Skin Care Update for Home Health Aides And Home Attendants

Faculty

Barbara Baker, RN, BSN, CWS
Nurse Consultant

Program Objectives

- **Describe the issues of elderly skin.**
- **List three risk factors associated with skin breakdown.**
- **Discuss proactive skin management of the homecare patient.**

Proactive Skin Management

- **Prevention!**
  - **The most important step a healthcare facility can take toward achieving a higher quality of care and reducing skin management costs.**

Good Skin Management

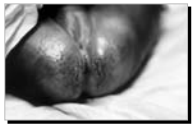
- **Reduce overall skin management cost.**
  - **Prevention.**
  - **Improving routine care.**
    - **Staff time efficiencies.**
    - **Supply reductions.**
    - **Better infection control.**
- **Improve quality of care.**
- **Minimize legal risk.**

High Risk Patients

- **Elderly - over 65.**
  - **Skin tears / skin stripping.**
- **Excessive dryness.**
- **Incontinent.**
  - **Perineal dermatitis.**
  - **Fungal infections.**

High Risk Patients

- Chronically ill.
  - Excessive dryness.
  - Bacteria colonization.
    - Fungal infections.



- Immobile.
  - Pressure ulcers.
  - Maceration.

Key Healthcare Settings

- Acute care.
  - ICU / CCU.
  - Geriatric units.
  - Cancer centers.
  - Diabetic centers.
- Long term care.
  - 90% - over 65 years of age.
  - 50% - incontinent.

Key Healthcare Settings

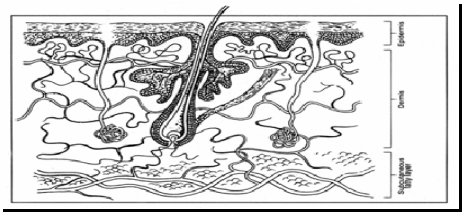
- Home health care.
  - Hospice patients.
  - Diabetic patients.
  - Incontinent patients.

Healthy Skin

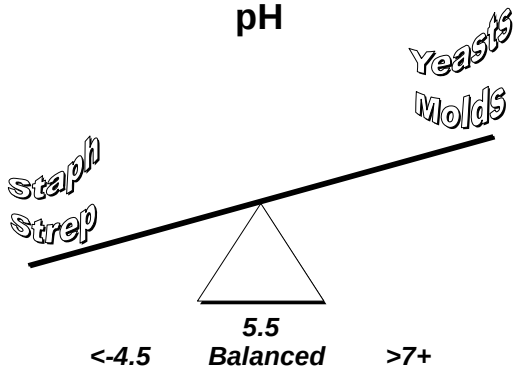
- Epidermis.
  - Contains a protective lipid layer to seal in moisture and protect from irritants.
- Epidermal - dermal juncture.
- Dermis.
  - Blood vessels, nerves, sweat and sebaceous (oil) glands.

Healthy Skin

- Acidic pH - 5.5
  - pH balanced 4-7.
  - Maintains normal skin flora.
  - Discourages bacterial colonization.



pH



pH

- Complications.
  - Dryness.
  - Irritation.
  - Bacterial / fungal balance.
- Factors to consider.
  - Emollients.
  - Rinse off vs. leave on.
  - Frequency of use.
    - Daily vs. 5 times a day.

Elderly

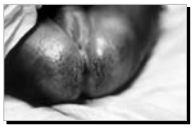
- Aging skin.
  - Decrease in barrier property.
  - Sweat and sebum production decreases.
  - Drier skin acquires more crevices in which bacteria can grow.
- Damaged skin - skin tears / skin stripping.
  - Dermal - epidermal junction flattens.
  - Epidermis, dermis and subcutaneous fat become thinner.

Elderly

- Increased complications.
  - Wound healing slows.
    - Epidermal regeneration occurs half as quickly.
    - Loss of dermal blood vessels.
  - Higher risk for infection.
    - Immune function decreases.

Incontinent Care

- Common complications.
  - Maceration.
  - Dermatitis / irritation.
  - Denudement.
  - Fungal infections.



Chronic Illness

- Cancer
- Diabetes
- AIDS

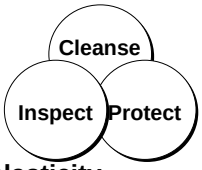
- Increased skin dryness.
- Decreased immune system.
  - Prone to fungal infections.
  - Unable to fight off infections.
- Medications and therapies.

Immobility

- High risk patients.
  - Bed bound.
  - Wheelchair bound.
  - Sensory impaired.
- Common complications.
  - Pressure ulcerations.
  - Maceration.

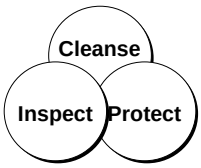
Proactive Skin Management

- Patient bathing.
  - Cleansing.
    - Remove soils, dead skin cells, perspiration and surface bacteria.
  - Inspection.
    - Early intervention.
  - Protection.
    - Improve skin hydration and elasticity.



Proactive Skin Management

- Incontinent care.
  - Cleansing.
    - Remove feces, urine and odor causing bacteria.
  - Inspection.
    - Early intervention.
  - Protection.
    - Protect from external irritants.



