Preventive Skin Care

Margaret Goldberg MSN, RN CWOCN

Guideline Recommendations

Skin Assessment
Preventive Skin Care
Guideline Recommendations: Skin and Tissue Assessment

Skin Assessment Policy Recommendations

Each health care setting should have a policy in place outlining recommendations for a structured approach to skin assessment relevant to the setting that include anatomical locations to be targeted and the timing of assessment and reassessment.

It should make clear recommendations for documenting skin assessment and communicating information to the wider health care team.

Guideline Recommendations: Skin and Tissue Assessment

Ensure that a complete skin assessment is part of the risk assessment screening policy in place in all health care settings

Educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration
Guideline Recommendations: Skin Assessment (Level C Strength of evidence)

In individuals at risk of pressure ulcers, conduct a comprehensive skin assessment:

• as soon as possible but within eight hours of admission (or first visit in community settings)
• as part of every risk assessment
• ongoing based on the clinical setting and the individual’s degree of risk
• prior to the individual’s discharge

Skin Assessment

• Increase the frequency of skin assessments in response to any deterioration in overall condition
• Inspect skin for erythema in individuals identified as being at risk of pressure ulceration
• Document the findings of all comprehensive skin assessments.
Guideline Recommendations:

Skin Assessment  (Level C Strength of evidence)

Inspect skin for erythema in individuals identified as being at risk of pressure ulceration

Caution: Avoid positioning the individual on an area of erythema wherever possible.

Guideline Recommendation

Skin Assessment

Differentiate the cause and extent of erythema. Differentiate whether the skin redness is blanchable or nonblanchable.

• **Blanchable erythema** is visible skin redness that becomes white when pressure is applied and reddens when pressure is relieved. It may result from normal reactive hyperemia that should disappear within several hours or it may result from inflammatory erythema with an intact capillary bed.
Guideline Recommendation: Skin Assessment

Nonblanchable erythema is visible skin redness that persists with the application of pressure. It indicates structural damage to the capillary bed/microcirculation.

A prospective cohort study of 109 individuals in an acute care hospital found nonblanching erythema to be an independent predictor of Category/Stage II pressure ulcer development (Nixon 2007).

Guideline Recommendation: Skin Assessment

Use the finger or the disc method to assess whether skin is blanchable or non-blanchable. Studies are mixed regarding the two commonly used methods to assess erythema:

• finger pressure method — a finger is pressed on the erythema for three seconds and blanching is assessed following removal of the finger.
• transparent disk method — a transparent disk is used to apply pressure equally over an area of erythema and blanching can be observed underneath the disk during its application.
Guideline Recommendation: Skin Assessment

Include the following factors in every skin assessment:

• skin temperature
• edema
• change in tissue consistency in relation to surrounding tissue.

Assess localized pain as part of every skin assessment.

Localized heat, edema and change in tissue consistency in relation to surrounding tissue have all been identified as warning signs for pressure ulcer development.

Guideline Recommendation: Skin Assessment in darkly pigmented skin

Prioritize assessment of:

• skin temperature
• edema
• change in tissue consistency in relation to surrounding tissue.

Assess localized pain as part of every skin assessment.
Skin Assessment: Tips for assessing darkly pigmented skin

- Use natural light or halogen vs fluorescent which gives illusion of bluish tint
- May not distinguish blanching, look for areas darker than surrounding skin, or taut, shiny indurated areas.
- Light from a camera flash may enhance visualization.
- Check for localized changes in skin texture and temperature

Skin Assessment: Tips for assessing darkly pigmented skin

- Erythema may cause hyperpigmentation with no redness visible.
- May appear dark bluish-purple tint
- Should be able to detect heat over an area of localized inflammation
- Injured skin may have non-pitting edema w/ or without color changes
Skin Assessment in darkly pigmented skin

Webinar, Hettrick, H. 2014

http://www.albany.edu/sph/cphce/goldstamp_webinar_1214.shtml

Skin Assessment – Darkly pigmented skin: Tool under development

Reinement of an Instrument for Assessing Incontinent-Associated Dermatitis and Its Severity for Use With Darker-Toned Skin

Donna Zimmuro-Bliss, Jennifer Hurley, Jean Gelata, Leigh Mahlem, Kathleen Borchert, Kay Savik

ABSTRACT

PURPOSE: The purpose of this study was to refine an instrument for assessing incontinence-associated dermatitis (IAD) and its severity for use on lighter- and darker-toned skin, the Incontinence-Associated Dermatitis and Its Severity for Use With Darker-Toned Skin (IADIDS-FTWDT).

