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)

Elaine Bethell	Lead Tissue Viability Nurse
Lisa Martin	Tissue Viability Nurse
Approved by SKIN Matters Group on:	22nd June 2015
Extension approved on:	6th January 2023
Review Date:	1st May 2025

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

Worcestershire Acute Hospitals NHS Trust

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

Other guidelines to be referred to:

Consent to Treatment Policy

Clinical Record Keeping Guidelines

Wound Management Formulary

Infection Control Guideline

Wound Assessment and Management Guideline

NICE Guideline Improving outcomes for people for skin tumours Feb 2006

NICE PUP guidelines 2014

NICE Nutrition 2006

Worcestershire Area Prescribing Committee Dermatology Guidelines

CONTENTS

1. Introduction

a. Skin is the largest organ of the body, being 10% of the body mass (White & Butcher 2006). It has the primary function of providing a barrier between the internal body structures and the environment. Several other functions include:

- Secretion;
- Thermoregulation;
- Absorption;
- Protection;
- Elimination;
- Sensation;
- Production of vitamin D; and
- Production of melanin.

b. The structure and function of an older person's skin reflects the cumulative effects of 'programmed' ageing and added ageing (Talarico 1998). 'Programmed' ageing is the true biological process, whereas 'added' ageing refers to the damage caused from exposure to the environment.

c. Elderly skin is less elastic, drier and the tissue mass is greatly reduced. The efficient function of the skin is often compromised in people whose mobility is restricted i.e. bed bound, wheel chair user, inability to move or alter position often enough. Skin inspection should occur on a daily basis however; frequency should be determined in response to changes noted in the individual's conditions, which may increase or decrease the frequency. .

d. 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.

e. When approaching assessment healthcare professionals/carers need to consider several factors, which may compromise healthy skin. These are both intrinsic and extrinsic:

Intrinsic	Extrinsic
Dryness	Continence
Atrophy	Smoking
Reduced elasticity	Environmental pollutants
Wrinkling	Ultra Violet Light (UVL)
Pigmented and other blemishes	Radiotherapy/chemotherapy
Chronic venous/arterial insufficiency	Decreased mobility
Known skin conditions	Chronic illness
Previous skin damage	Dehydration
	Poor nutrition
	Drug therapy
	Wound
	High level of exudate

2. Purpose of this Guideline/Procedure

The aim of this guideline is to provide advice for clinicians on skin care in relation to tissue viability. This guideline incorporates all patients across the Worcestershire Health and Care NHS Trust with tissue viability needs.

3. Scope

The guideline applies to all staff caring for patients 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 and where there is a skin care in tissue viability need, this is optimum treatment with an evidence base.
This guideline outlines the recommendations to assess and manage skin care in relation to Tissue Viability for people in all age groups. The guideline is to be used by all staff employed by the Worcestershire Health and Care Trust who may be engaged in the assessment and management of skin care in relation to Tissue Viability. It is recommended for use by all Care Homes across Worcestershire

4. Training/ Competencies

Registered Health care professionals and supervised Student Nurses who can demonstrate practical competence in skin assessment in relation to Tissue Viability. An educational programme, incorporating internal courses and accredited degree level study, is available. Informal and formal assessment is undertaken. This forms part of the individuals overall professional development (Knowledge and Skills Framework).

5. Skin Assessment and Documentation

a. When a patient's skin changes from its normal appearance or the skin integrity is breached, it is important that an early assessment is undertaken and interventions instigated. Peri-wound skin has a compromised barrier due to the underlying tissue inflammation and is therefore more susceptible to breakdown (Bishop et al 2003).

b. The following factors should be considered (Newton and Cameron 2003):

- Family history of skin problems;
- The effect of ageing;
- The impact of the skin;
- The effects of steroids;
- The effects of chronic illness, i.e. diabetes, rheumatoid disease, congestive cardiac failure;
- Mobility and positioning of the patient;
- Continence status;
- The presence of a wound and the impact its clinical characteristics may have on skin integrity;
- What treatments or actions have influenced the skin integrity; and
- The length of time the skin problem has been present and any trends in recurrence.

c. Several factors relating to the surrounding skin of the wound may be recorded on the Skin Assessment chart (See Skin assessment chart appendix 1) and are also included in the wound management assessment tool, see Wound Management Guidelines) including:

- Erythema (distance);
- Blanching/non blanching;
- Excoriated
- Macerated
- Dry/Scaly
- Oedema
- Healthy
- Fragile
- Skin organ failure/ end of life
- Skin stripping

d. 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.

6. Skin Assessment and Pressure Ulcer Prevention

a. Patients deemed at risk should have their skin assessed regularly with the frequency prescribed and titrated to vulnerability level and in response to any health condition change. On-going assessment is necessary to detect the early signs of pressure damage (EPUAP 2014). Individuals and carers should also be encouraged to inspect the skin and take responsibility for its condition (NICE 2014).

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

b. 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.

c. Where appropriate, patients should be asked to identify areas of discomfort or pain as this may be a pre cursor to tissue breakdown. Additionally the skin should be observed for pressure damage created by devices (EPUAP 2014) such as continence care devices.

Visual skin assessment and additional details such as discomfort or pain should be documented 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.

Skin assessment is to be undertaken as part of the SSKIN Bundle and documented on appendix1.

