

SESLHD PROCEDURE COVER SHEET



Health
South Eastern Sydney
Local Health District

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KEY TERMS	Skin assessment Skin care
SUMMARY	The purpose of this procedure is to inform all clinical staff involved in the care of skin to promote healthy skin, provide comfort and minimise skin complications.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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Wound – Skin Assessment and Care/Management

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1. PROCEDURE STATEMENT

This procedure is to inform all clinical staff of appropriate measures to promote healthy skin for patients under the care of SESLHD facilities.

This is achieved by holistic assessment of the patient and their skin. Skin re-evaluation is ongoing, and facilitates clinical decision-making; intervention and education which will minimise complications, aid optimal treatment and promote patient comfort. This plan will be kept within the patient's health care record.

2. BACKGROUND

It is essential to improve and maintain and protect the patient's skin whilst they are in our care. The skin is the largest organ of the body and has many properties that are essential to the patient health. Failure to care for, maintain and protect the skin will leave the patient at risk of skin failure and the normal tasks and functions of the skin will no longer be performed, including but not limited to first immune response, regulation of body temperature, absorption of vitamin D and medications eg, creams, protection from UV radiation, protection from loss of body fluid containing essential vitamin and minerals eg, albumin.

Skin Assessment is to provide individualised patient management that is based on a holistic assessment of the patient and their skin.

- 1) There is no tool that grades a person's skin fragility
- 2) Skin is different throughout a person's life span eg, neonate to older person

Management should be prompt, appropriate, and use available resources to promote an ideal environment to promote skin care.

Limitations of this procedure

It is outside the scope of this procedure to give advice on dermatological conditions.

If there are concerns with any dermatological condition or the skin is not responding to care then the patient should be referred to a dermatologist. For example, known dermatological conditions include Acne, Eczema, Psoriasis, Shingles, Allergic reactions, Fungal infections (not responding to first line treatments), Scabies (not responding to first line treatments), Urticarial (acute) (not responding to first line treatments).

Known medical conditions with associated skin breakdown should be referred to appropriate medical specialists related to the cause of the condition, some examples include:

- Skin cancers (SCC / BCC) - referred to a Plastic Surgeon
- Melanoma - referred to a Melanoma Clinic
- Pyoderma gangrenosum or Vasculitis - referred to an Immunologist
- Cellulitis or bites (eg, spider bite) - referred to the Infectious Disease team
- Calciphylaxis - referred to the Renal/Vascular Team
- Gout - referred to a Rheumatologist
- Raynaud's Disease - referred to a Rheumatologist
- Hydradenitis suppurativa - referred to the Infectious Disease team
- Scleroderma - referred to a Rheumatologist

Skin conditions in children eg, Chickenpox (Varicella), Eczema (atopic), Henoch-Schönlein, Impetigo purpure, Impetiginised eczema, Miliaria (sweat rash), Measles,

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Napkin dermatitis (nappy rash) Rubella (German measles), should be referred to the paediatric medical team/ paediatric unit for advice/GP and local paediatric policies and procedures related to these conditions.

If the patient's primary concern/illness/surgery is not dermatological; however, they have a dermatological comorbidity which is responding to their usual care, the care for this skin condition should be discussed with the treating medical team/GP, and if appropriate usual skin care continued or the patient should be referred to a dermatologist.

Not covered in this procedure are specific skin situations that have a procedure assigned to their care. Refer to:

- SESLHD - [Wound Assessment and Management](#)
- SESLHD - [Incontinence Associated Dermatitis \(IAD\)](#)
- POW/SSEH BR - [Care of the patient with Cellulitis](#)
- POW/SSEH BR - [Pressure Injury Prevention and Management](#)
- POW/SSEH BR - [Skin Tears - Prevention and Management](#)

3. DEFINITIONS

Education – patient/ carer	Education should be timely and continuous throughout the healing process and should include a maintenance plan. The information should be both verbal and written where necessary. Contact details for appropriate Health Care Professionals are to be made available for the patient/client.
Health Care Record	Documented account of a patient's/client's health, illness and treatment during each visit or stay at a hospital, nursing home, community health centre or other health care facility/service ² . The health care record may be in hard copy or electronic format, on approved Area forms or systems. Also known as patient medical records, it includes all documentation related to the individual patient/client, in any of the Area's health care settings. E.g. Patient Care Plan, Clinical Pathways, Progress Notes, eMR and CHOC-eMR; or various charts, e.g. Neurological, wound maps.
Patient	Any person to whom a health service provider owes a duty of care in respect of the provision of health services ²
Terminology	See appendix wound assessment policy

4. RESPONSIBILITIES

Area Director Nursing and Midwifery Services, Area Clinical Stream Director, Directors of Operations, Clinical Stream Directors and all clinical staff involved in wound management.

4.1 All clinical staff who attend wound management are: responsible at all times for the assessment of the wound, development of an appropriate wound management plan, completion of the wound assessment chart and ongoing **re-evaluation** of the wound management plan (in collaboration with the medical team). When nursing staff are involved a Registered Nurse (RN) is primarily responsible to ensure this happens.

An Enrolled Nurse (EN) or Trainee Enrolled Nurse (TEN) may be delegated specific wound management activities under the direct and indirect supervision of the RN.

4.2 Line Managers will: ensure all clinical staff are given the opportunity to attend District wound management education and that all nursing staff work within this procedure and have appropriate resource and stock items to implement the recommendations within this procedure

5. PROCEDURE

5.1 Assessment

5.1.1 Assess the skin

- Colour
 - Is the skin the normal colour for this patient?
 - Is there bruising present?
 - Is there erythema (redness) indicating infection or inflammation?
- Temperature
 - Does the skin feel the same as surrounding skin?
 - Does the skin feel warm to touch?
 - Does the patient have known infection to area?
 - Does the skin feel cold to touch indicating poor vascularisation?
- Texture
 - Does the skin feel dry or moist?
 - Is the skin papery or thin?
 - Is the moisture due to sweat or urine or wound exudate?
 - Is the skin macerated due to oedema?
- Integrity
 - Is the skin broken?
 - Is there a wound/skin tear/Incontinence associated dermatitis/pressure injury? Please refer to the appropriate LHD/facility policy/procedure (links above)
 - Is there epidermal stripping?
 - Is there a rash?
- Sensation
 - Pain - is the skin painful to touch?
 - Pruritus - does the patient complain of an itch?
- Infection
 - Does the patient have a known skin infection? eg, Cellulitis, Tinea, Fungal