Introduction

Incontinence-associated dermatitis (IAD) is the inflammation and irritation of skin in the perineal area due to contact with incontinent feces and/or urine. Incontinence-associated dermatitis skin damage occurs incontinent, i.e., a number of conditions may contribute to incontinence.
Skin Assessment

- Inspect the skin under and around medical devices at least twice daily for the signs of pressure-related injury on the surrounding tissue.
- Conduct more frequent (greater than twice daily) skin assessments at the skin-device interface in individuals vulnerable to fluid shifts and/or exhibiting signs of localized/generalized edema.

Skin Assessment – Tools AHRQ

PREVENTING PRESSURE ULCERS IN HOSPITALS: A TOOLKIT FOR IMPROVING QUALITY OF CARE
- Prepared by Dan Berlowitz, et al

Skin Assessment – Tools QSource
Checklists on the following pressure ulcer-related topics are included:

- Screening for Pressure Ulcer Risk
- Developing a Pressure Ulcer Care Plan
- Assessment and Reassessment of Pressure Ulcers Monitoring
- Treatment and Prevention of Pressure Ulcers
- Assessing Pressure Ulcer Policies
- Assessing Staff Education and Training

http://qsource.org/toolkits/pressureUlcer/docs/prU
PreventionMonitoring/pruFacilityAssessmentChecklist.pdf

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Skin Assessment - Tools

- A series of self-assessment checklists for nursing home staff to use to assess processes related to managing pressure ulcers in the facility, in order to identify areas that need improvement.
- You will find the checklists most useful if you need to look at your current practice more critically.
Skin Assessment – Tools

IHI Includes:

- Prevent Pressure Ulcers Brochure
- How-to Guide: Prevent Pressure
- Photographic Wound Documentation
- Preventing Pressure Ulcers Turn Clock

http://www.ihi.org/topics/pressureulcers/pages/default.aspx

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Skin Assessment - Tools

An Overview of Instruments for Wound and Skin Assessment and Healing

Jane V. Arndt & Teresa J. Kelechi

Arndt & Kelechi 2014

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Licensed staff can leverage CNA knowledge of resident daily routines, likes, and dislikes and incorporate CNA feedback into clinical decision making and care planning.
Guideline Recommendations: PREVENTIVE SKIN CARE (All level C)

1. Avoid positioning the individual on an area of erythema whenever possible.
2. Keep the skin clean and dry.
3. Do not massage or vigorously rub skin that is at risk of pressure ulcers.
4. Develop and implement an individualized continence management plan.
5. Protect the skin from exposure to excessive moisture with a barrier product in order to reduce the risk of pressure damage.
6. Consider using a skin moisturizer to hydrate dry skin in order to reduce risk of skin damage.
Guideline Recommendations

Avoid positioning the individual on an area of erythema whenever possible

Do not massage or vigorously rub skin that is at risk of pressure ulcers.

Guideline Recommendation

Protect the skin from exposure to excessive moisture with a barrier product in order to reduce the risk of pressure damage.

Consider using a skin moisturizer to hydrate dry skin in order to reduce risk of skin damage.
Guideline Recommendations:  
Keep skin clean and dry

Use of a 3-in-1 disposable washcloth that included a no-rinse skin cleanser, emollient based moisturizer, and dimethicone-based skin protectant decreased IADS scores and the occurrence of PU.

Multivariate analysis revealed that higher IADS scores were associated with a greater likelihood of developing a PU.

Park & Kim 2014
IAD – Prevention and Care

Skin Care - IAD

Recommendation

A consistently applied, defined, or structured skin care regimen is recommended for prevention and treatment of IAD

Doughty et al JWOCN 2012
Skin Care IAD – Recommendation

Product Selection

- Skin care products used for prevention or treatment of IAD should be selected based on consideration of individual ingredients in addition to consideration of broad product categories such as cleanser, moisturizer, or skin protectant.

