

KEY RECOMMENDATIONS FROM THE BEST PRACTICE STATEMENT ON THE CARE OF THE OLDER PERSON'S SKIN

This article presents two perspectives (hospital and community) on the key recommendations from the best practice statement *Care of the Older Person's Skin* (Wounds UK, 2012). Rosie Callaghan looks at the document in relation to providing care in the community, while Marie Wilson focuses on how the document's recommendations relate to the hospital setting.

Community perspective: Rosie Callaghan

Care of the Older Person's Skin (Wounds UK, 2012) is an invaluable document for all clinicians and is relevant across all healthcare settings. This article highlights the challenges faced within the community setting and the considerations needed to adopt the recommendations of this best practice statement into practice. The areas covered include skin assessment, pressure ulcer prevention, skin tears, care of dry skin, and skin care at end of life.

Throughout this article, the term "community" is interpreted as including community hospitals, private care homes, and the wider community (incorporating home visits).

Clinicians in all care settings need to be aware of the relevance of initiating an effective skin care

regimen. They need to ensure that their knowledge is kept up-to-date to provide evidence-based care. The need to prevent skin breakdown and protect vulnerable skin is a cornerstone of nursing care (Voegeli, 2008).

The Best Practice Statement includes recommendations concerning:

- ▶▶ Dry vulnerable skin.
- ▶▶ Pressure ulcers.
- ▶▶ Moisture-related skin damage.
- ▶▶ Skin tears.
- ▶▶ Skin changes at life's end.

The Best Practice Statement provides relevant information for those clinicians involved in the skin care of an ageing patient population. The implementation of this statement across the community setting can be challenging due to the varied client groups and settings encountered. This statement is written with the generalist clinician in mind.

Dry vulnerable skin

The Best Practice Statement

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encourages the regular use of emollients to promote healthy skin in older people. Causes of dry skin include:

- ▶ Other skin conditions, such as eczema.
- ▶ Frequent bathing and the use of harsh soaps.
- ▶ Reduction in the production of sebum.
- ▶ Environmental factors, such as central heating.

Within the care home sector, many clients have dry, itchy skin, which can be attributed to the client's age, the drying atmosphere of the care home, and the individual's frequent use of highly perfumed soaps.

The application of emollients is important and this task often falls under the remit of the healthcare assistant within care homes. They must ensure the client receives the right emollient therapy at the right time. In order to achieve this, creams and emollients have been removed from the medication administration report (MAR) sheets. Records of these are kept within the client's room on a separate MAR sheet so that creams and emollients can be applied as instructed.

The aim of storing creams and emollients in the client's room is to ensure they are available to be applied at the same time as personal care. The healthcare assistant will be required to sign for the cream on the client's MAR sheet and this is countersigned by a trained member of staff.

A short presentation around skin care and the application of emollients has been shown to staff and is delivered within the home by link nurses. This was developed by the Worcestershire Health and Care NHS Trust for link nurses to deliver across the local area, but it could be adopted by other areas, using the

Best Practice Statement as the basis for the presentation.

Skin tears

Protocols should be implemented to avoid skin tears, and appropriate assessment and management of skin tears should be undertaken when they occur. Skin tears are often misdiagnosed and mismanaged (Stephen-Haynes and Carville, 2011).

Following a review of clinical practice, Stephen-Haynes et al (2011) implemented a "Skin Tear Audit Research (STAR) classification system box" across their local community setting. The contents of the box included skin tear prevention guidelines, a wound assessment chart, a STAR classification tool, flowchart and care plan, dressings, and a patient information leaflet.

This led to the development of resources, as well as the development and implementation of guidelines, resulting in a standardised client care package to aid in the delivery of timely and appropriate care.

Pressure ulcers

A holistic and specific pressure ulcer risk assessment is the essential element of pressure ulcer prevention. The aspects that need to be included, as outlined in the Best Practice Statement, are:

- ▶ Skin inspection.
- ▶ Mattress, cushion, and chair provision.
- ▶ Repositioning.
- ▶ Classification of any pressure ulcer present.
- ▶ Promotion of healing.
- ▶ Risk allocation.

Pressure ulcers are high on the political agenda in the UK at present and the Best Practice Statement provides practical guidance for practice.

An assessment of the client's skin is essential and enables the early

detection of problems. "Red areas" act as a warning, indicating that action needs to be taken to prevent further problems.

The care home sector reports all category III and IV pressure ulcers to the Care Quality Commission. Clinical commissioning groups will also have a responsibility to ensure that pressure ulcers that develop within the care home sector are investigated through a root cause analysis.

The way in which this is monitored differs, county-by-county. Some TVNs have no input in the care home sector. However, this is expected to change as clinical commissioning groups become more active in their specific geographical area.