5.1.2 Skin break down caused from

- Incontinence of bladder and bowel
- Medical conditions of the skin
- Treatment of medical conditions which cause side effects to skin
- Failure to moisturise skin (skin becomes dry brittle or clubs on skin causing mounds of dead skin cells)
- Failure to clean skin around wounds
- Failure to clean skin after compression bandaging removed
- Obesity which causes skin to sweat (skin fold breakdowns)

Once the skin assessment is complete refer to Appendices for detailed information on cause and care:

5.1.3 Age Related Skin Changes see [Appendix A](#)

5.1.4 Bariatric skin folds see [Appendix B](#)

5.1.5 Cleaning unwashed skin see [Appendix C](#)

5.1.6 Contact dermatitis see [Appendix D](#)

5.1.7 Desiccation see [Appendix E](#)

- 5.1.8 Fungal see [Appendix F](#)
- 5.1.9 Hyperkeratosis see [Appendix G](#)
- 5.1.10 Ichthyosis see [Appendix H](#)
- 5.1.11 Lotions and potions see [Appendix I](#)
- 5.1.12 Maceration see [Appendix J](#)
- 5.1.13 Neonatal skin see [Appendix K](#)
- 5.1.14 Pruritus (Itching skin) see [Appendix L](#)
- 5.1.15 Radiotherapy Damaged Skin see [Appendix M](#)
- 5.1.16 Skin Care and Oedema/Lymphoedema see [Appendix N](#)
- 5.1.17 Skin stripping see [Appendix O](#)
- 5.1.18 Tinea see [Appendix P](#)
- 5.1.19 Venous Eczema see [Appendix Q](#)
- 5.1.20 Xeroderma (Dry Skin) see [Appendix R](#)

5.2 Management and evaluation

- 5.2.1 Patient's choice not to follow treatment plan must be recorded in the patient health care record indicating the reason for their decision.
- 5.2.2 To reduce and eliminate the risk of non-concordance to treatment, the clinician should discuss and explain the strategies employed in wound care to the patient/client and carer (if appropriate). This is to assist their understanding of the treatment involved. Advise them to be alert to signs and symptoms of any contrary reactions/discomfort to treatment or when to ask for additional assistance.
- 5.2.3 Patients/carers should be provided with appropriate handouts to reinforce teaching/learning. Where possible, translations should be provided for non-English speaking patients/carers.

5.3 Training and Education

To ensure evidence based knowledge and consistency of practice, all clinical staff involved in wound care should attend Wound Care Management education within SESLHD annually.

6. DOCUMENTATION

Wound assessment and management plan (form number S0056)
Any additional comments are to be recorded in the patient's/clients health care record.
Community Health Outpatients Care (CHOC) wound care templates/clinical pathways
Transfer documentation eg, from community to hospital or vice versa
Discharge letters should include wound assessment and management plan information

7. AUDIT

Yearly audit of wound assessment forms to ensure compliance to procedure

8. REFERENCES

8.1 External References

British Journal of Nursing. Downloaded from magonlinelibrary.com by 113.011.234.010 on February 21, 2016.

8.2 Internal References

Staff should also refer to site infection control manuals

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Date	Revision No.	Author and Approval
November/December 2016	Draft	Draft for Comment period
21.2.17	Final draft	SESLHD and ISLHD Wound Committee
March 2017	Final draft	Approved by Clinical and Quality Council
March 2018	1	Minor addition of Appendix T approved by Executive Sponsor.

Appendix A: Age Related Skin Changes**Definition:**

The physiologic cause of skin ageing is referred to as 'intrinsic' ageing which is a time dependant stochastic process. While 'extrinsic' skin ageing refers to continued and repeated exposures to environmental factors such as ultraviolet radiation, air pollution and smoking¹. Signs of intrinsically aged skin rarely manifest before the age of 70 years where the skin is pale, dry and characterised by fine wrinkles alone. Extrinsically aged skin features coarse wrinkles with increased laxity².

Additionally to the morphological changes skin and tissue ageing leads to a loss of functional capacity. Altered lipid content, reduced water, sebum production, and natural moisturising factors may cause dry skin and pruritus. Impaired acidification of the skin surface leads to decreased stratum corneum cohesion, disturbed skin barrier recovery and increased susceptibility to pathologic colonisation and infection. The flattening of the dermal-epidermal junction increases the risk for shearing injuries such as bullae and skin tears^{1,2,3}. Therefore, skin is increasingly less able to cope with external stresses and more susceptible to a wide range of age-related conditions, diseases, injuries and wounds.

Management:

- There is a need to preserve the skins integrity by sustaining moisture content as a potential barrier against infection.
- Emollients or moisturisers are interchangeable terms for topical applications that help to stop hardening and irregularities in the outer layer of the skin through the addition of moisture⁴.
- The skins structural integrity can be improved with daily skin cleansing (with a pH neutral and perfume free skin cleansers) and twice-per-day moisturising (again pH neutral and perfume free)^{3,5,6}.
- The selection and frequent application of an emollient/moisturiser is essential to good skin health.

References:

1. Kottner J Of youth and age: what are the differences regarding skin structure and function. *EWMA Journal*, 2015, Vol. 15, No. 2, 11-13
2. Blume-Peytavi, U; Kottner, J; Sterry, W; Hodin, MW; Griffiths, TW; Watson, RE; Hay, RJ & Griffiths CEM Age-associated skin conditions and diseases: current perspectives and future options. *The Gerontologist*, 2016, Vol. 56, No. S2, S230-S242
3. Watkins P The use of emollient therapy for ageing skin. *Nursing Older People*, Vol. 23, No. 5, 31-37
4. New Zealand Dermatological Society 2010 *Emollients and Moisturisers*. www.dermnetz.org/treatments/emollients.html (accessed July 10 2016)
5. Ryan, T Matt's hypothesis: How simple strategies can lead to better outcomes. *Journal of Lymphoedema*, 2016, Vol. 11, No. 1, 46-48
6. Stephen-Haynes, J & Carville, K Skin tears: made easy. *Wounds International*, 2011, Vol. 2, No. 4, 1-6

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Appendix B: Bariatric skin folds

Definition:

All skin fold in bariatric patients are at risk of breakdown due to the heat generated by the skin folds and lack of air flow to skin area causing the skin to sweat. Sweating is the body's normal response to overheating. If sweating is not controlled then the skin will become moist and breakdown.

Identifying and minimising potential risks:

Inflammatory factors and obesity –

Obesity is also associated with low-grade chronic inflammation within the fat tissue. Excessive fat storage leads to stress reactions within fat cells, which in turn lead to the release of pro-inflammatory factors from the fat cells themselves and immune cells within the adipose (fat) tissue. This leads to increased risk of infection.