Skin Care IAD - Recommendation

Timing

Cleansing should occur as soon as possible following an episode of incontinence to limit contact with urine and stool.

Timely cleansing, moisturizing, and application of a skin protectant are especially important following an episode of fecal incontinence.
Skin Care IAD - Recommendation

Cleansing:

• A pH-balanced skin cleanser (one whose pH range approximates the acid mantle of healthy skin)
• No rinse skin cleansers
• Gentle cleansing - using a soft cloth to minimize friction damage.

Skin Care IAD - Recommendation

Moisturizing:

Routine use of a moisturizer is recommended to replace intercellular lipids and promote moisture barrier function of the skin.
Skin Care IAD - Recommendation

• A moisturizing product or combination product with an emollient moisturizer is recommended to prevent IAD in intact skin, not recommended for hyperhydrated skin.

• A product that combines a cleanser and emollient-based moisturizer ensures application of both products in a single step.

Skin Care IAD - Recommendation

A skin protectant or disposable cloth that combines a cleanser, emollient-based moisturizer, and skin protectant is recommended for prevention of IAD in persons with urinary or fecal incontinence and for treatment of IAD, especially when the skin is denuded.
Skin Care IAD - Recommendation

- Commercially available skin protectants vary in their ability to protect the skin from irritants, prevent maceration, and maintain skin health
- Additional research is needed to establish a benchmark for measuring various skin protectants’ ability to block exposure to a specific irritant, maintain hydration of underlying skin, and prevent maceration.

Educate staff - IAD

- Importance of intact skin barrier and characteristics of healthy skin (acidic, soft, dry)
- Overview of IAD: prevalence; impact on patient; impact on staff; link between IAD and increased risk of pressure ulcer development
- Definition, risk factors, and pathology of IAD
- Assessment of IAD, including differential assessment of wounds with similar clinical appearance such as stage I and II pressure ulcers
- Preventive care guidelines for cleansing, moisturizing, and protecting skin, to include basic discussion of product categories and indications for each
- Treatment of IAD using an established decision tree (and ideally a pictorial guide)
Develop Formulary

The Economic Impact of Complex Wound Care on Home Health Agencies
Mary C. Vritis

ABSTRACT
The cost of care for home health clients with complicated wounds frequently exceeds reimbursement received from Medicare and other payer sources. As a result, home health agencies may be reluctant to accept this type of referral. Many of the costs associated with complex wound care can be substantially reduced by appropriate use of expensive therapies and dressings and establishment of a cost-effective wound care plan by $945.45, while continuing to assure positive clinical outcomes. Specifically, the wound care nurse could recommend a generic silver contact layer instead of a 4- to 7-day use paste, thus reducing the number of nursing visits and dressing changes to 1 to 2 per week. Alternatively, many companies now provide postoperative dressings with a silver contact layer and an adhesive border reducing the need for the dressings described previously. The wound care nurse also may wish to collaborate with the nurses to provide to inpatients.

Costs of wound care may exceed reimbursement Vritis 2013

Develop Formulary & Educate Staff

Skin Care Formulary Checklist
Cathy Thomas Hess, BSN, RN, CWOCN

The fundamental building blocks addressing the prevention of skin breakdown are generally overshadowed by the deluge of intervention strategies touted for patients with chronic wounds. It is paramount that providers take these proactive steps in clinical practice to develop sound skin care prevention and intervention pathways.

Use the following skin care product categories to help you develop a skin care formulary for your facility. When creating the skin care formulary, remember to include products under these categories. And be sure to understand the reimbursement guidelines for all products ordered. You may find that many skin care products are considered routine supply items and are included in the general cost of an inpatient stay.

- Moisture barriers (also called skin protectants): ointments, creams, or pastes that protect the skin from urinary and fecal incontinence by shielding the skin from irritants or moisture (e.g., dimethicone, petrolatum, and zinc oxide).
- Description: Moisture barriers, sometimes called skin protectants, are ointments, creams, or pastes that shield the skin from exposure to irritants or moisture from sources, such as incontinence, perspiration, and enzymatic and wound drainage. These common ingredients found in moisture barriers include dimethicone, petrolatum, and zinc oxide, or a combination thereof. Some products are formulated with additional properties, such as antibacterial, antioxidant, or antifungal ingredients. A moisture barrier may be formulated with a skin barrier.
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