Re-assess patient's skin on an on-going basis according to individual need and general condition change. **This is** dependent upon the general condition of the patient and reassessment may be required in as little time as 6 hours. The **maximum** agreed period before general **re-assessment for those on the District Nurse caseload is every 6 months and therefore re assessment may be up to a maximum of 6 months.**

7. Skin care

Reddened Skin: massage should never be undertaken in the presence of acute inflammation (reddening) due to the risk of increasing the existing damage to underlying blood vessels and potentially separating fragile skin layers. Washing of the area and cream applications should also be undertaken with care.

Dry Skin: is less tolerant to tissue distortion (stretching) and is thus more vulnerable to breakdown (Allman et 1995). Emollient should be applied, as available in the Wound Management Formulary to maintain the suppleness of the skin and reduce the risk of breaks/cracks forming. Barrier creams are also available when suppleness and a protective barrier is required. Skin should always be dried thoroughly after washing prior to application of products.

Excessively Moist Skin: prolonged exposure to excessive moisture (urine, faeces, exudate or sweat) increases the risk of damage from maceration, friction and shear forces (Defloor 1999). Skin that is exposed to or at risk of exposure to excessive moisture should be protected with a barrier forming product as available in the Wound Management Formulary

8. Skin Cleansing

a. Different parts of the body require different cleansing methods and will be considered in relation to incontinence and soiling, general hygiene and care of the lower limbs.

8.1 Incontinence associated dermatitis and Soiling

a. Incontinence-associated dermatitis is the clinical manifestation of inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture, including faeces, urine, perspiration and wound exudate, is known as incontinence-associated dermatitis (Gray *et al* 2007) but may also be referred to as moisture lesions. Incontinence Associated Dermatitis is most commonly experienced by people with faecal and urinary incontinence, as this causes the skins PH to become more alkaline causing skin irritation and breakdown (Langemo et al 2011).

b. Prolonged excessive moisture of the skin can lead to inflammation and dermatitis (Voegeli 2012), an increase in moisture leads to maceration of the skin intensifying the risk of damage from friction and pressure (Mayrovitz and Sims 2001). If left untreated symptoms may present as inflammation of the skin, redness and in severe cases swelling and blisters.

c. It is vital to differentiate between incontinence associated dermatitis and the presence of pressure damage, incorrect assessment can lead to the formation of inappropriate care and treatment. Ultimately this will result in a negative impact on the patients experience (Beeckman et al 2010). Incontinence associated dermatitis is most likely to be located on any part of the perineal area (not over bony prominences), tends to be superficial, involving only the epidermis and the upper dermal layers (NPUAP 2009). Incontinence associated dermatitis tends not to be localised, with the edges of lesions usually irregular and the surrounding area reddened as a result of the irritating nature of incontinence (Beeckman et al 2010). See appendix 3 for Staff guide to the classification, assessment and management of Moisture lesions and Pressure ulcers (Moisture or Pressure Tool MOPT).

d. To prevent the effects of incontinence associated dermatitis it is recommended that a comprehensive holistic continence assessment and documentation is undertaken with the patient. This is to ensure all causative factors e.g. faecal or urinary incontinence have been addressed in the first instance. It is also recommended that an appropriate skin cleansing regime has been adopted incorporating the use of a suitable skin barrier product (Nix and Haugen, 2010).

e. The Agency for Health Care Policy and Prevention (AHCPR, 1992) recommend that skin cleansing should occur at the time of soiling. Mild cleansing agents and warm water should be used rather than soap as this can have a drying effect and therefore cause more irritation. The area should be dried thoroughly; moisturiser/emollients should be applied to dry

areas of skin using the **dot** method, whereby small amounts (dots) of moisturiser are initially applied over the whole area to be covered. Skin rubbing and massage, particularly over bony prominence should be avoided as it can cause friction damage (Dyson, 1978, Nice 2005).

f. The aim of the treatment should be to minimise exposure to urine/faeces and reduce exposure to moisture and friction. It has been demonstrated that urine and faeces contain waste products that can irritate and chemically burn skin (Chilvers, 1999). Suitable barrier preparations may be needed (Appendix 4).

9. General hygiene

a. The use of soap products and detergents i.e. bars of soap, bubble bath/foam can strip essential lipids from the epidermal barrier. Many of these products are alcohol based which also has a drying effect. The pH level of normal skin is 5.5. Most soap is highly alkaline and removes the natural oils that keep the skin hydrated. An added hazard when using bars of soap is the risk of cross infection. Use of a soap substitute by older people reduces the incidence of dryness, redness and flaking of their skins (Hardy, 1990). Staff should advise patients that a soap substitute such as Aqueous cream will not produce lather. However (Hardy, 1996) suggests should a person wish to continue using soap a non-perfumed, hexachlorophene free super fatted soap (such as Dove Sensitive) should be used.

b. It is advisable not to use preparations that contain preservatives, fragrances, alcohol, perfumed moisturisers, and lanolin as these can all potentially cause sensitivity.

9.1 Care of the lower limb

a. For patients with lower limb ulceration soak leg in mains drawn tap-water in a plastic lined bucket for 10 minutes (see WHCT Leg Ulcer policy and guidelines). Caution should be exercised for those with confirmed arterial leg ulceration as these may need to be kept dry.

b. It is most important that if a patient's skin condition is a cause for concern and is not improving to refer for a Consultant Dermatologist's opinion as there may be an underlying skin disease that has not been diagnosed.