Prevention:

- Apply a layer of antiperspirant to towel-dried skin before bed and after showering. Antiperspirant must come into contact with skin fold edge. Select a high stretch good quality roll on antiperspirant eg, 24 hour sports antiperspirant*
- Combine/pads can be used to absorb sweat and protect clothing but need to be changed regularly. Ensure all clothing is thoroughly dry before wearing.

***Note** Deodorants reduce odor, but don't prevent wetness /sweating.

Obesity, smoking, and drinking alcohol can cause or intensify heavy sweating. Maintain a healthy weight, reduced smoking and limit excessive alcohol consumption will help in prevention of sweating and skin fold breakdown.

- Recommendations for removing products: wash off in shower or use bath bags daily, dry skin folds

References:

<https://www.betterhealth.vic.gov.au/health/healthyliving/obesity-and-hormones>

Appendix C: Cleaning unwashed skin**Definition:**

The top layer of human skin (stratum corneum) consists of four to five layers with the top layer (epidermis) consisting of dead cells (Keratinocyte). The natural process for skin revitalisation is that the top layer consisting of these dead cells break away from the live cells every hour of every day.

Cleaning of the skin removes the oldest dead skin cells to allow for new layer of cells to be exposed to protect the body. If you leave the Keratinocyte cells undisturbed, they will mix with the sweat and dirt on the skin surface to form an area for bacteria to breed putting the person at risk of infection.

Identifying and minimising potential risks:

Using high pH cleansers, such as soap, can lead to:

- A loss of skin integrity
- Loss of cohesion between skin layer
- Increased epidermal permeability
- Results in dry, flaky, irritated skin

The dry skin loses its natural protection against bacteria, which can then slip in through cracks and fissures in your skin.

Prevention:

Use PH friendly skin cleaning products

Management:

- Skin should be washed regularly, depending on exposure / problems /assaults, eg, incontinence wash skin each time the person's skin is soiled.
- Compression stocking / bandages wash the person's skin each time the bandages / stocking are removed
- General all over body cleaning is normally daily according to person's condition.

References:

<https://www.reference.com/science/much-skin-shed-day-4e93a661a80b649a>

Appendix D: Contact dermatitis

Reactions to dressing and other products applied to the skin may not be immediate, they can occur after repeated use. They are often underreported and can lead to increased cost of healthcare, affect quality of life and undermine confidence in the prescriber¹.

Definition:

Contact dermatitis results from skin contact with an exogenous substance either allergic or irritant. For example: dressing, stoma bag, adhesive tape, stoma effluent, soaps, wound exudate². Skin changes such as irritation and itching, inflammation, blisters and eczema occur.

Management:**• Identifying potential risks**

Identifying potential risks is achieved by taking a thorough patient history where able of previous skin reactions from being in contact with wound dressings, tapes or stoma bags. These are to be documented as per the organisations policy. Once alerted to this subsequent use of the allergen is to be avoided¹. If able patch testing can be performed to assess whether the product is suitable to be used on a larger area of skin (eg, stoma bag adhesive).

• Minimising risks

Awareness and avoidance of exposure to the product and selection of products that are less likely to cause irritation. If unsure contact your wound care expert for advice. Keep wound care products to a minimum and avoid multiple brands where possible. Use products as per manufacturer's recommendations^{1,3}.

• How to identify contact dermatitis

The reaction occurs at and is confined to the point of contact. There will be a clearly defined area of erythema which corresponds to the outline of the dressing/product used.

• What to do if allergy occurs (reporting and alerts)

Cease use of the offending product. The literature recommends topical steroids to treat allergic contact dermatitis⁴. However, this may prohibit adhesion of wound dressings or stoma/wound drainage bags. Often by removing the cause by changing to a different product will resolve the dermatitis. If not contact your wound care expert for advice.

Report the adverse reaction via the IIMS notification system.

References:

1. Conway, J. & Whettan, J. 2002 Adverse reactions to wound dressings, Nursing Standard, Vol 16, No. 4, Pp. 52-60
2. Lyon, C.C. & Smith, A. 2010 Abdominal stomas and their skin disorders 2nd Ed Informa healthcare, London
3. Jarvis, S. 2004 Contact dermatitis: causes and prevention, Practice Nurse 27; 4. Pp.44-47
4. Jones, R. & Horn, H.M. 2014 Identify the causes of contact dermatitis, The Practitioner, 1772, Pp. 27-31

Please also refer to the following policy/procedures

- [Incontinence Associated Dermatitis](#)
- [Patient Identification, Allergy and Alert Bands](#)

Appendix E: Desiccation**Definition:**

Dryness cause cell death and forms a physical barrier to the migration of epithelial cells from the wound edges^{1,4}. Desiccation can result in delayed healing and damage to underlying structure (eg, bone and tendons)¹.

Dry wounds restrict the movement of cells required for healing (wound in moist environment). White Blood Cells cannot fight infection, enzymes such as collagenase cannot breakdown dead material, and macrophages can't carry debris. The wound edges curl up to preserve the moisture that remains in the edge and the epithelial cells (new skin cells) fail to grow over and cover the wound. Healing grinds to a halt and necrotic tissue builds up².

Causes:

Topical mismanagement (wrong dressing choice)
A poorly vascularised wound bed
Necrotic tissue
Wound being left exposed for too long (usually at dressing changes)

Management:

Dry surrounding skin may indicate eczema which will require a dermatology review. If the problem is a little dryness, the skin can be moisturised².

Recommendation for Wound Care:

Dressings that promote moist environments and prevent additional drying out of the wound
Silicone
Hydrogels
Hydrocolloids
Film dressings

References:

1. Templeton, S. 2005. Wound Care Nursing: A Guide to Practice, Ausmed Publications, Melbourne, Australia.
2. Vuolo, J. 2009. Wound Care made incredibly easy, Lippincott Williams & Wilkins, London, England.
3. Collins, F., Hampton, S. & White, R. 2002. A-Z Dictionary of Wound Care, Quay Books, Wiltshire, England.
4. Chamanga, E. 2015. Effectively managing wound exudate, British Journal of Nursing, Vol. 20, Issue Sup. 9 Section 8

Appendix F: Fungal infections**Definition:**

Fungal infections are divided into groups depending on what type of organism is involved and where it is on the body. These include:

Athlete's foot - tinea pedis – located on the feet and toes, and **tinea manuum** located on the palm of hands and sides of fingers. Can contain fungus and bacteria which causes skin to become itchy, dry, scaly and red.

Nail infections –onychomycosis

Tinea unguium – ringworm of the nails. Nails become malformed, thickened and crumbly.

Ringworm of the groin – tinea cruris – causes an itchy, red rash in the groin area, caused by sweating.

