 cited by Wounds uk 2018).
■ **Production of melanin**: this is responsible for skin colouring and protection from sunlight radiation damage
■ **Communication,** through touch and physical appearance: this gives clues to the individual's state of physical wellbeing (Flanagan and Fletcher, 2003 cited by Wounds uk 2018).

In healthy individuals, the skin is strong, resilient and has a remarkable capacity for repair. As we age, structural and functional skin changes occur leading to the loss of our skins ability to carry out these functions and act as a barrier, maintain homeostasis and thermoregulation. Older skin is subject to drying due to co-morbidities, drinking less and reduced mobility generally. This renders the skin vulnerable to infection or wounding resulting from trauma, such as a knock or bump, or from sustained unrelieved pressure over bony prominences, shear and friction. Acute illness, high temperatures consequent to fevers and moisture from diaphoresis and incontinence can add to the vulnerability of aging skin. Therefore, it is vitally important that nurses know the condition of your patient's skin and to monitor for skin changes.

Our skin plays an important part in our life: it protects our organs and muscles. This is why it's so vital to keep an eye on skin integrity. Skin integrity means the health of our skin. Maintaining skin integrity is important for everyone, however bedridden and elderly people have a higher chance of developing skin problems. To prevent these, regular skin assessment and skincare is advised (Vilmos dermo 2021) Compromised skin integrity is associated with complications such as pressure ulcers, moisture lesions, skin tears, and infections, which can lead to pain, reduced mobility, poor quality of life, further health complications and increased healthcare costs (Moncrieff et al, 2013).

## Common skin conditions

- In the course of any day nurses come across a variety of skin conditions in their patients. These may include:
- Irritant reactions to stoma appliances and other dressing adhesives;
- Generalised rashes from latex allergies.
- Blisters (or bullae) due to dressing adhesives, fixation tapes or disease processes such as diabetes.
- Eczema associated with dermatitis and venous stasis disease.
- Hyperkeratosis (thick scaly skin) often seen in patients with lymphoedema, venous stasis disease or disease specific neuropathies and associated altered gait.
- Paper thin skin and purpura due to long term steroid or anticoagulation therapies.
- Dehydrated skin due to acute illness or nutritional compromise generally; and
- Excoriated skin conditions from prolonged exposure to moisture, urine and faeces or acidic effluent e.g. incontinence, leaking Supra Pubic Catheters (SPCs), high output stomas, Percutaneous Endoscopic Gastrostomy (PEG)tubes and other drains; and enterocutaneous fistulae.

Such conditions place the individual at a high risk for compromised skin integrity and subsequent infection making assessment even more important. (Fraser 2023)

Care of the skin is of prime importance when caring for any patient. If skin is compromised, it can have a dramatic effect on a person's well being. Regular re-assessment of the patients' skin and documentation of the findings forms an essential part of their holistic care.

A proactive approach needs to be taken to protect skin and prevent damage (including hospital-acquired damage), and for patients, families and carers to benefit from education that allows them to help maintain skin integrity. It is particularly important that multidisciplinary teams combine the skills of dermatology and tissue viability nurses. Wounds UK (2018)

Daily skin care routines are fundamental aspects of clinical nursing practice. Providing skin care, including skin cleansing and application of leave-on products have substantial impact on the prevention and treatment of a number of skin conditions skin protection helps to

prevent and treat incontinence-associated dermatitis, and the application of leave-on products treats dry skin and prevents skin tears.(Fastener et al 2023)

## 2. Purpose of this Guideline

This policy provides guidance on the prevention, identification, and management of Tissue Viability skin-related issues, for adult inpatients, in the Acute hospital setting. This policy excludes dermatological skin conditions /issues. The policy focuses on maintaining skin integrity, preventing skin breakdown, and promoting optimal skin health for all patients during their hospitalization within the Acute Trust

## 3. Scope

This guideline applies to all clinical and support staff involved in adult patient care across all departments and wards in the assessment, prevention and management of skin care in relation to tissue viability. It is designed to ensure patients skin is assessed and preventative strategies are implemented.
This guideline outlines the recommendations to assess and manage skin care in relation to Tissue Viability for people in adult age groups. The guideline is to be used by all staff employed by Worcester Acute Hospital Trust (WAHT) in the assessment and management of skin care in relation to Tissue Viability.

### 3.1 Objectives

1. To ensure all patients receive appropriate skin care to preserve skin integrity.

2. To give assurance for the prevention of skin breakdown, Moisture Associated Skin Damage (MASD), Incontinence Associated Dermatitis (IAD) Non incontinence Dermatitis (Non IAD) and other related skin conditions.

