Yeovil District Hospital NHS
NHS Foundation Trust

Skin Care Guidelines

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Staff/Groups Consulted	Pressure Ulcer Steering Group: Associate Directors of Nursing Matrons Ward Sisters Physiotherapy Dietetics Equipment Library Infection Prevention Control/Tissue Viability Team		
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Related procedural documents	Moisture Lesion Guidelines		
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1. INTRODUCTION – needs to describe the purpose of the guidance

The function of the skin

1.1. As the largest organ of the body. It consists of three main layers: the outer epidermis, the middle dermis and the subcutaneous tissue. Combined, these three layers of tissue provide the following functions:

1.2. Barrier to infection: a protective barrier, preventing damage to internal tissues from trauma, ultraviolet (UV) light, temperature, toxins and bacteria. Part of this barrier function is the physical barrier of intact skin, the other is the presence of sebum, an antibacterial substance with an acidic pH, which is produced by the skin.

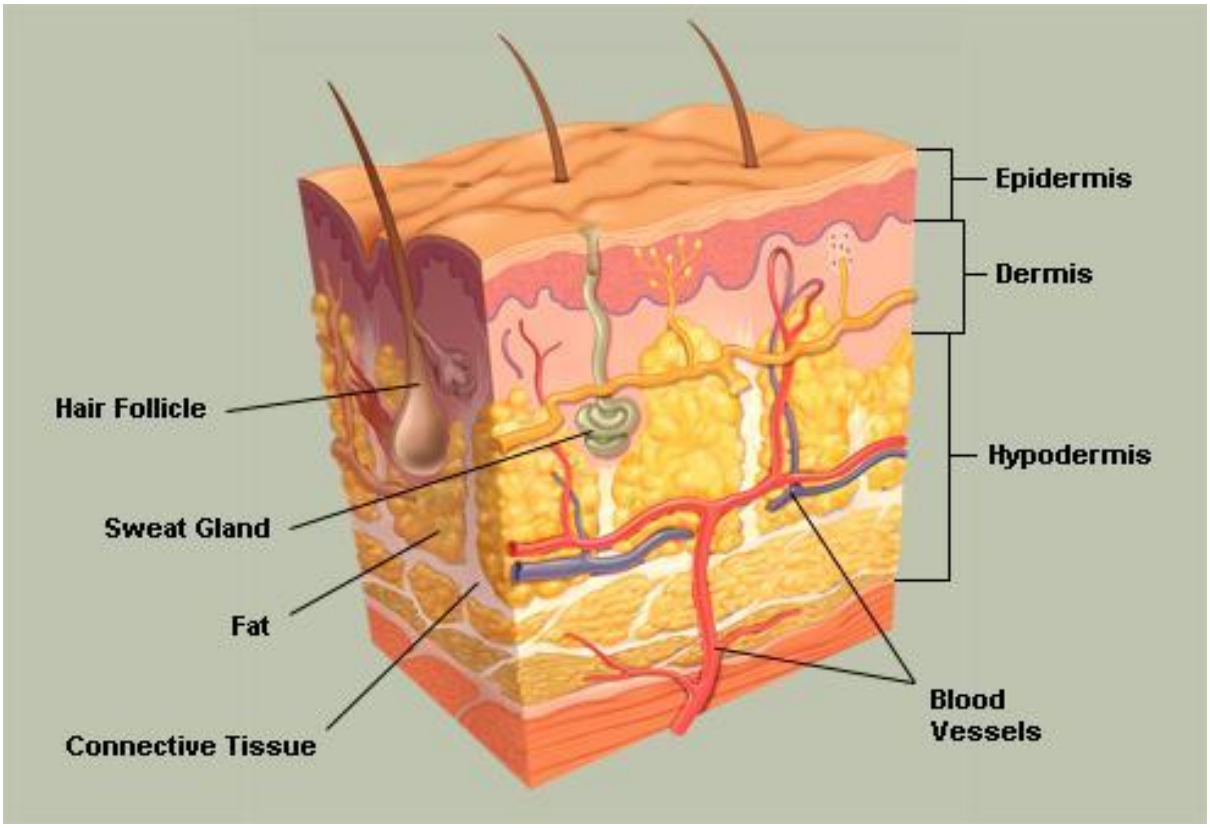
1.3. Pain receptor: nerve endings within the skin respond to painful stimuli. They also act as a protective mechanism by prompting the individual to move when they feel pain or discomfort, helping to prevent pressure damage.

1.4. Maintenance of body temperature: to warm the body, the vessels constrict (become smaller), thus retaining heat. If the vessels dilate, this leads to cooling.

1.5. Production of vitamin D in response to sunlight: this is important in bone development.

1.6. Production of melanin: this is responsible for skin colouring and protection from sunlight radiation damage.

1.7. Communication, through touch and physical appearance: this gives clues to the individual's state of physical wellbeing.