Ringworm on the body – tinea corporis – can be anywhere on the body. Red, raised or flat patches and rings that can merge, grow and spread from the centre. Rings are scaly at the edge, surrounding clear skin in the middle.

Pityriasis or tinea versicolour – This infection causes dark patches to form on pale skin and light patches on darker skin.

Causes of fungal skin infections

Taking antibiotics, short or long term steroid use, high blood sugar levels i.e. uncontrolled diabetes, obesity, history of fungal skin infections, being immunosuppressed.

Treatment:

- Topical creams, lotions and medicated powders applied to the infected areas.
- Use of medicated shampoos for infected scalps, sprays for infected feet.
- These products may need to be used for two weeks after the symptoms have disappeared to make sure the infection is completely gone.
- Strong oral medications may be prescribed for systemic management for up to 18 months.

Management:

- Showering regularly and drying skin carefully
- Wearing loose fitting clothes and underwear made of natural fibres to allow skin to breathe
- Not sharing towels, hair brushes or combs
- Washing bed linen and clothes often to get rid of fungal spores
- Wearing thongs in communal showers
- Throwing out shoes infected with spores and alternating new shoes to allow two to three days to allow shoes to dry out
- Keep blood sugar levels well controlled if a diabetic

References:

Fungal skin infection – body and groin. London: national institutes for Health and Clinical Excellence 2009

Appendix G: Hyperkeratosis**Definition:**

Hyperkeratosis is thickening of the stratum corneum, often associated with the presence of an abnormal quantity of keratin, and also usually accompanied by an increase in the granular layer.

Identifying and minimising potential risks:

Hyperkeratosis can also be caused by B-Raf inhibitor drugs such as Vemurafenib and Dabrafenib.

Management:

It can be treated with urea-containing creams, which dissolve the intercellular matrix of the cells of the stratum corneum, promoting desquamation of scaly skin, eventually resulting in softening of hyperkeratotic areas.

References:

<http://www.dermnetnz.org/>

Appendix H: Ichthyosis**Definition:**

There are many types of ichthyosis. Ichthyosis vulgaris is the most common type and it is a severe scaly skin condition, often of the front of the lower legs. This is not dry skin, but rather scaly skin caused by the failure of old skin to slough properly. Ichthyosis vulgaris causes dry, fishlike scales.

Different Types of Ichthyosis

- **Ichthyosis vulgaris:** Characterised by mild skin scaling and dryness. Ichthyosis vulgaris and another form, recessive X-linked ichthyosis, are relatively common and appear similar.
- **Epidermolytic ichthyosis** (previously called epidermolytic hyperkeratosis): Characterised by thick, often spiny dark scales and skin that may blister easily following trauma.
- **Lamellar ichthyosis:** Characterised by large, plate like scales and thickening of the skin.
- **Congenital ichthyosiform erythroderma:** Characterised by red skin and fine scales.
- **Localized ichthyosis:** Characterised by thick or scaly skin that is localized to particular regions such as the palms of the hands and soles of the feet.

Prevention:

Treatment is targeted at managing the signs and symptoms including creams, lotions, or ointments to relieve dryness. Products containing salicylic acid (aspirin) or urea may also ease scaling.

Treatment:

Ichthyosis is treated by dermatologists

References:

http://www.niams.nih.gov/Health_Info/Ichthyosis/

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Appendix I: Lotions and potions

Definition:

Washing, cleansing and moisturising a person's skin to maintain skin integrity has always been integral to the nurse/patient role.

Management:

- For basic skin washing use cleansers with a PH between 4-5 that contain surfactants not soap¹
- Once daily washing for people with dry skin¹
- Twice daily application of moisturisers improves skin barrier function and helps protect against irritants¹. An example of a common moisturiser used extensively is Sorbolene.
- Emollients close fissures by filling spaces and sealing moisture into the skin by the production of an occlusive barrier. They also help to soften the skin². Emollients are often an ingredient of a moisturiser eg, liquid paraffin².
- Lotions eg, calamine are more occlusive than oils and less than a cream or ointment – evaporates and cools the skin, absorbs moisture so is therefore drying³
- Creams include Sorbolene and aqueous cream and are more occlusive than oils and lotions³
- Ointments include white soft paraffin and are very good for intensive moisturising when required³
- Pastes eg, Zinc Oxide are occlusive and protective against moisture³

Recommendations for wound care

- Product selection is difficult because of terminology and labelling.

References

1. Lichterfield, A., Hauss, A., Surber, C., Peters. T., Blume-Peytavi & Kottner, J (2015) Evidence- Based skin care: A Systematic Literature Review and the Development of a Basic Skin Care Algorithm. *Journal of Wound Ostomy and continence Nursing*. Sept/Oct pp501-524
2. Andriessen, A. (2013) Prevention, recognition and treatment of dry skin conditions. *British journal of nursing* vol22, No 1
3. Classification of potencies of topical corticosteroids, Dermatology Expert Group (2009), Therapeutic Guidelines, Version3, therapeutic Guidelines limited, Melbourne & the Australian Medicines Handbook, 2010, updated.

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Vehicle				Medication Absorption	Practice Points	
Lotion e.g.: Calamine lotion	More occlusive than oils, less than creams and ointments	Acute inflammation Used for scalp, hairy areas, mild dryness on face, trunk Used for large areas	Evaporates and cools the skin Absorbs moisture, promotes drying	Effective water- soluble medication Delivers medication as uniform residual film	Liquid vehicle Often aqueous or alcohol based May contain salt in solution	May cause stinging and drying in intertriginous skin Shake well before use
Cream e.g.: Sorbolene aqueous	More occlusive than oils and lotions	Sub-acute inflammation Used for hair-bearing areas, moist lesions, intertriginous folds and large areas	Used when more emollience is required	No increase in medication percutaneous absorption	Aqueous (oil in water) Oily (water in oil) High water content, mostly evaporates Contains an emulsifier for stability contains a preservative to prevent overgrowth of micro-organisms	Non-greasy Easy to apply and remove Preservatives can cause irritant or allergic contact dermatitis, can cause confusion on skin assessments
Gel e.g.: Daibobet gel	Used for beneficial drying effect in hairy areas as an alternative to lotions	Exudative inflammation Sub-Acute inflammation Chronic inflammation Used for scalp	Drying and cooling May aid pruritic eruptions	Effective vehicle for water-soluble medication Leaves a film that stays on skin surface longer than aqueous cream	Transparent Semisolid May contain alcohol	Non-greasy Can sting, burn and aggravate dry cracked skin May be dehydrating Should be stored in airtight container