9.2 Skin Care Relating to the Lower Limb and Feet

a. Wash daily wherever possible using pH neutral soap substitute and dry thoroughly, particularly between the toes. Avoid using scented products.

b. Apply emollients at least once daily. Avoid the area between toes.

c. Avoid the use of talc.

d. Examine feet daily and if padding is in situ remove to allow examination of skin underneath.

e. Avoid soaking the feet.

f. Avoid use of proprietary corn preparations and plasters.

g. Treat areas of fungal infection as this can lead to subsequent infection in other areas.

9.3 Skin Care Relating to Barrier Protection

a. Changes in skin moisture level can lead to a reduction in the skin's barrier function, thereby allowing the penetration of irritants. The use of a barrier preparation may be beneficial when used in conjunction with personal hygiene.

b. The barrier cream and film in the wound management formulary is:

- Sorbaderm barrier film and cream

c. Sorbaderm barrier cream will not "clog" the continence pad and should be applied very sparingly every 3rd wash. A 10 pence coin size would be sufficient cream; over application leads to the skin feeling waxy. If waxy skin occurs do not apply further cream as there is sufficient already present.

9.4 Skin Care in Relation to Lymphoedema

a. Maintenance of skin integrity and the management of skin problems are very important to avoid the risk of infection.

b. General principles of skin care include:

- Wash skin daily, wherever possible, using pH neutral soap or a soap substitute, and dry thoroughly. Avoid scented products.
- Legs should be washed with tap water and soaked in a lined bucket. [Best Practice For The Management of Lymphoedema]
- Ensure skin folds, if present, are clean and dry
- Apply Emollients at least once daily.
- The WHCT Lymphoedema Clinic recommends Aqueous cream or 50/50 paraffin if the skin is dry.
- If the client has a particular skin problem, then this should be discussed with the clinic staff who will recommend appropriate treatment.
- If the affected limb is injured, wash thoroughly and apply antiseptic cream straight away. Observe for redness, heat, more swelling, pain and general malaise - contact the GP/Nurse Practitioner as antibiotics may need to be prescribed.
- Patients with Lymphoedema are at risk of fungal infection and should be monitored for cellulites and treated with appropriate medication.
- Avoid sunburn, use a high factor sun-block if the skin is exposed.
- Insect repellent spray is also advisable for people with Lymphoedema.

9.5 Lymphorrhoea management

a. Medical review to determine the underlying cause.

b. Surrounding skin should be protected with emollient, and a non adherent absorbent dressing applied to the weeping skin. Multi-layered Lymphoedema bandaging then applied to reduce the underlying Lymphoedema, and reduce the Lymphorrhoea. The bandaging will need to be changed frequently to avoid maceration of the skin.

10 Common Skin Conditions

10.1 Eczema

a. The literal Greek meaning of eczema is to 'boil over' (Collins et al 2002). Eczema is an inflammatory disorder of the skin, which causes dryness

itching, redness and excoriation. There are many types of eczema that can affect different parts of the body, and these conditions can vary in their severity, from mild to severe. Eczema, (also known as dermatitis) may be described as wet or dry, localised or general in nature and may be explained as endogenous (linked to internal factors) or exogenous (reaction to an external stimulus). In practice, patients with endogenous eczema will also be susceptible to irritation/aggravation by external factors.

b. A common form of eczema found in a large number of older adults is Varicose/Gravitational/Stasis eczema (National Eczema Society 2005). It is associated with poor venous return and is known to affect those with varicose veins, obesity, lower limb oedema, phlebitis or previous deep vein thrombosis. A higher percentage of women compared to men are likely to suffer with varicose eczema due to increased pressure on the deep pelvic and leg veins during pregnancy.

c. Common forms of Eczema in the elderly:

Gravitational Eczema	Known as varicose eczema. Associated with poor venous return Caused by increase in pressure within the veins (High pressure damages the small blood vessels, releasing red blood cells into the skin, leading to pigmentation. The skin becomes thin breaks easily and becomes flaky, inflamed and itchy.)
Discoid Eczema	Known as nummular eczema Itchy, symmetrical, coin shaped lesions. Begins as slight bump on the surface and then patches begin to weep. This can lead to scaling, itching, crusts and infection.
Asteatotic Eczema	Eczema due to dry skin and often frequent use of soaps, with the appearance of dried cracked riverbed. It occurs on the legs most frequently and often causes tiny fissures, bleeding, scaling, itching and soreness.

10.2 Contact Dermatitis

a. Contact Dermatitis occurs when there is an inflammatory reaction of the skin to an external agent. The severity of the reaction will vary according to the method of exposure, the area of skin involved and the substance/concentration used. These can include topically applied creams/lotions, dressings/bandages, soap etc.

b. There are two main causes of contact dermatitis: irritants and allergens (British Skin Foundation 2007).

c. Irritants - substances that strip the skin of its natural oils, and cause dermatitis to develop if contacted frequently and without skin protection. When this happens, the skin changes are known as an irritant contact dermatitis. The most important factor in causing this type of contact dermatitis is the amount of irritants to which an individual is exposed.

d. Allergens - immune systems can develop a specific reaction after exposure to an external agent. Good examples include substances such as nickel, rubber and perfumes or preservatives used in some creams and cosmetics. This type of dermatitis is called an allergic contact dermatitis. It is not known why some people who are exposed to these allergens develop it while others do not.