3. To provide consistent guidelines/pathways for identifying patients at risk and implementing early intervention.

4. To ensure continuous education and awareness for staff regarding skin health. 5. To support staff with involvement of patients and their family or care givers in their care through education. This will empower individuals to become involved in their care and help them to look after their skin once discharged. (Fraser 2023)

### 3.2 Responsibilities

**Clinical Staff** (Doctors, Nurses, Allied Health, Health Care Assistants)**:**

- Conduct daily skin assessments, especially for patients with risk factors.
- 
- Implement and document appropriate interventions to maintain skin health.
- Educate patients and families on skin care and hygiene practices.
- Ensure timely reporting and documentation of any skin concerns or breakdowns.

**Ward Managers/Supervisors:**

- Support staff in the implementation of this policy and ensure adequate resources availability.
- Monitor compliance through audits and regular skin care assessments.
- Allow staff to attend ongoing education and training to clinical staff on implemented skin care products /pathways.

**Tissue Viability Nurse Specialists:**

- Provide expertise on complex cases involving skin and tissue integrity issues based on evidence based current evidence based ,best practice.
- Support staff with tailored care plans for patients with existing skin problems.
- Advise on referrals to further Multidisciplinary Team (MDT) members and Dermatology speciality Teams for further input/ treatment /diagnosis advise for skin conditions.

## 4. Training

Clinical Staff (Doctors, Nurses, Allied Health,) Health care Assistants (HCAs) and supervised Student Nurses who can demonstrate practical competence in skin assessment in relation to Tissue Viability (TV). Referral to a dietician, physiotherapist and occupational therapist will provide interdisciplinary management ensuring the best possible outcome for the patient.

Internal Educational programmes are available. This forms part of the individual's healthcare workers overall professional development to keep up to date with best practices and addresses deficits in their knowledge and practice. Magwenya, R, Ross, A (2022)

## 5. Skin Assessment and Documentation

### 5.1 Skin Assessment

A comprehensive skin assessment is essential to detecting early signs of skin breakdown to protect our patients from harm and ensuring they receive prompt treatment for identified problems. In the healthcare setting, a comprehensive skin assessment is a process in which the entire skin of a patient is examined for abnormalities. It requires looking at and touching the skin from head to toe, with a particular emphasis on bony prominences and skin folds. Comprehensive skin assessment is repeated on a regular basis to determine whether changes in the skin's condition have occurred. The goal of a skin assessment is to identify problem areas promptly for treatment and prevention. (Morgan, N.2025) Conduct a systematic, head-to-toe assessment, Check skin folds, between fingers and toes, and under and around medical devices for skin integrity

### 5.2 Assessment of Skin Integrity:

**The signs alerting damage presence include:**

- persistent erythema (reddening)
- non-blanching hyperaemia (capillaries do not empty and refill)
- blisters (superficial)
- localised heat (warm to touch)
- localised oedema (swelling)
- Induration (hardness)
- purplish/bluish localised areas in those with dark skin

### 5.3 Skin assessment Under / around devices:

Inspect the skin under and around medical devices (e.g. Oxygen masks, tubing, splints, casts, braces, compression stockings, urinary catheters & assistive technology) at least daily for signs of injury on the surrounding tissue documenting on Electronic Patient Records (EPR) skin bundle in addition to any specific device care plans:

- Conduct more frequent assessments in patients vulnerable to fluid shifts and in those exhibiting signs of localized or generalized oedema.
- Remember that you can combine the skin inspection with other clinical risk assessments. (Morgan, N.2025)

### 5.4 Assessment of darker skin tones

Assessment should include awareness of skin tone to monitor any changes to the patient's skin. Clinicians should be aware that skin tone is separate to ethnicity and have the confidence to talk about this in a professional way, treating the patient as an individual It is important to note that patients with all skin tones should receive an equitable level of assessment. Dark skin should not be seen as a 'challenge' in clinical practice, but assessing skin for colour so that early identification can be made of any changes or issues should be a routine part of care for every patient The senses – especially touch – should be considered as part of skin inspection and assessment

Recognising reddened areas of the skin is a significant factor in identifying the earliest signs of pressure damage and is an indication that further action and preventative nursing care is required. Bennett (1995) cited by Wounds UK (2021) recommended that in dark pigmented skin tones you must assess:

- Whether the colour of intact skin may remain unchanged when pressure is applied,
- Localised skin colour changes can occur where pressure is applied,
- Areas of intact skin subject to pressure may feel either warm or cool when touched,
- Healed previous pressure damage may be lighter in colour,
- The skin may be purplish/bluish/violet in colour,
- There may be localised oedema, causing taut, shiny skin,
- Patients/carers may indicate pain or discomfort at body sites.
- The skin tone tool (adapted from Ho & Robinson, 2015 cited Wounds UK 2021) is a validated classification tool that shows a range of skin tones [Figure 1] so that the tone can be selected that most closely matches the patient's inside upper arm. The skin tone tool has been found to be a simple and economical way of assessing skin tone and can be used across care settings.