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<p>Ointment e.g.: white soft and liquid paraffin or petroleum jelly</p>	<p>Emollient, occlusive and protective Penetration is improved if skin is hydrated prior to application</p>	<p>Chronic inflammation</p>	<p>Used for drier, thicker, scallier areas</p>	<p>Increased absorption enhancing potency of medication Effective vehicle for lipid-soluble medications Penetration is improved if skin is hydrated prior to application</p>	<p>Includes pure oil preparations High content of oils and fats Generally preservative free</p>	<p>Greasy and difficult to wash off Not prone to mould or bacteria growth Not recommend for extremely eczematous inflammation or intertriginous skin Folliculitis can develop Use of thick quantities on large areas can hinder normal perspiration Increased potential for irritation and maceration Paraffin-based emollients pose a fire risk as they are easily ignited by a naked flame, especially when soaked into dressings or clothing</p>
<p>Pastes: Lassar’s paste - zinc oxide and salicylic acid, Upton’s paste- salicylic acid & trichloroacetic acid</p>	<p>Occlusive, protection, prolonged contact with skin</p>	<p>Chronic inflammation</p>	<p>Used for well-defined areas</p>	<p>Effective vehicle for lipid-soluble medications Effective base for irritant medication application to a limited area</p>	<p>Ointment base Stiff consistency High proportion of power i.e. starch or zinc oxide</p>	<p>Difficult to wash off</p>

References: Riley, J. & Rothenbuhler, H. (2015) Skin Revealed, course text book, p27

Appendix J: Maceration**Definition:**

Maceration is defined as a softening of tissues by soaking until connective fibres can be teased apart¹. Excessive or unmanaged exudate floods the wound and spills out onto the skin, where the constant moisture causes maceration. Maceration is difficult to reverse and can result in increased wound size and cell death³. Over hydration of the wound can damage cells to the extent where migration of cells across the wound surface is diminished or nonexistent¹. Maceration around the wound may appear as reversible white, spongy, wrinkly and soft skin^{1,2,3}.

Maceration in the peri wound is usually described as irritation and damage caused by supersaturation of the skin adjacent to the wound¹. It can be intrinsically caused by excessive or unmanaged wound exudate or extrinsically from perspiration or urine or faeces. Maceration weakens the wound edges and predisposes the wound to infection² (ideal environment for bacteria spread). Maceration can lead to excoriation and further wound breakdown⁴.

Causes:

- Topical mismanagement (wrong dressing choice)
- Lack of compression (in venous ulcer cases)
- Chronic inflammation
- A foreign body in the wound (eg, suture material)
- An underlying medical condition (eg, Lymphoedema, Low albumin, Infection (untreated/unresponsive), medications)

Management:

Excessive wound discharge must be contained using highly absorbent dressings³ or bagging. For patients who perspire freely, frequent changes of clothes and drying of skin might be necessary. Leakage from stomas must be attended to immediately, and appliances should be changed if required².

Recommendation for Wound Care:

- Moisture balance can be maintained by applying the correct dressing for the level of exudate and condition of the wound. This requires accurate identification of wound aetiology and assessment of the wound characteristics.
- Application of a protective barrier around the wound (no sting film barrier, zinc based skin protectant)¹
- Review of the current dressing selection to a more absorbent dressing³
- Hydrofibre dressings
- Foam dressings
- Absorbent secondary dressings
- Bags (eg, those used for drains or stomas)

References:

1. Gray, M. & Weir, D. 2007, Prevention and treatment of moisture-associated skin damage (maceration) in the periwound skin, *Journal of Ostomy Continence Nursing*, vol. 34, Issue. 2, pp 153-157
2. Templeton, S. 2005, *Wound Care Nursing: A Guide to Practice*, Ausmed Publications, Melbourne, Australia.
3. Vuolo, J. 2009, *Wound Care made incredibly easy*, Lippincott Williams & Wilkins, London, England.
4. Collins, F., Hampton, S. & White, R. 2002, *A-Z Dictionary of Wound Care*, Quay Books, Wiltshire, England

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Appendix K: Neonatal skin

Definition:

A neonate is a baby in the first month of life whether it be full-term or premature. Specific issues that neonates especially premature infants encounter are:

- Thinner stratum corneum (protective barrier) – usually 20-30 layers in an adult – in full-term neonates 20% thinner, and in neonates born under 30 weeks only three layers
- Transepidermal water loss (TEWL) – increased in neonates so more prone to dehydration
- Decreased adhesion between the epidermis and dermis – high risk of skin injury
- Skin PH – in FT infants skin PH becomes acidic within four days thus forming a protective barrier but with premature infants this takes much longer^{1,2}

Management:

- PH neutral or slightly acidic cleanser²
- Non –alcohol baby wipes with PH buffering capacity²
- Barrier creams containing zinc or Vaseline²
- Regular / daily change of tape and re-position of any tubes/drains¹

Recommendations for wound care:

- Hydrocolloids – stoma bags, tapes, wound management
- Hydrogels
- Silicone
- Film dressings
- Any adhesives should be gently removed whilst holding the skin firmly – use a silicone remover wipe without alcohol if required³

References:

1. Expert Forum – Neonatal skin health and skin care symposium 12th Sept 2015 from Australian College of Neonatal Nurses (ACNN)
2. Hugill, K (2014) Neonatal skin cleansing revisited: Whether or not to use skin cleansing products *British journal of midwifery vol. 22 no 10*
3. Royal Hospital for Women (2011) Skincare Guidelines (unpublished)

Appendix L: Pruritus (Itching skin)

As with all conditions the reason pruritus has developed needs to be investigated and if possible eliminated or reduced to over the itch.

Definition:

Pruritus (itching) can be acute or chronic. It may occur without a rash or skin lesions. Pruritus can feel like pain because the signals for itching and pain travel along the same nerve pathways. Scratching may cause breaks in the skin, bleeding, and infection

It can be associated with a number of disorders, including:

- Dry skin
- Alcohol abuse
- Anaemia Check serum iron and ferritin levels
- Body lice look for lice and nits in the seams of underwear
- Diabetes Mellitus
- Drying out of skin common in older people
- HIV/AIDS Check HIV ELISA test
- Lymphoma especially in young adults, check for enlarged lymph nodes clinically and on chest x-ray
- Medication reactions
- Obstructive jaundice (may occur in patients with primary biliary cirrhosis before jaundice occurs). Check liver function tests and autoimmune profile.
- Polycythemia Rubra Vera (itching especially after a hot bath). Check full blood count (FBC)
- Pregnant women eg, pemphigoid gestationis, pruritic urticarial papules plaques, intrahepatic cholestasis and atopic eruption
- Psychological look for evidence of stress depression, anxiety or emotional upset
- Seasonal allergies, hay fever, asthma, and eczema
- Thyroid disease both hypo- and hyperthyroidism: check T4 and thyroid stimulating hormone levels
- Uraemia (also seen in 80% of patients on maintenance haemodialysis). Check creatinine and urea.