End-of-life care

End-of-life care can be a challenging area for the clinician. This clinician must often think creatively in terms of the care that is administered. It is important to remember this patient group should be encouraged to express what is important to them regarding their everyday routine.

Skin failure is common at the end of life. The skin is an organ and, as such, can fail like the liver or heart. Anecdotally, staff often feel demoralised when clients develop a pressure ulcer at the end of life. However, if they have done all they can to prevent it, we can deduce the ulcer is unavoidable.

Clinicians should share the Best Practice Statement with colleagues. When trying to implement a document such as this it is important to empower staff so they have the confidence to float ideas and solutions to the problems they encounter. Clinicians should ensure their assessment and documentation is relevant and up to date.

Hospital perspective: Marie Wilson

Life expectancy is increasing and it is predicted that by 2085 there will be more than 11.5 million people aged 80 or over in the UK (Office for National Statistics, 2012). These figures present a clear challenge to the clinician in the provision of high-quality care needed by this group who are often sick and vulnerable and require more intensive care.

One challenge is the need to maintain the integrity of the older person's skin. One of the consequences of the natural ageing process is the change in the skin's general condition, making it more susceptible to damage. It is important that procedures are put in place for this section of the population in the protection of vulnerable areas and the prevention of skin damage (Voegeli, 2008).

However, the need to prevent damage poses another challenge for the clinician who while juggling an already heavy workload may not be able to access and review current literature to establish what changes should be made to their practice. Thus, a Best Practice Statement has been developed to assist the care giver – *Care of the Older Person's Skin* (Wounds UK, 2012).

The skin and ageing

The skin is the largest organ of the body consisting of three main layers – outer epidermis, middle dermis, and the subcutaneous tissue. These layers act as a protective barrier, pain receptor, they maintain temperature, produce melanin and vitamin D, and act as a mediator for touch and physical appearance.

When the skin ages and the epidermis thins creating a greater susceptibility to damage from

trauma, moisture, and friction (Wounds International, 2010). Meanwhile, the dermis reduces in thickness by an estimated 20%, creating the paper-thin appearance commonly associated with older people (Haroun, 2003). The thinning dermis is also linked to loss of sensation, as well as a reduction in temperature control and moisture retention. There is some atrophy of sweat glands resulting in older people perspiring less. This can make it difficult to keep the skin hydrated creating dry skin that is more prone to splitting or cracking.

Pressure ulcers

As the skin ages it faces many changes that create a greater risk of damage to the individual. One type of damage that is high on the political agenda currently is pressure ulceration. Indeed, the target reduction of category III and IV pressure ulcers is 80% in an acute setting and 30% in the community by 2014 (Department of Health, 2010).

Pressure ulcers are costly in terms of not only quality of life, but also in terms of the burden placed on healthcare resources (European Pressure Ulcer Advisory Panel, 2009). It is plausible to consider that the continuing prevalence of pressure ulcers may be directly linked to extremes of age and underlying comorbidities. However, strategies must be devised to protect and enhance the skin barrier function and, therefore, prevent pressure ulcer development. One such strategy is the requirement to undertake a risk assessment and skin inspection within 6 hours of admission into the acute care setting (NICE, 2005).

Deep tissue damage may have occurred in the days prior to admission and this may present as a red or discoloured area in the first instance. If these red areas are recognised in their early stages,

a potential pressure ulcer can be avoided.

The introduction of skin bundles or surveys ensures the regular inspection of the vulnerable individual's skin on each repositioning (*Figure 1*).

These documents were created to act as visual reminders to staff to inspect the patient's skin immediately on admission, during hygiene and skin care, and on discharge. All staff responsible for skin care are encouraged to undertake the skin survey, with the majority of these staff at healthcare assistant level. As they are not in a position to recommend and give skin/wound care, they are advised to report any skin changes or damage immediately to their senior staff. It is the responsibility of the registered nurses and ward managers to assess the patient who has been recognised as having skin changes or damage and act accordingly.

On discovering pressure damage, the nurse should be advised to contact their senior nurse to re-evaluate the care given to the individual. If necessary, they should contact the tissue viability team

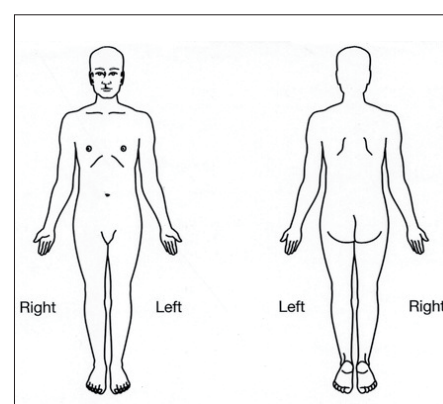


Figure 1. Skin survey: If red areas or skin damage is observed, the clinician must follow the wound care documentation. Include the body map (as above), wound care assessment, repositioning chart, and care plans.

for direction and advice regarding skin care and pressure relieving equipment. This is to support the staff in their actions and present how important the skin survey is for quality patient care and damage prevention.