The Munsell colour chart – provides a more objective measurement of skin tone which can improve pressure ulcer risk assessment (Bates-Jensen et al., 2016 cited by Wounds UK 2021)

The skin tone tool should be used to record baseline skin tone for monitoring purposes

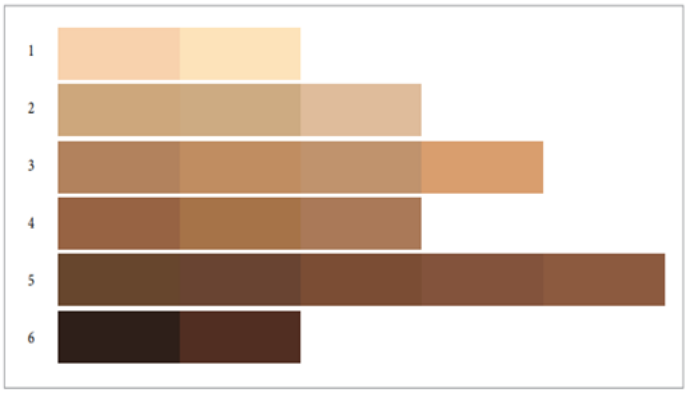



*Figure 1. Skin tone tool (adapted from Ho and Robinson, 2015)*

Validated skin tone tool (adapted from Ho & Robinson 2015, from Wounds UK (2021)

Where appropriate, patients should be asked to identify areas of discomfort or pain as this may be a pre cursor to tissue breakdown.

Visual skin assessment and additional details such as discomfort or pain should be documented within the Trusts (EPR) to allow monitoring of the progress of the individual and to aid effective communication between professionals. Patients unable to feel pain due to sensory loss or unable to communicate their pain should be more frequently and closely observed for early signs of damage.

## 6. Skin Integrity Assessment

Inspection should include assessment of the skin's colour, temperature, texture, moisture, integrity and include the location of any skin breakdown or wounds. As a general guide, components of assessment of the patient's skin and what to look for are outlined in table.

*Table 1: Components of skin assessment and what to look for.*

| Assessment | What to look for |
|---|---|
| Colour | What is normal for the patient?<br><br>What colours can you see e.g. red, purple, unusual pigmentation of the lower limbs and gaiter regions (brownish) or blue/grey hues of distal limbs (lower limbs and feet)?<br><br>Is there any bruising present? Or purpura? |
| Temperature | Does the skin feel cool to touch (possibly due to poor peripheral perfusion) or hot due to fever or infection? |
| Texture | Does the skin feel dry or moist, papery, thin or leathery? |
| Moisture | Is moisture due to excessive sweating, urine or leakage from a wound or drain? Is the skin becoming macerated (white appearance)? Is oedema present? |
| Integrity | Are there any broken areas? Presence of skin tears, blisters, wounds, pressure injuries or epidermal stripping due to adhesive tapes or dressings? |
| Location | If there is a failure in skin integrity identify and document the anatomical location i.e. sacrum, heels or toes, gaiter region of lower legs, dorsal/plantar surface of foot, groin or under skin folds and so on. |
| Adapted from: Holloway & Jones, 2005, p. 1175 4 | |

Skin integrity assessment is an essential part of nursing care and should be conducted on admission and at least daily depending on the individual's circumstances within currently used documentation within the Trust (EPR) skin bundle. This may be based on questioning the patient about their skin. Clearly document the on the Pressure Ulcer Risk Assessment Tool (PURAT)( Pressure Ulcer | National Wound Care Strategy Programme May, 2024) (refer to policy **WAHT-CG-087)** Skin damage that is established to be as a result of incontinence and/or moisture alone should not be recorded in the notes as a pressure ulcer but should be referred to as Moisture Association Skin Damage to distinguish, and be recorded separately. However, where this might be because of neglect or poor oversight it should be explored not ignored. Skin damage that has been determined as combined, that is, caused by both moisture and pressure, must be recorded in the notes as a pressure ulcer (DoH&SC ,2024) Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK

To identify patients at risk for skin failure, risk assessment for those admitted to hospital should be done within 6 hours of admission (Nice, 2015)
Skin assessment is to be undertaken as part of the SSKIN Bundle (on admission/ inter ward transfer/discharge and daily whilst an In Patient) and documented on the Trusts EPR skin bundle (Appendix 1)
Re-assess patient's skin on an on-going basis according to individual need and general condition change Information gathered from the skin inspection and aspects of management should be clearly documented in the patient's notes and care plan, (paper or EPR).