10.3 Folliculitis

a. Folliculitis is the name given to skin conditions where there are inflamed hair follicles. The result is a tender red spot, often with a surface pustule at the base of each affected hair. Folliculitis can be due to infection, occlusion, irritation and specific skin diseases. The use of emollients/moisturising creams can cause folliculitis and when used should always be applied in the direction of natural hair growth.

10.4 Candida

a. Candida is the name for a group of yeasts (a type of fungus) that commonly infect the skin and often occur in moist skin folds. These areas include:

b. Between toes, web spaces of the hands (skin is moist, white, peeling and uncomfortable).

c. Under breasts/in the groin/between the buttocks (the onset of bright red irritable skin is usually abrupt and may peel and the moist skin fold is cracked and sore. There are usually tiny surface "satellite" spots, blisters or pustules).

d. NB. If a candida infection is suspected it is important to consult a nurse, doctor or pharmacist for examination, advice and appropriate treatment.

10.5 Cellulitis

a. Cellulitis is an inflammatory bacterial infection of the skin and subcutaneous tissue which will require assessment by a health care professional and antibiotic therapy. Classic characteristics of cellulitis in an acute wound are: pain and tenderness, redness, swelling and heat (Morison et al 1999) and often associated fever, malaise and other systemic symptoms.

b. Erisepilas is a more superficial infection than cellulites, almost exclusively streptococcal and characteristically with a more well-defined border. Management is the same as for cellulites.

c. However in an infected chronic wound (leg ulcer, pressure ulcer) the situation is slightly more complicated. Diagnosis may depend on other host reactions or clinical signs (Cutting and Harding 1994). These include increased wetness, changes in pain, and change in appearance of granulation tissue, odour and presence of pus (although not commonly found in chronic wounds).

10.6 Pruritis

a. Pruritis (generalised itch) is a frustrating and sometimes debilitating condition that can impact severely on an individual's quality of life. Thorough assessment is essential to establish a possible cause which can often be found to be linked to an underlying skin condition or systemic disease. In some individuals however a cause cannot be identified (Gawkrodger 1992). Avoidance of potential irritants such as perfumes, soaps and powders should be encouraged whilst emollients and use of topical antipruritics may be beneficial.

11. Emollients

a. Emollient is the medical term for a non-cosmetic moisturiser. They soothe, smooth and hydrate the skin and are indicated for all dry or scaling disorders. Their effects are short-lived and they should be applied frequently, even after improvement occurs. Emollients are useful in dry and eczematous disorders -

light emollients are suitable for many patients with dry skin, but a wide range of more greasy preparations are available.

b. The severity of the condition, patient preference and site of application will often guide the choice of emollient and they should be applied in the direction of hair growth. The Skin Care Campaign (SCC 2009) advocates that patients should be given the widest possible choice of skin treatments which should be accompanied by a demonstration of the application technique.

c. Patients with eczema should use moisturisers in the bath (taking care about slipping), shower and direct to the skin.

- Avoid soap and use bath or shower moisturisers.
- Bland moisturisers should be applied directly to the skin.
- Control inflammation with corticosteroid ointments or creams.

d. If Infected – Bacterial infection may be signified by weeping, pustules, crusts, fever, malaise, worsening eczema, failure to respond to therapy. Refer to GP and Area Prescribing Committee Dermatology Guidelines.

e. Ointments are the most greasy emollients, have optimum skin penetration and are the most effective moisturisers.

f. Creams have a higher water content, contain less grease and are therefore easier to apply. They may contain preservatives which can cause irritation or occasionally allergic reactions.

g. Lotions are the least effective as they have the least oil content. These are most commonly used in patients with hairy skin where there is a tendency to folliculitis.

h. Bath oils are designed to disperse into fine droplet suspensions when added to bath water and are designed to coat the immersed skin. They do not contain water and are self-preserving (Kingsley 2005).

i. Pastes are ointments with insoluble ingredients are very useful for soothing fissures.

j. Emollients may contain therapeutic additives, such as urea which can effectively hydrate the skin. However evidence for their benefit is limited.

k. Where possible the simplest emollient with the least additives (preservatives and fragrances) is recommended (Me Rec 1998). NB Preparations containing an antibacterial should be avoided unless infection is present or is a frequent complication.

l. A thin and even layer of emollient should be applied that covers the area and can be gently smoothed into the skin so that it glistens (National Eczema Society 2005). Downward stroking motions should be used in order to avoid Folliculitis.

11.1 Moisturisers and Emollients

a. As a soap substitute:

- Aqueous Cream 500 gm;
- Diprobase Cream 500 gm;
- Oilatum Shower Emollient 125 gm;
- Doublebase Shower emollient;
- Emulsifying Ointment;
- Epaderm;
- E45 wash 250 ml; and

- If infected – Dermol 200 or 500.

b. In The Bath:

- Oilatum Emollient 500 ml;
- Balneum 500 ml;
- Emulsiderm 300ml/1L;
- Cetraben Bath emollient;
- Doublebase Bath emollient;
- Alpha-Keri Bath Oil 240ml/480ml;
- Diprobath 400 ml;
- Aveeno Bath Oil 250 ml;
- Hydromol 350 ml/1L;
- If infected – Oilatum Plus 500 ml, Dermol 500/600 500 ml
- *Oilatum Plus is only a bath product and must not be applied directly to the skin as it would be irritant in an undiluted form*.