Identifying and minimising potential risks:

- 1) Avoid use of high pH cleaners eg, soap
- 2) Use appropriate moisturiser or emollient
- 3) Warm shower -- not hot water.
- 4) Avoid wool or synthetics fabric, cotton is best

Management/ treatment: Is based on the cause:

- a. to relieve itching, place a cool washcloth over the area that itches, to prevent scratching
- b. antihistamines and/or topical steroids may be needed.

References:

<http://www.webmd.com/skin-problems-and-treatments/guide/skin-conditions-pruritus>

Appendix M: Radiotherapy Damaged Skin**Challenges**

Can result in acute and chronic changes to the skin. Acute injuries manifest as erythema similar to a burn, whereas when radiation is delivered in higher doses it can result in injuries similar to a partial thickness burn, full thickness ulceration and necrosis^{1,2}. Acute injuries repair quickly whereas chronic injuries may manifest months to years later and are progressive and permanent¹.

Recommendations for skin care

- Skin reactions are more common in those areas of the body with skin folds eg, the groin because these areas are likely to receive an increased dose of radiation known as the 'bolus affect', and are more prone to bacterial contamination².
- Aqueous cream, Aloe Vera and other lanolin free hydrophilic products can be used to moisturise skin and are widely recommended².
- Topical corticosteroids were found to significantly reduce the severity of skin reactions².
- Cavilon no sting barrier film has also been found to be useful in preventing moist desquamation in breast cancer patients³
- General advice given to people having radiotherapy is to avoid metallic-based products eg, zinc oxide and deodorants with an aluminium base and wear loose fitting clothes².
- Mepitel film has been found to be useful in decreasing the severity of radiation-induced acute skin reactions including moist desquamation in people having radiation for breast cancer when used prophylactically⁴.

Recommendations for wound care

- Assessment of pain is extremely important with appropriate pain relief prescribed and given.
- For acute injuries especially dry desquamation the use of wound gels is comforting for patients but leads to a longer healing time², whereas with moist desquamation hydrocolloid dressings can be used for both comfort and to prevent infection².
- More severe injuries may require topical antibiotic dressings eg, flamazine or antimicrobial dressings eg, silver dressings¹.
- Hyperbaric Oxygen therapy has been found to be useful in healing chronic radiotherapy injuries eg, radiation necrosis by stimulating angiogenesis and neovascularisation⁵.

References

1. Hamm, R. (2015) Text and Atlas of Wound Diagnosis and Treatment, McGraw-Hill, USA pages 287,290, 311
2. Salvo, N. Barnes, E. Van Draanen, J. Stacey, E. Mitera, G. Breen, D. Giotis, A. Czarnota. G. Pang, J. and De Angelis, C. (2010) Prophylaxis and management of acute radiation-induced skin reactions: a systematic review of the literature
3. Graham, P. Browne, & L. Capp, A et al (2004) Randomized, paired comparison of No-Sting barrier film versus Sorbolene cream (10% glycerine) skin care during post-mastectomy irradiation. *Int. J Radiation Oncology Biol Phys*, 58:241-6
4. Herst, P. Bennett, N. Sutherland, A. Peszynski, R. Paterson, D. & Jasperse, M. (2014) Prophylactic use of Mepitel Film prevents radiation-induced moist desquamation in an intra-patient randomised controlled trial of 78 breast cancer patients. *Radiotherapy Oncol.* Jan; 110(1):137-40.
5. Meyers, L. (2013) Hyperbaric Oxygen Therapy for Radiation Necrosis Acelity.com.

Appendix N: Skin Care and Oedema/Lymphoedema**Definition**

Oedema is an excess of fluid in the tissues (peripheral oedema). It may or may not be reversible.

Lymphoedema is a chronic generally irreversible condition caused by a dysfunction in the lymphatic system. This results in an accumulation of protein rich interstitial fluid in the affected area. This can occur in the extremities, face, abdomen, and genital areas.

Oedema that is widespread may be caused by sodium retention or low plasma proteins. Other causes are venous congestion, right side heart failure, venous hypertension, liver failure (ascites), nephrotic syndrome, local obstruction eg, DVT, tumour, infection, injury or surgery.

Skin thickening occurs over time, primarily in the epidermal layer of the skin making it prone to dryness, cracking and undernourishment as nutrients and water do not flow into the area efficiently. This leads to the skin losing its ability to keep out bacteria and allergens making it prone to infection. Some skin changes are:

- o Lymphangioma – blister like lesions caused by dilated lymph vessels
- o Hyperkeratosis- dry thick scales build up on the surface of the skin, the creases in between are prone to fungal and bacterial infection
- o Papillomatosis – fibrous tissue protrude from the skin as elevated nodules.

Management

1. Careful observation of the skin
2. Cleansing of the skin using a non-soap PH neutral soap or wash
3. Perfume free bath oils
4. Moisturise the skin using creams, lotions or ointments once or twice a day depending on skin dryness
5. Patting skin dry rather than rubbing it
6. Barrier creams around wounds where fluid is leaking
7. Treatment of the oedema/lymphoedema where possible

Recommendations for wound care

Use of highly absorbent wound care products that take fluid way from the skin include:

- Foams
- Hydrofiber
- Alginates
- Highly absorbent pads containing soft cellulose and polymers.

Compression bandaging and/or garments are used to manage chronic oedema and lymphoedema as prescribed and applied by trained health professionals.

References

1. Best practice skin care management in lymphoedema – Jake Nowicki & Alex Siviour (2013)
2. The Lymphoedema Support Network, Skin Care for people with Lymphoedema (2012)
3. Oedema: causes, physiology and nursing management – Casey G (2004) *Nursing Standard* vol. 18, no 51

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Appendix O: Skin stripping

Definition:

Skin stripping is a skin injury related to medical adhesive usage. Medical adhesives include tapes, dressings, electrodes, stoma supplies and patches. It presents with erythema and/or other manifestations or cutaneous abnormality and persists 30 minutes or more after removal of the adhesive.

A medical adhesive is a product used to approximate wound edges or to affix an external device (i.e., tape, dressing, catheter, electrode, pouch or patch) to the skin.

Identifying and minimising potential risks:

Daily skin assessment or at time of device changes. Obtain a history of patients known or suspected allergies and sensitivities to minimise risk of skin stripping.