Skin inspection forms part of the Waterlow Pressure Ulcer Risk Assessment (PURAT) which is the chosen national validated risk assessment tool used within WAHT(Appendix 2). It is important that this risk assessment is appropriately completed for all inpatients to maintain skin integrity. Skin damage can have several causes, some relating to the individual patient who may be unwell

**Initial Assessment**: All patients should undergo a comprehensive skin assessment within 6 hrs of admission (Nice 2015), particularly focusing on identifying risk factors for skin breakdown (e.g., immobility, malnutrition, moisture exposure).
**Ongoing Assessments**: Skin assessments should be conducted at least daily, or more frequently for high-risk patients. Document all findings, including any signs of skin breakdown or pressure damage. Individuals and carers should also be encouraged to inspect the skin and take responsibility for its condition (NICE 2015).
Use appropriate PURAT tools such as the Waterlow Scale, for risk assessment in patients at risk for pressure ulcers.

To identify MASD, skin inspection is required. This is because staff must see the affected area to confirm the cause and category of skin damage. The following must be considered:

The patient should be offered a full skin inspection upon admission, whilst ensuring the patient's wishes are taken into consideration regarding gender of the staff carrying out the assessment. If this cannot be undertaken, then a clear rationale should be documented in the patient's electronic patient record.
• Skin inspection must always be document on the EPR skin bundle body map
• Skin inspection should occur regularly, and the frequency will be determined in response to changes in the patient's condition. Patients who are assessed as 'at risk' have an increased risk of developing MASD and should have ongoing reviews as part of the reassessment process. Water Low Top Tips Guide has been developed to support staff (Appendix 3).
• Patients or relatives/carers should be encouraged to participate where necessary, following appropriate information/training. Skin inspection can be undertaken during routine care, considering patient consent and should be documented in their electronic patient record and any problems acted upon. (Policy for consent to examination or treatment WHAT-CG-075)

• Skin inspection should be based on an assessment of the most vulnerable at-risk areas for each patient.

Skin inspection should occur regularly, and the frequency will be determined in response to changes in the patient's condition. Patients who are assessed as 'at risk' have an increased risk of developing MASD and should have ongoing reviews as part of the reassessment process. Water Low Top Tips Guide has been developed to support staff (Appendix 3).
• Patients or relatives/carers should be encouraged to participate where necessary, following appropriate information/training. Skin inspection can be undertaken during routine care, considering patient consent and should be documented in their electronic patient record and any problems acted upon. (Policy for consent to examination or treatment WHAT-CG-075)
• Skin inspection should be based on an assessment of the most vulnerable at-risk areas for each patient.

• Patients who decline to have a skin inspection completed should have this documented on their EPR and the risks fully explained to them. When patients continually decline consider undertaking a Mental Capacity Assessment (MCA) Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005 (policy WAHT-KD-026

## 7. Maintaining Skin Integrity

Ensuring skin is cleansed, dried thoroughly and moisturised daily will reduce the risk of excoriation and help to keep the skin in peak condition. Using non-soap cleansers with a pH close to 5.5 will help to protect the acid mantle and prevent the skin from drying out while moisturisers applied at least twice daily hydrate the skin helping to keep it in good condition If your patient is incontinent ensure their continence aid is checked , is appropriate for the patients' needs ,changed regularly and the exposed skin cleansed, carefully dried and moisturised each change to reduce the risk of moisture lesions and painful excoriation.

The use of protective skin barriers may reduce incontinent associated dermatitis. Please refer to the Moisture Associated Skin Damage Pathway. (Appendix 4,5, 6 & 7)

For patients with a high BMI be sure to pay particular attention to creases and skin fold Intertriginous dermatitis is an inflammatory skin condition commonly seen in the skinfolds of bariatric patients. It results from the weight of skin, which creates skin-on-skin contact coupled with friction forces and trapped moisture from perspiration. Dermatitis most often occurs in skinfolds behind the neck, under the arms and breasts, under the abdomen or pannus, on the side, and on the inner thigh.