11.2 Moisturisers/emollients used after washing/bathing and at least 3 times daily

a. Creams:

- Cetraben;
- Diprobase cream;
- Doublebase;
- Aveeno cream;
- Unguentum Merck;
- Hydromol cream;
- Neutrogena Dermatological cream; and
- Hydrous ointment (oily cream).

b. Ointments:

- Epaderm (greasy but very effective) or Hydromol ointment;
- White Soft Paraffin/Liquid Paraffin 50:50 (greasy but very effective) 500 gm;
- Emulsifying Ointment; or
- If infected – Dermol 500 as soap substitute, Dermol 600 to bath, Dermol 200 shower emollient.

11.3 More detailed information

Product	Uses	Ingredients	Excipients	Comments
Aqueous Cream	Can be used as soap substitute	Emulsifying ointment 30%, phenoxyethanol 1% in freshly boiled and cooled	Excipients include cetostearyl alcohol	Use as soap substitute. Consider cross infection when using tubs. Use a spatula or

		purified water		a clean gloved hand
Product	**Uses**	**Ingredients**	**Excipients**	**Comments**
Emulsifying Ointment *	Use as a soap substitute	Emulsifying wax 30%, white soft paraffin 50%, liquid paraffin 20%	Excipients include cetostearyl alcohol	Use as soap substitute. Consider cross infection when using tubs. Use a spatula or a clean gloved hand
Diprobase Cream	Indicated for dry skin conditions and soap substitute	Contains Cetomacrogol 2.25%, cetostearyl alcohol 7.2% liquid paraffin 6% white soft paraffin 15%	Excipients include cetostearyl alcohol, chlorocresol	In pump dispenser
50/50 Ointment*	Indicated for use as an emollient	Liquid paraffin 50%, white soft paraffin 50%	Excipients - none	Use as an emollient
Sorbaderm Cream and Non sting barrier film	Protection from body fluids including wound exudate Protection from tapes and dressings	Apply cream very sparingly after every third episode of incontinence (NB Cream is not no-sting) Film will aid adhesion of tapes and adhesive dressings, creams will not prevent dressings from sticking	Infected skin Very fragile skin, as Cavilon film will aid adhesion of the dressing	Cream 2g, 28g & 92g Film 1ml, 3ml, 28ml WILL NOT BLOCK INCONTINENCE PADS
Conotrane	Use for nappy/urinary rash	0.1% dimeticone		
Cetraben Emollient	Inflamed, damaged, dry or chapped skin including eczema	Contains White soft paraffin 13.2% and light liquid paraffin 10.5%	Exipients include parabens cetostearyl alcohol	In pump dispenser
Doublebase (Dermal)	Use a soap substitute and moisturiser	Contains Isopropyl myristate15%, liquid paraffin15%	Exipients-none	In pump dispenser
Epaderm	Indicated for use as emollient or soap substitute	Contains emulsifying wax 30% yellow soft paraffin 30% liquid paraffin 40%	Exipients include cetostearyl alcohol	Oil based - need to consider protecting clothing
Dermol 200 shower, 500 lotion or 600	Antiseptics	Benzalkonium	Cetostearyl alcohol	Used when patient at risk of recurrent infection.

bath				

*Paraffin products are FLAMMABLE.

11.4 Product container contamination

The following list supports best practices in preventing container contamination (Kingsley 2005)

Do	Do not
Keep it for the same patient	Return to the store cupboard
Label it with the name and start date	Use longer than pharmacist or manufacturer recommends
Use clean non-sterile gloves	Apply product to skin and return to the receptacle for more without washing hands or changing gloves
Decant product into a gallipot or convenient clean surface	Return the gallipot to the main receptacle
When using a multi-use pot use a clean spatula, gloved hand	Wipe the nozzle on the skin
Re-seal the main container before proceeding to apply to the skin	Handle the tube or pot with unclean gloves
Work the product onto the skin from the gallipot	Use old products 'found in the cupboard' or damaged containers

11.5 Topical Corticosteroid Preparations

a. Topical Corticosteroid Creams/Ointments will settle the inflammation and itching of eczema when it is active. They come in different strengths/potencies. Topical corticosteroid preparations should be used in combination with moisturisers in a planned skin care 'regime'.

b. A medical practitioner or supplementary prescriber is required to prescribe the preparation and potency used.

c. *Steroid ointments should be used rather than creams as ointments are oil based and contain fewer preservatives than creams*. Creams can be used for weeping eczema or on the face.

d. Topical corticosteroids are safe as long as they are used in the right way. Use the right strength to improve a flare up; stop using them or reduce their strength once the eczema has improved. Stopping topical steroids abruptly may allow the eczema to flare up (rebound) again; therefore reduce applications gradually and continue using them on 1-2 days a week for approximately two weeks after eczema has settled.

e. Skin thinning from topical corticosteroid preparations should not be a problem if they are used properly. It usually arises when a potent steroid has been used for too long, or in a 'delicate' area where the skin is thin.

Weaker topical steroids should be used where the skin is particularly thin, such as on the face, eyelids, and armpits: stronger steroids can be used at other sites.

f. Steroids are classed as mild, moderate, potent and very potent; and it is sometimes recommended to have a range of suitable creams available of different strengths and to move up and down the steroid ladder, depending on how the skin responds to treatment. In this way stronger preparations may be used while skin is inflamed and milder ones as the eczema settles (British Association of Dermatologists 2006).