2. THE EFFECTS OF AGEING ON SKIN

2.1. The changes in the skin that occur as an individual ages affect the integrity of the skin, making it more vulnerable to damage. The epidermis gradually becomes thinner, making the skin more susceptible to damage from the mild mechanical injury forces such as moisture, friction and trauma.

2.2. With ageing there is also a flattening out of the dermo-epidermal junction, which makes it more fragile and more susceptible to shearing forces. This can cause stretching of the skin and damage to blood vessels.

2.3. There is also an estimated 20% reduction in the thickness of the dermis, which results in the characteristic paper-thin appearance commonly associated with the elderly. This thinning of the dermis sees a reduction in the blood vessels, nerve endings and collagen, leading to a decrease in sensation, temperature control, rigidity and moisture retention.

2.4. The reduction in the number of sweat glands and in the production of sebum can make it difficult to keep the skin well hydrated and can lead to dryness and itching. In addition, elderly people may not be able to detect temperature changes readily, making them more susceptible to the cold and hypothermia.

2.5. Incontinence can be a problem associated with old age; not only will urine and faeces change the pH of the skin from acid to alkaline, they will also increase the need to cleanse the skin. Cleansing the skin can cause further skin damage, as traditional soaps can change the skin's pH to alkaline. This may increase the risk of the effects of dehydration and alter the normal bacterial flora of the skin, allowing colonisation with more pathogenic species.

2.6. With a reduced ability of the skin to regenerate and a less efficient protective immune system, the elderly are at an increased risk of skin breakdown. It is therefore vital that care of the older person's skin is seen as a priority.

3. PRESSURE ULCER PREVENTION

3.1. Early recognition of people who are at risk of developing pressure ulcers is an essential part of prevention.

3.2. All individuals should be assessed within six hours of start of admission to the episode of care and reviewed on a regular basis as dictated by the pressure ulcer risk assessment tool.

3.3. Those individuals considered 'at risk', or those with pressure ulcers, should receive appropriate interventions in relation to the pressure ulcer risk assessment tool.

3.4. An incident form then needs to be completed

3.5. An avoidable pressure ulcer is one that occurs when risk assessments, preventive actions and continued re-evaluations have not been implemented.

3.6. Where an area of redness or skin discoloration (erythema/hyperaemia) is noted, further examination is required and appropriate interventions put in place. Extra care is needed in patients with dark skin pigmentation.

3.7. Further examination will indicate if the skin changes are the early stage of pressure ulcer development

3.8. All patients should be encouraged to reposition themselves regularly when able to do so. For those who require assistance, repositioning should be undertaken with consideration for the patient's comfort, dignity and functional ability. Any repositioning must take into account that while pressure is being relieved/ redistributed, it is also important the patient is able to function, for example, take adequate nutrition and fluids in that position.

3.9. When repositioning a patient, manual handling techniques must be used to avoid further damage to the skin through shear and friction.

3.10. If the individual is to remain in bed, his or her position should be changed regularly and at least every two hours (although this should be adjusted to suit individual requirements as some patients may need more frequent intervention than others). Patients should be rested at a 30-degree tilt and on alternate sides to avoid prolonged pressure over bony prominences.

4. MOISTURE-RELATED SKIN DAMAGE

4.1. The skin produces sebum that enables it to maintain a naturally acidic pH, usually between 4.0 and 5.5. The mixing of urine and faeces creates an alkaline skin pH in incontinent patients. This is due to the production of ammonia when bacteria in the faeces digest urea from the urine. The raised pH around the perianal area, increases protease and lipase activity, causing skin irritation. This is responsible for the dermatitis excoriation seen in individuals with incontinence.

4.2. The increase in moisture resulting from episodes of incontinence, combined with bacterial and enzymatic activity, leads to the breakdown of vulnerable skin, particularly in those who are very young or elderly. For those individuals suffering the effects of irritation from incontinence, it is important to avoid exacerbating this further

through inappropriate methods of cleansing the skin. A protective barrier spray or cream can be used to prevent irritated skin from breaking down further.

4.3. Skin damage as a result of exposure to excessive moisture is defined as a skin lesion associated with incontinence and not caused by pressure or shear. This may be referred to as a moisture lesion, moisture ulcer, perineal dermatitis or incontinence associated dermatitis (IAD).

4.4. Moisture lesions are often misclassified as pressure ulcers and it is therefore important that healthcare practitioners are able to differentiate between the two conditions in order to implement appropriate clinical interventions. The key to these differences lies in the location, shape and depth of the damage and recognising when ulcers are caused by a combination of moisture and pressure. Please refer to the Moisture Lesion Guidelines and the Excoriation Tool for more information on managing moisture.