Clean the patient's skin frequently with a pH-balanced cleanser Medicare Plus Skin cleanser or soap substitute emollient, using gentle strokes to avoiding harming fragile tissues. (Appendix 5 & 8) Avoid scrubbing. Handheld showers and no-rinse cleansers can simplify this process. Advise patients to wear loose-fitting clothing made of absorbent fibres.

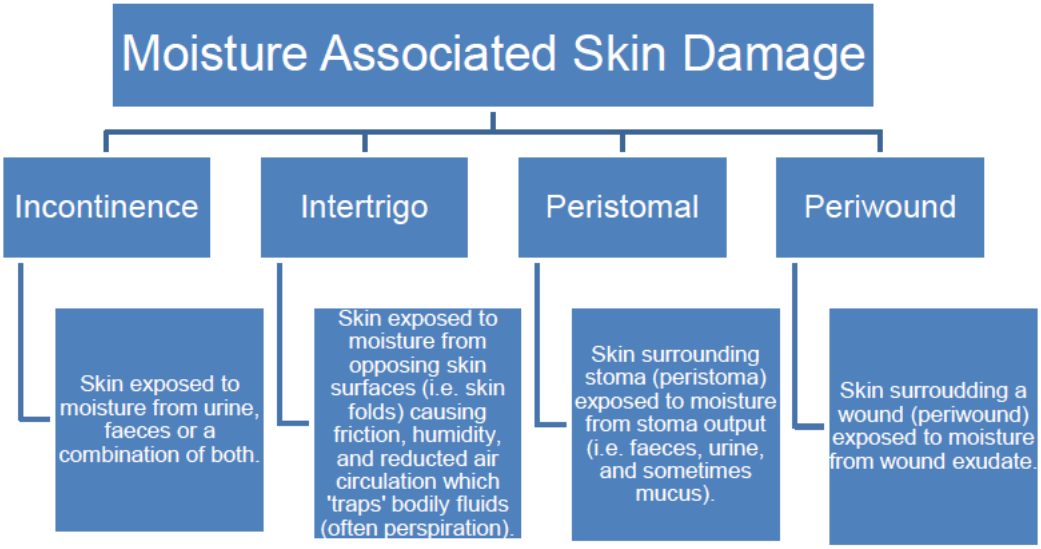
Soaps are generally alkaline having a pH of around 8 or 9.3 creating an environment for opportunistic bacterial growth which may lead to infection, especially if the skin is compromised. Be mindful of the pressure used to cleanse frail skin as this can cause skin tears and/or bruising if too much force is applied. Be mindful of frail skin avoiding firm pressure when cleansing and drying or massaging areas that could be easily damaged (Appendix 8)

Similarly high output stomas, prolonged nausea and vomiting; and diarrhoea, if excessive, will lead to dehydration, placing the person at risk for compromised skin integrity and reduce their tissue tolerance to pressure.
Perspiration and wound drainage can also make the skin more vulnerable to injury. When the skin is damaged it is more susceptible to bacterial and fungal infections. Please note that swabs or a fungal scrape may need to be taken to ascertain what bacteria/fungal infections are present so that appropriate treatment can be recommended, if necessary, this requires referral to Dermatology Specialist service.

Documentation is a key component to good communication. Document your findings and interventions in the patient's clinical notes on EPR and communicate these to your team members including nurses, doctors and allied health staff, Health Care Assistants (HCAs). (Fraser,2023)

## 8. Moisture Associated Skin Damage (MASD)

MASD is an umbrella term, underneath which sits four different causes of skin damage directly associated with prolonged exposure to moisture. The problem is always attributable to presence of moisture, but the cause varies in the source of the moisture (Young, 2017) Correct identification is integral to the implementation of appropriate management (as discussed in section 5.3




Moisture-Associated Skin Damage (MASD) can sometimes be mistaken for a Category 2 pressure ulcer, and vice versa—particularly when located on the buttocks and when risk factors such as immobility or incontinence are present.

Typically, pressure ulcers are found over bony prominences, such as the sacrum or ischial tuberosities (sitting bones), and present with a more regular shape. In contrast, MASD is more commonly located within the natal cleft (between the buttocks) and tends to have an irregular appearance, often described as a 'mirrored butterfly' shape.

Staff are reminded to refer to the Trust's Wound Assessment and the *Prevention and Management of Pressure Ulcers* guidance for detailed information on pressure ulcer categorisation. Accurate identification is essential, as it directly influences the wound management plan.