To enhance the risk assessment and skin survey, a pressure ulcer *pro forma* (PUP) could be created. This document should be concise and developed following staff feedback who may have voiced concerns over previous assessment documents. The PUP contains a Waterlow Risk Assessment Tool that combines the nutrition section to a Malnutrition Universal Screening Tool (MUST) flow chart, a daily pressure ulcer checklist, repositioning chart, wound assessment tool, and care plan.

Many Trusts have created pressure ulcer task forces – groups created to address pressure ulcer issues within an individual Trust and work towards the reduction of pressure ulcers locally. These groups usually comprise members from the multidisciplinary team (i.e. tissue viability nurse, senior trust nurses, matrons, and dieticians).

Moisture-related skin damage

A degree of moisture is essential for wound healing to occur (Winter, 1963), however, too much moisture can cause health problems. When the skin is exposed to fluids and moisture for an extended period of time it can become soft, wrinkled, and almost sponge-like.

Urinary and faecal incontinence can have a detrimental effect on skin integrity and are considered to create an increased risk for pressure ulcer development (Beldon, 2008). The skin produces natural protective secretions and oils that maintain a level acid PH balance to assist the skin to remain intact.

In the case of individuals with urinary incontinence, the ammonia produced by the urine on contact with the tissue raises the PH balance of the skin making it more permeable (Beldon, 2008). In the faecally incontinent individual, the properties in the faeces act in a similar manner to that of urine, thus the protective barrier of the skin can be breached.

As it is suggested that the prevalence of incontinence increases with age (Millard and Moore, 1996) this combined with other age-related changes, such as underlying medical conditions and dementia, only places the older person's skin at higher risk of damage.

Damage caused by incontinence may initially present as an area of erythema or skin irritation to the buttocks and/or perineal area which, if not treated can deteriorate into blistering as the compounds in the urine or faeces erode the top layer of the skin. These areas are often referred to as moisture lesions or incontinence-associated dermatitis (Cooper et al, 2008).

If moisture lesions are not addressed sufficiently this, in turn, will place the skin at higher risk of pressure ulcer development as the compounds in the urine or faeces are able to colonise the area and increase any inflammation present. This leads to an increase in the size and depth of the moisture lesion, which can eventually create pressure ulceration.

The clinicians caring for such patients must have the knowledge and skills to be able to not only recognise but also to manage moisture lesions. They must also broach the topic of continence issues with the patient to prevent tissue breakdown and pressure damage.

The causes of incontinence are often multifactorial and, therefore, a multidisciplinary approach is required with the continence adviser guiding the plan of care.

For those for whom bladder or bowel control is not possible there is a choice of products to contain the excess fluids (i.e. urinary catheters, faecal collectors, and management systems are options). However, these products in themselves carry a risk and should be used only after appropriate risk assessment. Thus, the most common product used is the disposable pads that come in various sizes. These are generally made of an absorbent material that turns into a gel to lock away the fluids from the skin. These require regular inspection and changing. Additionally, tissue viability training should incorporate continence and skin care into pressure ulcer study days and all mandatory induction sessions. The difference between moisture lesions and category II pressure ulcers should be explored and the need for prevention and good management to prevent further skin breakdown explained.

Regular cleansing of the skin especially after incontinence episodes is advised with the need to pat or air dry versus rubbing to reduce friction explained. The use of soap for the at-risk individual is not advised as it is alkaline-based and places more stress on the skin. This is linked to the skin survey as regular skin inspection is vital in skin protection and damage prevention.

The availability of barrier creams has also been reviewed locally and changes have been incorporated into practice. The creams were previously ordered on an *ad hoc* basis, causing delay for the patient, but are now delivered as a weekly stock item for every area of care to ensure they are freely available

as and when needed. These are used to form a protective layer on the skin to prevent or manage damage. If the individual has a severe moisture lesion, this is referred to the matrons and tissue viability service who will suggest an alternative cream that is more suitable for more severe excoriation.

Conclusion

The aim of the Best Practice Statement on the care of the older person's skin is to provide relevant and useful information to guide those active in the clinical area, who are responsible for the management of skin care in an ageing population (Voegeli, 2008). The changes that occur in skin as it ages lead to an increased vulnerability to skin breakdown and damage. Healthcare providers have a responsibility for the care of the skin of older people and, as such, need guidance on how to undertake this appropriately.

It is vital that senior-level managers and clinical staff appreciate the importance of the Best Practice Statement and ensure it is incorporated into local guidelines and practice of all members of the multidisciplinary team at a local level. This article touches on how this may be undertaken on a local level.

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