Care of the Older Person’s Skin

Nicky Morton – Senior Nurse for Tissue Viability and Clinical Procurement
Basic wound care

- What type of wounds?
  - Pressure ulcers
  - Moisture associated skin damage
  - Skin tears
Function of the skin

- Protection
- Barrier to infection
- Pain receptor
- Maintenance of Body temperature
- Production of vitamin D in response to sunlight
- Production of melanin
- Communication through touch
Effect of Aging

- Epidermis (outer layer) becomes thinner
  - More at risk from moisture, friction, trauma

- Reduction in sweat glands and production of sebum (protective function)

- Increased necessity to cleanse the skin eg. Due to incontinence
  - Soaps increase pH to alkaline leading to dehydration and altering the normal skin bacteria which allows bad bacteria to take hold

- Skin has less elastin – stretches, wrinkles etc

- 20% reduction in thickness of the dermis
  - Seen in paper thin skin
  - Results in reduction in all functions of the skin
Best practice

- Care for dry, vulnerable tissue
- Ensure adequate hydration
- Prevent pressure ulcers
- Manage incontinence
- Prevent maceration
- Prevent skin tears
Dry vulnerable tissue

- All residents should be assessed to determine condition of skin
- Emollient soap substitutes should be used if skin is dry or where residents are incontinent and frequent washing of the skin is performed
- Thoroughly dry skin (pat don’t rub!)
- Vulnerable skin should always have application of a bland moisturiser or barrier cream applied at least twice daily
- Application of the cream should follow direction of body hair and be gently smoothed into the skin
Pressure Ulcer Prevention

- A.S.S.K.I.N.G.
  - Assess Risk
  - Skin assessment
  - Support surfaces
  - Keep Moving / Repositioning
  - Incontinence
  - Nutrition & Hydration
  - Give Information
Assess Risk

- Assess all residents using formal and informal assessment tools to determine their level of risk
- Reassess at regular intervals if condition or treatment alters
Skin inspection

- All residents at risk of pressure ulcers or with existing pressure ulcers will have their skin assessed as part of the whole assessment process.
- For those with pressure ulcers, a classification score will be used to determine level of damage (Category 1–4)
- Special attention must be given to all areas with bony prominences
Erythema

**Blanchable Erythema:** Reddened area that temporarily turns white or pale when pressure is applied with a fingertip. Blanchable erythema over a pressure site is usually due to a normal reactive hyperemic response.

*National Pressure Ulcer Advisory Panel USA (1998)*
Non blanchable erythema

A Grade I pressure ulcer is an observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following:

- skin temperature (warmth or coolness);
- tissue consistency (firm or boggy feel);
- sensation (pain, itching).
Category 1
Pressure Ulcer *Non-blanchable erythema*

**Definition of Category 1:** non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.
Category 2 Pressure Ulcer:

**Definition of Category 2**: partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.
SSKIN BUNDLE

- Skin Inspection
- Support surface
- Keep Moving/reposition
- Incontinence
- Nutrition
<table>
<thead>
<tr>
<th><strong>SSKiN Care Bundle</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KEY</strong></td>
</tr>
<tr>
<td>Care delivered</td>
</tr>
<tr>
<td>✓ - Yes</td>
</tr>
<tr>
<td>X - No (record why not)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Name</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of care delivery (circle as appropriate) 1hrly 2hrly 3hrly 4hrly</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Time – record using 24 hour clock</td>
</tr>
</tbody>
</table>

**Surface**
- Mattress appropriate (please state)
- Cushion appropriate (please state)
- Functionality/integrity check of equipment performed

**Skin Inspection**
- All pressure areas checked
- Redness present Y/N

**Keep moving**
- B
- E
- D
- Right side
- Left side
- Back
- CHAIR

**Incontinence**
- Urine
- Bowels

**Nutrition**
- Diet (please state)
- Fluids (please state)
- Supplement(s) (please state)

| **Initials** |
Support surfaces

- **Mattresses**
  - Check carefully if a patient is deteriorating

- **Seating**
  - Pressure mapping for long-term seating

- **Reposition**

- **Heels – free of the bed**
  - Knee slight flexion (to avoid DVT)
Pressure Ulcers – mattresses, chairs and cushions

- Patients at risk of pressure ulcers or those with pressure ulcers should be provided with a pressure reducing foam mattress as a minimum.
- The decision to provide any pressure reducing equipment is taken as part of a comprehensive treatment/management strategy.
- Equipment needs may vary as the patients' condition varies.
- Appropriate pressure reducing equipment must be used if the patient is sitting out of bed.
- Patients who are long-term wheelchair users have their needs assessed by wheelchair services.
Keep Moving

If the patient cannot move........