If concerns please refer to Pressure Ulcer or MASD Gudance ( Appendix 10)

MASD is not caused by pressure, however many patients will have risk factors for both MASD and pressure ulcer development. Also, if a person is experiencing MASD then prolonged pressure to the area may contribute to wound deterioration and will delay wound healing

The Skin Moisture Alert Reporting Tool (Medicare Plus, 2019 [online]), which is recognised and endorsed by NICE, 2019 [online], categorises MASD dependent on the severity of skin damage. Correct identification is integral to the implementation of appropriate management as per SMART, MASD categories are as follows:

| Category | Description |
|---|---|
| **Mild** | • Erythema to affected skin<br>• All affected skin remains intact with no open wounds, but is at risk of breaking down |
| **Moderate** | • Erythema to affected skin<br>• Less than 50% of the affected skin is 'open'<br>• Area may have some exudate and/or bleeding |
| **Severe** | • Erythema to affected skin<br>• More than 50% of the affected skin is 'open'<br>• Area is likely to have exudate and/or bleeding |

**Open wounds caused by MASD will always be superficial in depth with granular tissue to the wound bed. If the wound depth becomes full thickness, or wound develops slough and/or necrosis, this indicates another contributing factor (such as pressure) and can no longer be classed as 'only' MASD.**

The WAHT Moisture -Associated Skin Damage /Incontinence Associated Dermatitis Pathway (supported by Medicare Plus) is recognised and endorsed by NICE, 2019 [online], categorises MASD dependent on the severity of skin damage. (Appendix 5 & 6)

Following a consistent and evidence based skin care regime the risk of further injury and hospital-acquired conditions, such as infection, skin tears and pressure injuries, can be reduced Skin basics include – assessment, movement, skin care, pressure relief, nutrition and hydration, education and communication (documentation, referral and clinical handover)

In addition to the skin integrity assessment, maintaining skin integrity requires a holistic and interdisciplinary approach.

Document your findings and interventions in the patient's clinical notes on EPR and communicate these to your team members including nurses, doctors and allied health staff, Health Care Assistants (HCAs). (Fraser,2023)

### 8.1 Prevention and Management of MASD

The management of MASD will include management of the source of moisture in accordance with the cause, and the use of barrier products in accordance with the category. The management of MASD is discussed below.

It is important for staff to recognise patients who are at risk of developing MASD so that interventions can be implemented to prevent skin damage occurring. This will involve management of, and if possible, the reduction of the exposure of moisture to the skin. Some examples of patients at risk of developing MASD may include (but are not limited to):

Patients who experience incontinence
• Patients with a highly exuding wound
• Patients with areas of skin in contact with each other, i.e. skin folds, joint contractures e.g. hand contractures

• Patients having trouble with their stoma i.e. leakage from pouch

• Patients experiencing hypersalivation

Patients at risk of developing MASD must be supported to implement effective moisture management/reduction and good levels of skin hygiene.

Many barriers to healthy skin in bariatric patients can be eliminated by reducing moisture on the skin, avoiding skin-to-skin contact, minimizing heat build-up on these tissues, and keeping the skin clean. Using absorbent materials can accomplish these goals. For instance, Interdry AG® Textile (from Coloplast, Inc.) is impregnated with ionic silver, which provides broad-spectrum antibacterial and antifungal action for up to 5 days. It's designed to wick away moisture and reduce skin-to-skin friction. (Appendix 9)

Any management plan that is being implemented must be clearly documented within a patient's electronic patient record, and this management plan must be handed over to all staff involved in their care.

**It is important to acknowledge the patient's personal preferences and wishes. Wherever possible these preferences need to be considered to promote collaborative decision making, privacy and dignity, and, to prevent iatrogenic harm.**

**Further information can be obtained from the Consent to Examination or Treatment Policy, the Privacy and Dignity Policy (**WAHT-CG-433**)**

**8.2 Reporting MASD:**
All incidences of MASD must be reported via the Trust's incident reporting system and documented within the patient's electronic patient record. It must be stated whether this was present upon admission, developed whilst the patient was accessing our services, or present on transfer from another care setting i.e. acute hospital or nursing home.

All Hospital Acquired MASD incidents will be reviewed by the Tissue Viability Team, and **only** if required, the team will contact to arrange further assessment.

Patients who are experiencing MASD **do not need** an automatic referral to the Tissue Viability Team unless there are concerns or advice is required. Many cases of M<ASD are manageable at ward level when using MASD pathway for guidance purposes.

If there is an immediate concern regarding a patient who has MASD, for example a patient who has signs of systemic infection, then urgent assessment should be sought via a Medic, Tissue Viability champion for your area.


