MAINTENANCE OF SKIN INTEGRITY

PREAMBLE

The skin is the largest organ of the body. The skin protects us from microbes and the elements, helps regulate body temperature, and permits the sensations of touch, heat, and cold.

Skin has three layers:

- The epidermis, the outermost layer of skin, provides a waterproof barrier and creates our skin tone.
- The dermis, beneath the epidermis, contains tough connective tissue, hair follicles, and sweat glands.
- The deeper subcutaneous tissue (hypodermis) is made of fat and connective tissue.

Care practices which maintain clean and intact skin are very important because aged and disabled people usually have a very high risk of skin breakdown. The usual causes are associated with changes in skin structure and function due to aging and/or chronic disease processes.

POLICY

1. Resident's skin condition is impacted by their mobility, continence, cognitive, nutrition and hydration status are assessed on entry and regularly thereafter to ensure that the resident's skin integrity is consistent with their general health.

2. Reassessment of the resident's skin condition and risks is warranted under these conditions:
   - Health and/or functional condition changes
   - Return from extended hospital leave

3. Care staff must assess the resident's skin condition and risks on entry using Norton Scale and when health changes (as per item 2). Their skin condition must be observed daily for any abnormalities during personal hygiene care. Some skin abnormalities are but are not limited to:
   - Broken areas/pressure sores
   - Reddened areas/spots
   - Rashes
   - Bruises
   - Dryness/skin flakes

4. Report any changes in skin integrity (as item 3 above) to Registered Nurse on duty immediately. Registered Nurse to initiate corrective actions and monitoring using the Skin Monitoring Record or provide treatment using the Wound Care Chart as appropriate.

5. Skin problems that warrant completion of an incident report includes:
   - Skin tears
   - Pressure sores
   - Bruises

6. Protective dressings, manual handling devices and correct lifting techniques must be used to avoid skin injury caused by friction/shear during manual handling of the resident.

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7. Residents' assessed needs in relation to skin integrity must be documented in their progress notes and on their care plans and reviewed regularly. See also these policies:

- Documentation
- Resident Assessment and Care Planning

**PROCEDURE:**

**Skin**

1. The following preventative measures must be used to assist in maintaining skin integrity and reducing risk:
   - Regular repositioning of confined, mobility impaired or unconscious resident.
   - Use of pressure relieving devices (e.g. sheep skins, gel/foam cushions, pressure relieving mattresses, air mattresses, overlays) for residents who are assessed at risk (Norton scale) of developing pressure sores. Turn and reposition chair/bed bound residents at least second hourly and documenting on the Repositioning Chart.
   - Prevention of shearing forces when repositioning of residents by use of slide sheets and proper repositioning techniques.
   - Use of limb protectors for frail skin.
   - Use of disposable incontinence aids and regular toileting schedule where relevant. Clean skin at time of soiling; avoid hot water and irritating cleaning agents.
   - Screen for risk of skin breakdown by using Norton scale and take appropriate preventative actions.
   - Do not use donut type cushion on residents for relieving pressure.

2. The following general skin care must be provided on a regular basis to maintain skin integrity and to assist in preventing skin breakdown:
   - Bath/shower/sponge resident in accordance with hygiene needs, best practice and resident choice
   - Use of non-irritating, Ph balance soap or alternative cleansing preparation to reduce cause of dryness
   - Use of skin moisturiser – applied to dry skin at least twice daily (after shower and before going to bed and more often if needed). Avoid use of sorbolene cream on residents with sensitive skin as it is an aqueous cream which can lead to epidermal loss & dry skin. For such case, use non-aqueous cream such as QV, Nivea, Cetophil or Dermaveen.
   - Particular attention should be paid to skin folds (under breasts, between buttocks and in groin) – dry these areas properly after shower and during hot weather.
   - Wash and dry affected skin thoroughly after episodes of incontinence. Apply skin barrier cream where appropriate.

**Hair and Nail Care:**

1. Residents' hair must be washed in accordance with assessment of general condition, length and texture of hair (should not be less than three times per week) and/or residents preference. Anti-dandruff shampoo should be used if there is evidence of dandruff.

2. Residents' nails must be kept clean, shaped and trimmed regularly.
3. Residents' toe nails will be maintained by Podiatrist – charges as per the Schedule 1, Quality of Care Principles 2014 under the Aged Care Act 1997.

General Care Issues and Interventions:
- Use written schedule for turning and repositioning resident
- Use pillows or other devices to keep bony prominences from direct contact with each other
- Raise heels of bed-bound residents off the bed; Use a 30-degree lateral side lying position; do not place residents directly on their trochanter
- Keep head of the bed at lowest height possible
- Use lifting devices (slide sheet) to move residents in bed
- Use pressure-reducing devices (static air, alternating air, gel or water mattresses
- Reposition chair- or wheelchair-bound residents every hour
- Use pressure-reducing device (not a donut) for chair-bound residents
- Keep the resident as active as possible; encourage mobilization
- Do not massage reddened bony prominence
- Avoid positioning the resident directly on his or her trochanter
- Do not use donut-shaped devices
- Avoid drying out the resident's skin; use lotion after bathing
- Avoid hot water and soaps that are drying when bathing elderly
- Use body wash and skin protectant
- Teach resident, caregivers and staff the prevention protocols
- Manage moisture by determining the cause; use absorbent pad that wicks moisture
- Offer a bedpan or urinal in conjunction with turning schedules
- Manage nutrition; consult a Dietician and correct nutritional deficiencies
- Increase protein and calorie intake and A, C, or E vitamin supplements as needed
- Offer a glass of water with turning schedules to keep resident hydrated
- Manage friction and shear
- Elevate the head of the bed no more than 30 degrees
- Protect high-risk areas e.g. elbows, heels, sacrum and back of head from friction injury
- Use a slide sheet to move and turn residents in bed
- Use transfer techniques that prevent friction or shear
- Avoid bedrails if possible, pad wheelchair arms and leg support
- Support dangling arms and legs
- Use non-adherent dressing on frail skin (intact):
  - If must use tape, be sure it is made of paper, and remove it gently
  - Also apply the tape to hydrocolloid strips placed strategically around the wound rather than taping directly onto fragile surroundings Skin around the skin tear
  - Use gauze wraps (combine), stockinettes, flexible netting, or other wraps to secure dressing rather than tape

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Use no-rinse soap-less bathing products

Cross reference to other policies/procedures:
* Documentation Policy
* Resident Assessment and Care Planning Policy
* Continence Management Policy
* General Safety Policy

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Facility Manager

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