11.6 Cautions/Contra-indications

a. Avoid prolonged use of a topical corticosteroid on the face (and keep away from eyes). In children avoid prolonged use and the use of potent or very potent corticosteroids except under specialist supervision. Extreme CAUTION is required in treating infants, including nappy rash—treatment should be limited to 5–7 days.

b. Topical corticosteroids are contra-indicated in untreated bacterial, fungal, or viral skin lesions, in acne rosacea, and in perioral dermatitis; potent corticosteroids are contra-indicated in widespread plaque psoriasis. (BNF2009)

11.7 Side-effects

a. Mild and moderately potent topical corticosteroids are associated with few side-effects but care is required in the use of potent and very potent corticosteroids. Absorption through the skin can rarely cause adrenal suppression and even Cushing's syndrome, depending on the area of the body being treated and the duration of treatment. Absorption is greatest where the skin is thin or raw, and from intertriginous (skin fold) areas and is increased by occlusion.

b. Local side-effects include:

- Spread and worsening of untreated infection;
- Thinning of the skin which may be restored over a period after stopping treatment but the original structure may never return;
- Irreversible striae atrophicae and telangiectasia;
- Contact dermatitis;
- Perioral dermatitis;
- Acne, or worsening of acne or acne rosacea;
- Mild depigmentation which may be reversible;
- Hypertrichosis also reported
- Cataracts and glaucoma if used around the eye.

c. In order to minimise the side-effects of a topical corticosteroid, it is important to apply it thinly to affected areas only, no more frequently than twice daily, and to use the least potent formulation which is fully effective (BNF2014).

11.8 Corticosteroid Potency Ladder and Formulary.

Potency	Product

Mild:	Hydrocortisone 1%
Moderately Potent:	Clobetasone (Eumovate) Betamethasone 1 in 4 (Betnovate RD)
Potent:	Betamethasone (Betnovate) Fluocinolone (Synalar) Fluocinonide (Metosyn) Hydrocortisone butyrate (Locoid) Mometasone (Elocon) Fluticasone (Cutivate)
Very Potent:	Clobetasol (Dermovate) Diflucortolone (Nerisone Forte)

11.9 Application

a. Topical corticosteroid preparations should be applied no more frequently than twice daily; once a day is often sufficient. Topical corticosteroids should be spread thinly on the skin; the length of cream or ointment expelled from a tube may be used to specify the quantity to be applied to a given area of skin. This length can be measured in terms of **a *fingertip unit*** (the distance from the tip of the adult index finger to the first crease). One fingertip unit (approximately 500 mg) is sufficient to cover an area that is twice that of the flat adult palm. The use of emollients will reduce the need for topical steroids and emollient usage should generally exceed steroid use by 10 to 1 in terms of quantity (Lawton 2009).

b. The fingertip unit method:

- FTU = Fingertip unit (Adult).
- 1 FTU = ½g of cream or ointment.
- Measurement based on 5mm nozzle

Face and Neck	One Arm	One Hand	One Leg	One Foot	Trunk (Front)	Trunk (Back)
2½	3	1	6	2	7	7

11.10 Maintenance, re-assessment and review of on-going treatment

a. The GP should monitor amount of steroid prescribed, and refer to the Dermatologist if they consider too much/ too potent steroid is being used in order to keep the condition under control.

12. Staff Education

Staff will be offered education relating to 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 WHCT.

13. Clinical Audit

An annual Audit of prescribing of creams will be undertaken as part of the wound management review and the findings presented to the Trust Board, Locality Managers, Clinical Governance and County Tissue Viability Team.

14. 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 regularly, timing dependent on patient condition/change in condition	PUP audits , spot checks when RCA's for PU completed . education on mandatory training	PUP audits monthly	PUP –Matrons RCA'S & mandatory training TV team,	PUP audits reported on monthly incidence reports sent to matrons, Directors of nursing , clinical Goverance leads , safeguarding , business intelligence . Skin matters group	Monthly

15. Contribution List

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

Name	Designation
Lindsey Webb	Chief of Nursing
David Shakespeare	Associate Chief of Nursing for Infection Prevention and Control
Lisa Miruszenko	Deputy Director of Nursing
Ann Carey	Divisional Director of Nursing
Sarah King	Divisional Director of Nursing
Carole Brooks	Divisional Director of Nursing
Patti Paine	Divisional Director of Nursing
Susan Aston	Clinical Governance Lead
Denise Curson	Clinical Governance Lead
Brenda Smith	Clinical Governance Lead
Christine Mitchell	Clinical Governance Lead
Isla Brown	Clinical Governance Lead
Surjit Bhogal	Business Intelligence Consultant
Jennifer Garside	End of Life Facilitator
Justin King	Clinical Governance
Suzanne Hardy	Safeguarding Adults Lead Nurse

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

Committee/Group
SKIN Matters
Clinical Policies Group

16. References

Beekman, D.Defloor, T. Verhaeghe, S.Vanderwee, K.Demarre, L.Schoonhoven, L. (2010) what is the most effective method of preventing and treating incontinence associated dermatitis? Nursing Times. 106, 38,22-25.

Bishop, S. Walker, M. Rogers, A. & Chen, W. (2003) Importance of moisture balance at the wound dressing interface. Journal of Wound Care.Vol 12, No4, p125-128

British National Formulary Online (2014) http://www.bnf.org/bnf/

British Association of Dermatologists (2007) Patient Information leaflet. Atopic Eczema http://www.bad.org.uk/public/leaflets/atopiceczema.asp 6/03/07

British Skin Foundation (2007) What is Contact Dermatitis http://www.britishskinfoundation.org.uk/standard.aspx?id=202 . 6/03/07

Collins, F. Hampton, S. White, R. (2002) A-Z Dictionary of Wound care. Wiltshire. Mark Allen Publishers.