Prevention:

- Identification of patients at high risk by daily skin assessment and at time of device changes
- Skin care
- Good nutrition and hydration
- Suitable product selection based on assessment of patient and product factors
 - Intended purpose
 - Anatomic location
 - Conditions at application site
 - Adhesive properties such as adhesive gentleness, breathability, stretch, conformability, flexibility.
- Consider potential adverse consequences of adhesion failure when securing a critical device
- Consider and anticipate skin movement with oedema when selecting medical adhesive products
- Adhesive products should be stored in a manner that prevents contamination and single use based products be used as much as possible
- Use proper application and removal techniques for adhesive-containing products to minimise skin damage.

Recommendations for applying and removing products:

- Application of a skin barrier prior to application of an adhesive product
- Limit or avoid use of substances such as tincture of benzoin which increase stickiness of adhesives
- Use proper application and removal techniques for adhesive-containing products
- Utilise adhesive removers to minimise discomfort and skin damage associated with removal of adhesive products.

Management:

- Assessment as per SESLHDPR/297 [Wound Assessment And Management Policy](#) as a general wound
- Exclude dermatitis- either contact or allergic
- Monitor sites exposed to adhesive materials for manifestations of infection
- Consult wound care expert if skin stripping injury does not respond to conservative management within seven days or the wound deteriorates despite conservative care.

References:

1. McNichol L, Lund C, Rosen T, Gray M. Medical adhesives and patients safety: state of the science JWOCN 2013; 40(4): 356-380.

Appendix P: Tinea**Definition:**

Tinea is a contagious fungal skin infection. The most commonly affected areas include the feet, groin, scalp and beneath the breasts.

Tinea of the stratum corneum of the feet is called tinea pedis or dermatophyte.

Tinea can be on nails is called Tinea unguium

Tinea symptoms can include:

- Itching and stinging
- Red scaly rash that is shaped like a ring (annular)
- Cracking, splitting and peeling in the toe web spaces
- Blisters (blistering eruption is quite itchy)
- Brittle or thick nails
- Yellow or white discoloration of the nails
- Bald spots on the scalp.

Identifying and minimising potential risks:

All fungi need warm, moist environments to multiply. Hot, sweat-prone areas of the body are the most likely areas for a tinea infection to occur.

People at risk of fungal infection include

- People with diabetes;
- People with disease of the small blood vessels (peripheral vascular disease)
- Older women (perhaps because estrogen deficiency increases the risk of infection)
- People of any age who wear artificial nails (acrylic or "wraps").

Tinea can be spread by skin-to-skin contact or indirectly through towels, clothes or floors (communal showers).

Prevention:

- After washing, dry the skin thoroughly, particularly between the toes and within skin folds.
- Expose the skin to the air as much as possible.
- Wear cotton instead of synthetics.
- Use antiperspirants to control excessive perspiration (sweating).
- Wear thongs to communal shower areas.

Management:

Treatment includes antifungal medication, antifungal creams, antiperspirants and good hygiene

References:

http://www.medicinenet.com/skin_problems_pictures_slideshow/article.htm

<https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/tinea>

Appendix Q: Venous Eczema

Definition:

Venous eczema is also known as gravitational eczema, varicose eczema, dermatitis hypostatica, stasis eczema, stasis dermatitis and congestive eczema. It is caused by sustained venous hypertension¹ and is a manifestation of established venous disease. Venous eczema can be present with or without venous leg ulcers. The affected skin is frequently itchy, red and scaly and may ooze, crust and crack².

Treatment

- Presenting symptoms should be treated concurrently with the underlying disease²
- The use of potassium permanganate soaks can be useful in drying up weeping eczema. A 400 mg tablet in four litres of water will provide 1 in 1000 solution. The leg can be placed in a bucket containing the solution for 15-20 minutes. Inform the patient this treatment can discolour the toe nails. If soaking the leg is not possible apply gauze soaked in the solution on the affected area
- Antibiotics may be required as *Staphylococcus aureus* frequently colonizes eczema. Topical steroid creams and ointments can be used to treat severe episodes of venous eczema¹.

Prevention

- Once the symptoms have subsided emollient therapy should be commenced to maintain hydration³
- Zinc paste may be useful in the prevention of another outbreak
- Weight loss should be encouraged if obese and length of time standing reduced
- Wearing of compression garments and leg elevation above the heart will reduce venous hypertension
- The use of soaps and cleansers that will strip the skin of oils should be discouraged^{1,2,3}.

References

1. Patel, G.K., Llewellyn, M., & Harding, K. G. (2001) Managing Gravitational Eczema and Allergic Contact Dermatitis. *British Journal of Community Nursing*. Vol. 6 No. 8
2. Nazarko, L. (2009). Diagnosis and Treatment of Venous Eczema. *British Journal of Community Nursing*. Vol. 14, No. 5
3. Barron, G. S., Jacob, S.E. & Kirsner, R.S. (2007). Dermatologic Complications of Chronic Venous disease: Medical Management and Beyond. *Annals of Vascular Surgery*. Vol. Issue 5 pp 652-662

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Appendix R: Xeroderma (Dry Skin)

As with all conditions, the reason dry skin has developed needs to be investigated and if possible eliminated or reduced to over the skin condition.

Definition:

Dry skin (Xerosis) is a common dermatosis affecting people of various skin types, ages and areas of the body. It is associated with both skin thickening and skin thinning and is triggered by exogenous (eg, climate, environment, lifestyle) and endogenous (eg, medication, hormone fluctuations, organ diseases and auto immune diseases) factors. Some hereditary conditions such as ichthyosis, psoriasis and atopic dermatitis are causes of dry skin. Other factors include malignant disease such as Hodgkin’s lymphoma, infectious disease (human immunodeficiency virus) psychiatric disorders (anorexia nervosa) endocrine disease (thyroiditis) renal dialysis and vitamin deficiency in A, B C or E.

Skin requires a water content of 10-15% to remain supple and intact. Differences between dry skin and healthy skin are evident on examination. Visually dry skin may appear dull, often with a flaky surface and patchy dry white areas. Cracks and fissures may be visible and surrounding skin may appear red indicating the presence of inflammation and possible secondary infection. Skin may feel tight, rough and uneven. The person may have sensory changes such as tingling, itching, stinging or pain.

Dry skin is characterised by a lack of the appropriate amount of water in the most superficial layer of the epidermis. Older people are more prone to dry skin as they have diminished amounts of natural skin oils and lubricants. The area most at risk of dry skin is the lower legs. Severe dry skin can cause skin to flake off become irritated or cracks and breaks in the skin.