**8.3. Peristomal MASD Management**

Patients experiencing peristomal MASD must be supported to meet their stoma care needs. Staff supporting patients experiencing peristomal MASD must seek advice from specialist stoma services, to ensure appropriate stoma products are being used to reduce the moisture exposed to their skin.

**8.4 Peri wound MASD Management**

Staff supporting patients experiencing peri wound MASD must ensure an appropriate wound care plan is in place to manage wound exudate, including appropriate dressing change frequency, wound cleansing and dressing selection. Wound care advice can be found within the Tissue Viability (TV)wound management plan embedded within the TV assessment on the EPR. Guidance on dressing selection can be found within policy WAHT**-NUR-090** (Wound Assessment and management Guidelines)

## 9 Staff Education

Staff will be offered education relating to Tissue Viability & skincare and are expected to maintain evidence of their own up to date, evidence-based knowledge and skills as part of their professional registration and/or development and will be available within WAHT.

## 10 Clinical Audit

Audits around personal hygiene and MASD will be fed into the Fundamentals of Care Committee. The Acute Tissue Viability Specialist team will Monitor MASD prevalence via Datix incident reporting system and fed via monthly Tissue Viability Governance Steering Group.

## 11. Monitoring Tool

| Page/ Section of Key Document | Key control: | Checks to be carried out to confirm compliance with the policy: | How often the check will be carried out: | Responsible for carrying out the check: | Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)* | Frequency of reporting: |
|---|---|---|---|---|---|---|
| | **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| | These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe. | What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.) | Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'. | Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description? | Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference. | Use terms such as '10 times a year' instead of 'monthly'. |
| 6 | Skin assessments are undertaken against FOC Dashboard Quality App questions | Fundamentals of Crae Committee (FOCc) Exception report: FOC Dashboard Quality app | monthly | TV team | Fundamentals of Crae Committee (FOCc) Exception report: FOC Dashboard Quality app | Monthly |
| | Hospital Acquired Moisture Associated Skin Damage (MASD) is manged appropriately. | Monitor MASD prevalence is Datix incident reporting system | monthly | TV team | Tissue Viability Governance Steering Group<br>Fed into FOC committee report | Monthly |

## 12. Contribution List

This key document has been circulated to the following individuals for consultation;

| Name | Designation |
|---|---|
| Alison Robinson | Deputy Chief Nursing Officer |
| Fundamentals of Care Committee members | |

This key document has been circulated to the chair(s) of the following committee's/groups for comments;

| Committee/Group |
|---|
| Tissue Viability Governance Steering Group |
| Fundamentals of Care Committee |
| Tissue Viability Governance Steering Group members |

## 13. References

Fraser,B(2023)Aging skin and the importance of skin integrity assessment Skin Integrity - Ageing skin and skin integrity assessment - HealthTimes

Fastner, A, Hauss, A, Kottner, J (2023) Skin assessments and interventions for maintaining skin integrity in nursing practice: An umbrella review. International Journal of Nursing Studies. Volume 143, no 104495

Hebert, G (2025) Providing skin care for bariatric patients, Wound Care Advisor, Practical Issues In Wound, Skin and Ostomy Management https://woundcareadvisor.com/providing-skin-care-for-bariatric-patients-vol4-no6

Magwenya, R, Ross, A (2022) Continuing professional development in the last decade – A scoping review. Sage Journals Vol 29. Issue 2

Morgan (2025) Comprehensive skin assessment Wound Care Advisor, Practical issues in Wound, Skin and Osteotomy Management. Comprehensive skin assessment - Wound Care Advisor

Moncrieff G, Cork M, Lawton S et al (2013) Use of emollients in dry skin conditions: consensus statement. Clinical and Experimental Dermatology 38(3):231-8

National Wound Care Strategy ProgrammeNWCSP-PU-Clinical-Recommendations-and-pathway-Updated-21st-May-2024.pdf

NICE (2015) Pressure ulcers: the management of pressure ulcers in primary and secondary care. National Institute for Health and Clinical Excellence. London.
www.nice.org.uk/guidance/qs89/chapter/quality-statement-1-pressure-ulcer-risk-assessment-in-hospitals-and-care-homes-with-nursing

NICE (2019) Endorsed resource – S.M.A.R.T (Skin Moisture Alert Reporting Tool) [online] https://www.nice.org.uk/guidance/cg49/resources/endorsed-resource-s.m.a.r.t-skin-moisture-alert-reporting-tool-7022579437
Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern
Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK

Skin Care Campaign (2009) The Skin Care Campaign Objectives. www.skincarecampaign.org/pages/home.htm