Cutting, K. Harding, K. (1994) Criteria for identifying Wound Infection. Journal of Wound Care. 3(4) 198-201

European Pressure Ulcer Advisory Panel, EPUAP. (2014). Pressure Ulcer Treatment: Quick Reference Guide. epuap.org/guidelines/Final_Quick_Treatment_pdf Accessed November 2014.

Gawkrodger, D.J. (1992) An Illustrated Colour Text Dermatology. Edinburgh. Churchill Livingstone.

Gray, M. Bliss, DZ. Doughty, DB. Ermer-Seltun, J. Kennedy-Evans, KL. Palmer, MH. (2007) Incontinence-associated dermatitis: A consensus. Journal of Wound, Ostomy and Continence Nursing. 34,1,45-54.

Kingsley, A. (2005) Essential skincare. Educational resource pack. Infection control and use of emollients. Wound care Society.

Me Rec (1998) Bulletin The use of emollients in dry skin conditions. 9: No 12.

Morison, M. Moffatt, C. Bridel-Nixon, J Bale, S. (1999) Nursing Management Of Chronic Wounds. 2nd.Ed. London. Harcourt Publishers.

Langemo, D. Hanson, D, Hunter, S. Thompson, P. Oh IE (2011) Incontinence and incontinence associated dermatitis. Advances in Skin and Wound care. 24,3, 126-140.

Lawton,S. (2009) Practical issues for emollient therapy in dry itchy skin. British Journal of Nursing. Vol 18 No 12 S8-11

Mayrovitz, HN. Sims, N. (2011) Biophysical effects of water and synthetic urine on skin. Advances in skin and awound Care. 14,6, 302-308.

National Eczema Society (2005) Sara Burr. Eczema and dry skin in the older person. London.

Newton, H. & Cameron, J. (2003) Skincare in Wound Management. Clinical Education in Wound Management. Medical communications UK Ltd

Nix, D. Haugan, V. (2010) Prevention and Management of Incontinence Associated Dermatitis. Drugs Aging 27 (6), 491-496.

NICE (2014) Pressure ulcers: the management of pressure ulcers in primary and secondary care. National Institute for Health and Clinical Excellence. London. http://guidance.nice.org.uk/CG29/Guidance/pdf/English Accessed Nov 2014.

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

White, R. & Butcher, and M. (2006) The structure and functions of the skin: paediatric variations in Paediatric Skin and Wound Care. Wounds UK

Worcestershire Dermatology Guidelines. 2014

Vogeli, D. (2012) Moisture associated skin damage: aetiology, prevention and treatment. British Journal of Nursing. 21,9, 517-521.

Appendix 1: Pressure Ulcer Prevention Plan

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD_____ CONS_____

PRESSURE ULCER PREVENTION CARE PLAN

Worcestershire NHS
Acute Hospitals NHS Trust

EXPECTED OUTCOME:
Patient will not develop a pressure ulcer.

Treatment care plan must be used on patients with pressure ulcers.

PROBLEM:	GOAL:	ACTIONS:	COMMENTS	Sign/Print Name Designation/Date & Time
To prevent deterioration of patients skin and prevent infection	To assess patient to ensure that a hospital acquired pressure ulcer does not develop.	Pressure ulcer risk assessment (Waterlow) undertaken within 4 hours of admission to identify at risk patient.		
		Appropriate mattress is in place refer to Flowchart for Pressure Relieving Equipment Mattress ordered: Date / Time Mattress in place: Date / time		
		Implementation of electric profiling bed frame as appropriate		
		SSKIN bundle including Care & Comfort assessment completed		
		Repositioning schedule completed and patient turned regularly (use slide sheet for assistance)		
		Patient is not sat out for more than 2 hrly intervals using an appropriate pressure reducing cushion.		
		Patient information leaflet given		
		Nutritional status assessed and appropriate action taken		
		Waterlow risk assessment is to be completed daily for very high risk patients and every 3 days for high risk patients, every 7 days for at risk		

NHS
Worcestershire Acute Hospitals
NHS Trust

CARE PLAN EVALUATION

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD_____ CONS_____

DATE & TIME	CARE PLAN EVALUATION (Each entry must be signed, name printed and designation)

SF~WR2074~Pressure Ulcer Prevention Care Plan~Version 2~Page 2 of 2

Worcestershire Acute Hospitals NHS Trust

Appendix 2: Wound Assessment and Evaluation Chart

Worcestershire NHS
Acute Hospitals NHS Trust

Affix Patient Label here or record

NAME: .....

NHS NO:

HOSP NO:

D.O.B: / / MALE FEMALE

WARD:.....CONS:.....