There are different levels of dry skin and this needs to be assessed. Refer to Table 1

table 1 Classification of dry skin	
Mild dry skin	Rough and /or scaling (+) No or mild itching (- or +) No pain (-) No or minimal erythema (- or +) No fissures (-)
Moderate dry skin	Rough and /or scaling (++) Mild or moderate itching (- or ++) Mild or moderate pain (- or ++) Mild erythema (++) May have fissures (- or +)
Severe dry skin	Rough and /or scaling (+++) Severe itching (+++) Severe pain (+++) At least mild erythema (++) May have fissures (- or + to +++)
Notes; + = mild, ++= moderate, +++= severe Itching is defined as moderate if it’s present 10% of the time and interferes with ADL. Itching is defined as severe if it’s there most of the time and wakes the individual up at night	

Recommendations for wound care

Identifying and minimising potential risks:

- Dry skin may result as a consequence of over washing of the skin or using skin cleaners with high pH disrupting the acid mantle (protection) of the skin
- Dry skin may occur in individuals who are dehydrated or as a side effect to certain medications, eg, Diuretics
- Dry skin is more common in individuals with a history of eczema or hypothyroidism

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- Secondary infections may result from any skin breakdown
- Note: Dry skin may be mimicked by a genetic condition called ichthyosis. Refer to Appendix H.

Prevention:

- Ensure individuals hydration level
- Avoid use of high pH cleaners eg, soap
- Use appropriate moisturiser or emollient.

Management:

- A visual inspection of the skin including all creases
- Look for signs of inflammation/infection and treat as appropriate
- Bathe with warm (not hot) water using pH neutral products
- Emollients should be the first line therapy for all dry skin conditions
 - Patients should be given the opportunity to consider a variety of emollients from the whole spectrum of products available and to identify the most suitable product for their skin. An adequate quantity of emollient should be prescribed for optimal effect (250-500g/week). They may require more than one emollient product depending on lifestyle, time of day, seasonal factors or disease severity. Emollients have a steroid sparing effect, and should be supplied in a 10:1 ratio of emollient to steroid in order to achieve the full benefit. Patients prescribed a leave on emollient should also use an emollient washing product. Patients offered emollient therapy need to be advised about safety issues such as cross-infection, risk of slipping and flammability where appropriate.
- Consider using a humidifier during the winter to ensure a relative humidity setting of 45-60%
- Consider 0.05% to 0.1% betamethasone valerate one to two times daily if dry skin or pruritis are severe for a limited time. If no improvement occurs after several days consider underlying medical causes.

References:

1. Pons-Guiraud, A. (2007) Dry skin in dermatology: a complex physiopathology
2. Voegeli, D. (2007) The role of emollients in the care of patients with dry skin, Nursing Standard 22,7,62-68
3. Moncrieff, G. Cork, M. Lawton, S. Kokiet, S. Daly, C. and Clark, C. (2012) Use of emollients in dry skin conditions: consensus statement – http://www.medicinenet.com/dry_skin/article.htm
4. Andriessen, A. Prevention, recognition and treatment of dry skin conditions British Journal of Nursing, 2013, Vol 22, No 1 Downloaded February 21, 2016.

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Appendix S: Glossary

Abscess	Pus-filled lesion (>1cm).
Alopecia	Hair loss.
Annular	Round or ring shaped.
Atrophy	A diminution of tissue.
Blister	Fluid-filled lesion (any size).
Bulla	Fluid-filled lesion, circumscribed elevation (>1cm).
Burrow	Linear lesion caused by parasites.
Callus	Hyperplasia of the stratum corneum due to physical pressure.
Cellulitis	An inflammation of cellular tissue.
Comedone	Papule plugging sebaceous follicle containing sebum and cellular debris.
Crust	Accumulation of dried exudate.
Cyst	A closed cavity or sac lined with epithelium containing fluid, pus or keratin.
Erosion	Loss of epidermis which heals without scarring.
Erythema	Redness of the skin caused by vascular congestion or perfusion.
Excoriation	Loss of skin substance produced by scratching.
Extensor	Extensor surfaces (e.g. elbows and knees).
Fissure	A linear gap or slit in the skin's surface.
Flexor	Skin fold (e.g. back of knees).
Folliculitis	Inflammation of the hair follicles.
Keloid	Elevated progressive scar without regression.
Lesion	A single area of altered skin: it may be solitary or multiple.
Lichenification	A flat-topped thickening of the skin often secondary to scratching.
Linear	Straight line, often caused by scratching.
Macule	Flat circumscribed area of discolouration (<1cm).
Milium	A tiny white cyst containing lamellated keratin.
Nodule	Round elevated solid lesion (>1cm).
Nummular/discoid	Disc shaped.
Oedema	Tissue swelling.
Papule	Any raised lesion or scaly, crusted, keratinised or macerated surface (<1cm).
Patch	A large macule, change in colour only, surface is always normal (>1cm).
Petechia	A punctated haemorrhagic spot 1–2mm in diameter.
Plaque	Raised, flat-topped lesion (>1cm).
Polymorphic	Lesions have varied shapes.
Purpura	Discolouration of the skin or mucosa due to extravasation.
Pustule	Pus-filled lesion (<1cm).
Rash	A widespread eruption of lesions.
Scab	A hard crust of dried blood and serum which forms over a wound during healing.
Scale	Visible and palpable flakes due to aggregation and/or abnormalities of shed epidermal cells.
Scar	Fibrous tissue replacing normal tissue destroyed by injury or disease.
Striae	A linear, atrophic, pink, purple or white streak or band on the skin due to changes in the connective tissue.
Telangectasia	A visible vascular lesion formed by dilatation of small cutaneous blood vessels.
Ulcer	Loss of epidermis (often loss of underlying dermis and subcutis).
Umbilicated	Papules or vesicles with a central dell or hollow.
Vesicle	Fluid-filled lesion (<1cm).
Weal	Central itchy white plaque surrounded by an erythematous flare.

Reference: Bianchi, J., Page, B. & Robertson, S. (2013) Your Dermatology Pocket Guide: Common skin conditions explained

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Appendix T:

Comfort Shield Wipes by SAGE are used for treatment and prevention of Incontinence Associated Dermatitis (IAD) and Moisture Associated Skin Damage (MASD).

Recommended Skin Care Management;

IAD

Urinary Incontinence:

Apply Comfort Shield wipe only after each episode of incontinence.

Use of soap and water is NOT necessary.

Faecal Incontinence:

1. Clean excessive faecal matter from area with water and rediwipe.
2. Continue clean up with 1-2 Comfort Shield Wipes

Note: Continue to use wipes Clean, Treat and Protect as long as incontinence continues.

MASD

Use 1-2 Comfort Shield Wipes in affected area (may be groin, apron, breast folds) twice daily. Consider use of Zetuvit or Combine between skin folds to manage moisture.

Note: Continue to use Comfort Shield wipe on affected areas until healed.