Vilmos dermo 2021.Skin integrity: definition, how to maintain and how to restore Skin integrity: definition, how to maintain and how to restore –

Wounds UK (2018) Best Practice Statement Maintaining skin integrity. London: Wounds UK. Available to download from: www.wounds-uk.com

Wounds UK (2021) Best Practice Statement: Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones. Wounds UK, London. Available to download from: www.wounds-uk.com

Young, T (2017) Back to basics: understanding moisture-associated skin damage. *WoundsUK,*13(2) https://www.woundsuk.com/journals/issue/450/article-details/back-basics-understanding-moisture-associated-skin-damage

## 14. Appendix

Appendix 1 EPR Skin Bundle example

Appendix 2 Waterflow Purat (EPR)

Appendix 3 Waterflow Top Tips

Appendix 4 Clinell Conti plan brochure

Appendix 5 Medi derma pathway

Appendix 6 Medi Demra barrier Products and Order Codes

**Appendix 7 Washing a patient Guide**

**Appendix 8 Interdry Fact Sheet/Instructions**

**Appendix 9 – Pressure Ulcer Vs MASD poster**

**Appendix 10 Paper wound assessment**

## Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

**Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form**
**Please read EIA guidelines when completing this form**

**Section 1 - Name of Organisation** (please tick)

| | | | | | |
|---|---|---|---|---|---|
| Herefordshire & Worcestershire STP | | Herefordshire Council | | Herefordshire CCG | |
| Worcestershire Acute Hospitals NHS Trust | X | Worcestershire County Council | | Worcestershire CCGs | |
| Worcestershire Health and Care NHS Trust | | Wye Valley NHS Trust | | Other (please state) | |

| | |
|---|---|
| **Name of Lead for Activity** | **Claire Hughes** |

| | | | |
|---|---|---|---|
| **Details of individuals completing this assessment** | **Name** | **Job title** | **e-mail contact** |
| | **Claire Hughes** | **Lead Nurse Tissue Viability** | **claire.hughes9@nhs.net** |
| | | | |
| | | | |
| **Date assessment completed** | **25/7/2025** | | |

**Section 2**

| | |
|---|---|
| Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.) | **Title: Guidelines for the Care of the Skin in Adults, in Relation to Tissue Viability** |
| What is the aim, purpose and/or intended outcomes of this Activity? | Guidance for implementation for Appropriate, safe Care of the Skin in Adults, in Relation to Tissue Viability |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| Who will be affected by the development & implementation of this activity? | X<br>X<br>X<br>❑ | Service User<br>Patient<br>Carers<br>Visitors | X❑<br>❑<br>❑ | Staff<br>Communities<br>Other _____ | |
| Is this: | X Review of an existing activity<br>❑ New activity<br>❑ Planning to withdraw or reduce a service, activity or presence? | | | | |
| What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc. | NICE Guidance<br>Current best practice and evidence-based practice | | | | |
| Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required) | Leads for Fundamentals of Care committee<br>Tissue Viability Steering Group | | | | |
| Summary of relevant findings | | | | | |

## Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| **Age** | √ | | | |
| **Disability** | √ | | | |
| **Gender Reassignment** | √ | | | |
| **Marriage & Civil Partnerships** | √ | | | |
| **Pregnancy & Maternity** | √ | | | |
| **Race including Traveling Communities** | √ | | | |

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| **Religion & Belief** | √ | √ | | |
| **Sex** | | √ | | |
| **Sexual Orientation** | | √ | | |
| **Other Vulnerable and Disadvantaged Groups** (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.) | √ | | | |
| **Health Inequalities** (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies) | √ | | | |

**Section 4**

| What actions will you take to mitigate any potential negative impacts? | Risk identified | Actions required to reduce / eliminate negative impact | Who will lead on the action? | Timeframe |
|---|---|---|---|---|
| | | . | | |
| | | | | |
| | | | | |
| **How will you monitor these actions?** | | | | |
| **When will you review this EIA?** (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation) | | | | |

**Section 5 -** Please read and agree to the following Equality Statement

## 1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

| | |
|---|---|
| **Signature of person completing EIA** | Claire Hughes |
| **Date signed** | 25/7/2025 |
| **Comments:** | |
| **Signature of person the Leader Person for this activity** | Claire Hughes |
| **Date signed** | 25/7/25 |
| **Comments:** | |

## Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | Title of document: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | NO |
| **2.** | Does the implementation of this document require additional revenue | NO |
| **3.** | Does the implementation of this document require additional manpower | NO |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | NO |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | NO |
| | Other comments: | |

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.