WOUND ASSESSMENT & EVALUATION

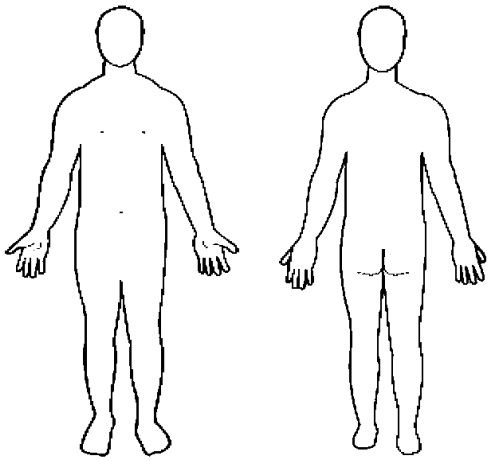
FACTORS WHICH COULD DELAY HEALING: (Please tick relevant box)

Immobility	☐	Poor Nutrition	☐	Diabetes	☐	Incontinence	☐		☐
Respiratory/Circulatory	☐	Anaemia	☐	Medication	☐	Wound Infection	☐	Disease	☐
Inotropes	☐	Anti-Coagulants	☐	Oedema	☐	Steroids	☐	Chemotherapy	☐

Other..... Allergies & Sensitivities.....

BODY DIAGRAM

Front Back



Mark location with 'X' and number each wound

Type of Wound — Total number & duration of each type of wound

Leg Ulcer .....

Surgical Wound .....

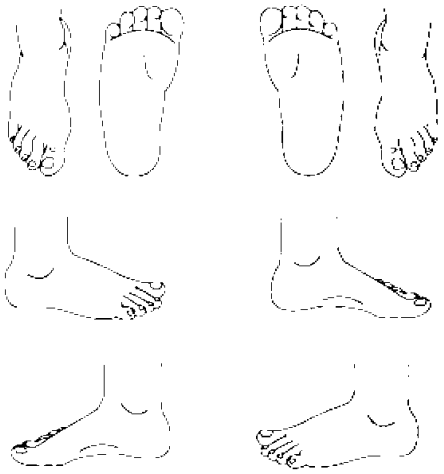
Diabetic Ulcer .....

Pressure Ulcer .....

Other, specify .....

FEET DIAGRAM

Right Left



Mark location with 'X' and number each wound

Date referred to:

TVN ..... Physiotherapist.....

Podiatrist..... Dietician.....

Other (please specify).....

Equipment required and date implemented

.....

.....

Complete on initial assessment and thereafter complete at every dressing change:

Date of Assessment							
Number of wounds							

FILE IN INPATIENT SECTION OF PATIENT MEDICAL RECORD

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

FORMAL WOUND ASSESSMENT

WARD:.....CONS:.....

		Evaluation	Evaulation	Evaluation	Evaluation
	Length (cm/mm)				
	Width (cm/mm)				
	Depth (cm/mm)				
	Tracing / Photo No:				
T	Epithelialising (Pink)				
	Granulating (Red)				
	Sloughy (Yellow)				
	Infected (Green)				
	Necrotic (Black)				
	Hypergranulating (Red)				
	Over granulation				
	Infection * 2 or more of these signs may indicate possible infection				
I	Colonised				
	Critically colonised				
	Local infection				
	Systemic Infection				
	Swab sent				
	Organism isolated				
	Anti-microbial therapy				
	Managing exudate				
M	Colour				
	Amount				
	Type				
	Odour				
	Edge of Wound: Cliff/flat/rolled				
E	Surrounding skin				
	Erythema (distance)				
	Blanching/non-blanching				
	Excoriated				
	Macerated				
	Dry / scaly				
	Oedema				
	Healthy				
	Pain Assessment				
	YES - specific pain assessment chart				
	No				
	Nurses Signature:				
	Date:				

Worcestershire Acute Hospitals NHS Trust

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD:.....CONS:.....

WOUND TREATMENT AND EVALUATION CHART

To be completed when treatment or dressing type / regime altered **NB Please write clearly**

Date	Wound number	Cleansing Method Dressing choice & rationale	Frequency	Evaluation & Rationale for changing dressing type	Signature

Please send a photocopy to the District Nurse / Carer on discharge

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD:.....CONS:.....

WOUND ASSESSMENT CHART GUIDELINES

The purpose of the wound assessment chart and guidelines is to assist in assessment and documenting of wounds to improve continuity of care and enhance communication. This chart should be used in conjunction with local guidelines.

PAGE 1

Complete chart as indicated. Ensure all wounds are numbered and type and duration of wound completed.
Factors which could delay healing.
Complete allergies and sensitivities and include wound products which appear to have caused similar problems.

PAGE 2

It is advised to use one formal wound assessment for each wound.
Use continuation sheets if more than one wound.
If infection suspected or signs present consider sending a wound swab to confirm organism.
If photograph obtained please ensure consent obtained.

NB. Formal wound assessment is to be completed on initial assessment, when wound bed changes or every 7 – 10 days (as per page 2).

PAGE 3

Complete as indicated.
Ensure numbers correspond with the wounds taken from the body / feet diagrams on page 1.
Please ensure you write in primary, secondary and supplementary dressing where appropriate.
Please document care of surrounding skin if appropriate.
Use continuation sheets when required.
Use this section for any other relevant information e.g., antibiotic commenced.

***Pressure Ulcer Monitoring'**

If the patient is admitted with or develops a pressure ulcer please complete an incident form & ensure their details have been entered on to Datix

If the patient develops a hospital acquired category / grade 2, 3 or 4 pressure ulcer please complete the Root Cause Analysis

Please file in inpatient section of case notes
Please send a photocopy to the District Nurse / Carer on discharge

Appendix 3
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.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Transgender	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment & mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	NA	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources

Appendix 4
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.