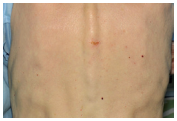
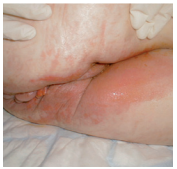
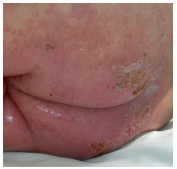
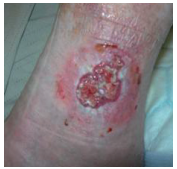
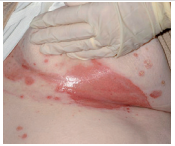
QUICKGUIDE

SKIN PROTECTION

Wounds UK

SKIN PROTECTION GUIDE

Use this chart to help identify the skin damage type and choose the most effective product from the Medi Derma-S skin protectant range

	Type of skin damage	Barrier cream (skin moisture/protection)	Barrier film (skin protection)
	Intact skin at risk of breakdown due to fragility (eg elderly skin, skin stripping due to frequent dressing changes, stoma site)	As required	At each dressing/ application change
	Intact, irritated skin at risk of skin breakdown due to incontinence (urine and/or faecal)	As required After each episode of incontinence	Every 72 hours
	Irritated broken skin due to incontinence (urine and/or faecal)	As required After each episode of incontinence	Every 48 to 72 hours
	Macerated periwound skin due to excess exudate	N/A	At each dressing change
	Moisture-related skin damage (skin folds) due to perspiration *Note: Seek further medical advice if you suspect intertrigo, which might require topical steroid and, possibly, anti-fungal or antibiotic treatment.*	N/A	Up to 3 times a day

CAUSES OF SKIN DAMAGE

The skin can come into contact with fluids such as:

- Sweat
- Exudate
- Urine and/or faeces.

If fluid contact occurs for any sustained period, the outer cells of the epidermis absorb fluid and swell, making skin weaker and less elastic, and more susceptible to damage from friction and shearing forces. The combination of these processes increases the risk of moisture lesions, moisture-related skin fold damage and pressure ulcers.

Maintaining skin integrity is crucial to preventing skin breakdown. Keep vulnerable skin clean and dry, and use:

- Protective skin barrier products (eg Medi Derma-S)
- Gentle cleansers
- Simple moisturisers
- Incontinence products
- Faecal management systems
- Highly absorbent dressings (if needed).

A multidisciplinary approach might be required with the involvement of a continence advisor.

- **If a patient develops a moisture lesion or pressure ulcer, establish the cause and assess the level of tissue damage.**

TIPS FOR SKIN PROTECTION

- ✓ Take a full history and carry out a full assessment
- ✓ Inspect the skin daily in high-risk patients
- ✓ Minimise skin exposure to moisture (ie contain urine/faeces)
- ✓ Avoid use of traditional soap and water when cleansing
- ✓ Consider use of emollients
- ✓ Use a skin barrier product if skin is irritated or broken. Ensure you choose the appropriate product as not all can be applied to broken skin*
  - Barrier films are generally available as a spray, wipe and foam applicator
  - Barrier creams are generally available in a sachet or tube
  - Document all skin barrier product use and mark area on body map
- ✓ Know the difference between a moisture lesion and a pressure ulcer
- ✓ Recognise when ulcers are caused by a combination of moisture and pressure

***Note:** Medi Derma-S film and cream formats can be used on both irritated and broken skin

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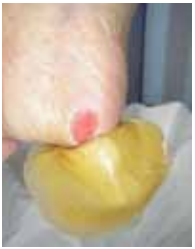
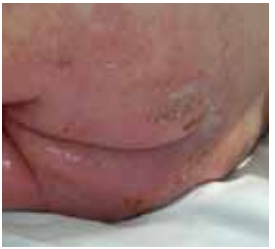
DIFFERENTIATING PRESSURE ULCERS FROM MOISTURE LESIONS

Moisture will contribute to a pressure ulcer. However, it is important to understand the difference between a pressure ulcer and moisture lesion, as treatment approaches differ.



Pressure ulcers are caused by pressure, shear or friction, and typically present:

- As partial-thickness skin loss and full-thickness skin loss
- Over a bony prominence or where equipment is used
- With distinct edges and regular shape
- As isolated, individual lesions.



Moisture lesions due to incontinence will:

- Be superficial
- Have multiple lesions
- Sometimes present a 'kissing' lesion — the same pattern where both buttocks touch
- Be irregular in shape and have ill-defined, wandering edges
- Often be purple in colour
- Often occur over fatty tissue in the perineum, buttocks, groin and inner thigh, skin folds — not necessarily over a bony prominence
- Have skin that might be shiny and wet.