..................move the patient

Or

..................move the pressure

And always ACT as soon as the risk is recognised.
Pressure Ulcers – positioning

- Position to minimise friction, shear and pressure
- 30 degree tilt
- Appropriate seating
- Move patients who are unable to move themselves
Incontinence

Skin Excoriation Tool for Incontinent Patients
NATVNS (Scotland)

0 = Healthy Skin
Healthy, intact skin. No erythema (redness).
Clean skin with skin cleanser

1 = Mild excoriation
Erythema (redness) of skin only. No broken areas present.
Use durable barrier cream

2 = Moderate excoriation
Erythema (redness), with less than 50% broken skin.
Oozing and/or bleeding may be present.
Use barrier film spray

3 = Severe excoriation
Erythema (redness), with more than 50% broken skin.
Oozing and/or bleeding may be present.
Seek advice from Tissue Viability Nurse where available for local guidelines/guidance

www.tissueviabilityonline.com/pu

Images: Collins Salt Medical Photographer Inverclyde Royal Hospital (IRH) Greenock / Science Photo Library
Skin care – incontinence

- Patients with incontinence should have their continence status reassessed regularly.

- Soap and water should not be used when cleansing following episodes of incontinence.

- Foam cleansers / tap water or Aqueous cream & tap water should be used instead of soap for patients with incontinence.

- For prevention, Medi Derma S barrier cream should be applied (pea sized amount) twice daily.

- For superficial broken skin, the skin should be washed with Hydromol and warm water and Medi Derma S barrier film applied.
Nutrition – food first! Promote additional calorie intake and weigh to monitor fluctuation.

Offer milkshakes if appropriate to increase calories.

Hydration – key to prevention of pressure ulcers and skin tears. Consider hourly fluids for those at risk of dehydration.
Priorities for Prevention

- **Skin inspection** is absolutely essential
- **ACT before** significant tissue damage occurs
- **Continence management** for moisture lesions
  - Manage the microclimate
- **Offload heels** in all high risk patients, particularly:
  - Peripheral vascular disease
  - Diabetic patients
  - Rheumatoid arthritis
- **Reposition**, reposition, reposition!!!!
  - SSKIN bundle or repositioning chart
- **30 Degree tilt** with both legs elevated off mattress
Pressure Ulcers – promoting healing

- Any pressure ulcers should be referred on to District Nurses for assessment and management
- Ensure that the GP is informed if the patient develops a pressure ulcer
- The patient will require a full plan of care for prevention of further pressure ulcers
Skin tears

First Aid:
- Stop bleeding,
- Prevent infection,
- Minimise pain and discomfort,
- Recover skin integrity

Management
- Elevate limb
- Wash hands
- Apply pressure to stop bleeding
- Bathe with warm saline
- Smooth flap over wound if possible
- Apply simple non-adherent dressing
- Contact DN for review of patient
Why skin tears are complex and require careful assessment and management

Figure 5a
Skin flap rolled upward to cover wound

Figure 5b
Dressing applied with arrow to indicate correct direction of removal

Figure 5c
Any dressing over the skin flap should be removed in the same direction
Prevention of skin tears

- Have I been given an individualised skin care plan?
- Am I using an emollient every day?
- Am I eating sensibly and drinking enough water?
- Am I keeping as active and mobile as possible?
- Have I thought about wearing clothing to protect my skin — e.g. long sleeves or tubular bandages?
- Has my environment been made as safe as possible — e.g. adequate lighting, no obstacles and using padding on furniture if required?
- Discuss use of protective clothing — e.g. shin guards, long sleeves or retention bandages
- Am I wearing sensible/comfortable shoes to avoid falls?
- Do my carers have trimmed nails and are they bare below the elbow?