Improving Skin Hydration

- Evidence suggests that an association may exist between dry, flaky, or scaling skin and an increased incidence of pressure ulcer development.
- Adequate hydration of the stratum corneum helps protect against mechanical insult.
- Severely dry skin is associated with fissuring and cracking of the stratum corneum, which can harbor infection.

Patient Bathing

Tips

- Cleanse.
  - Mild cleaner.
    - No rinse for bed bathing.
  - Warm not hot water.

Patient Bathing

Tips

- Inspect.
  - Handle carefully.
  - Document any visual changes in the skin's condition.
    - Excessive dryness.
    - Redness.

Patient Bathing

Tips

- Protect.
  - Apply moisturizing protection to skin immediately after bathing.

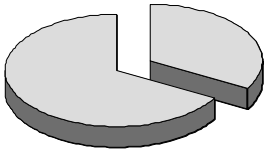
No-Rinse Bed Bathing

Benefits

- **Saves nursing time.**
- **Reduces linens and supplies.**
- **Less irritating than bathing with bar of soap.**
- **Ideal for patient.**
  - **Transporting is difficult.**
  - **Where tub or shower bath may be traumatic.**
  - **In between routine bathing.**

Incontinent Care

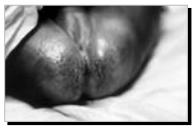
Combined Effect of Urine and Feces



- **Perineal dermatitis will occur in 33% of unprotected incontinent patients within 2 days.**

Perineal Dermatitis and Fungal Infections

- **Perineal Dermatitis.**
  - **Caustic fluids (feces, urine), friction, allergic reactions.**
  - **Signs and symptoms.**
    - **Erythema (redness).**
    - **Pain, denudement (weepy, broken skin).**



Perineal Dermatitis and Fungal Infections

- **Candida (Yeast).**
  - **Moisture and warmth.**
  - **Signs and symptoms.**
    - **Pruritis (itching).**
    - **Painful, erythema (redness).**
    - **Scaling (flaking).**
    - **"Satellite" papules and pustules.**

Incontinent Care

- **Preventing perineal skin injury.**
  - **Prevent excessive skin wetness.**
  - **Maintain natural pH.**
  - **Minimize contact with urine and feces.**
  - **Minimize local micro-organisms.**

Incontinent Care

Tips

- **Cleanse.**
  - **Remove / emulsify fecal soils and surface bacteria.**
  - **No-rinse, pH balanced cleanser.**
- **Inspect.**
  - **Document every time a change in skin condition is detected.**
    - **Redness, dry patches.**

Incontinent Care

Tips

- **Protect.**
  - **Apply protective ointment after each cleaning to protect from external irritants.**

Effects of Antimicrobials on Skin

Why use them?

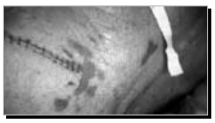
Misconception:
Kills *"everything"* and reduces risk of infection.

Antimicrobials

- **Routine / Preventative Use.**
  - **Bacterial resistance.**
  - **Irritation.**
  - **Alters normal skin flora.**

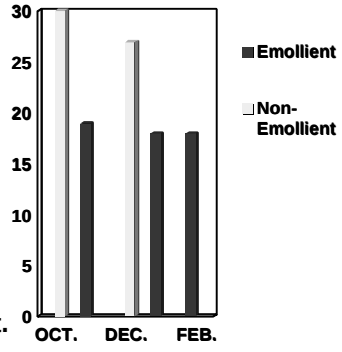
Trauma

- **Definition.**
  - **Physical injury.**
- **High risk patients.**
  - **Immobile.**
  - **Impaired skin integrity.**
  - **Sensory or cognitive impairments.**
- **Complications.**
  - **Skin tears and skin stripping.**
    - **Immunosuppressed.**
    - **Decreased healing ability.**



Skin Tears and Skin Hydration

- **Emollient enriched cleanser reduced skin tears by 34.8%.**
- **3rd month 43% increase in skin tears non-emollient.**



Cost Effectiveness

	Incidence	Daily Cost of Care	Cost/ Month	Cost Savings / Month
Average Skin Tear Management Cost	10	$5	$1500	
Decreasing Skin Tear Incidence by 40%	6	$5	$900	$600

Savings: $7,200 Annually

Trauma Protection

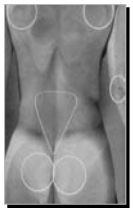
- Who needs protection?
  - All patients at high risk for skin damage due to trauma.
    - Skin tear in the last 30 days.
    - Known high risk for skin abrasions.

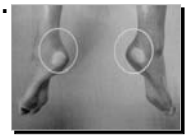
Trauma Protection

- Protection options.
  - Protective coverings.
    - Protection from skin tears.
    - Protection from irritation.
  - Protective padding.
    - Pressure reduction.

Pressure Protection

- Pressure ulcerations.
  - Tissue necrosis caused by prolonged pressure.
- Who needs protection?
  - Immobile (temporary or permanent).
    - Bed or wheelchair bound.
  - Chronically ill (sensory impaired).
    - Diabetes.





Pressure Protection

- Routine turning schedules.
  - Every two hours for bed and wheelchair bound patients.
- Pressure relief surfaces.
  - Completely immobile.
- Frequent skin assessments.
  - Notify nurse in charge immediately upon identifying Stage 1 ulcerations.

Maceration

- Definition.
  - Skin softening due to an overfilling of the tissues with fluid.
- Excessive skin wetness increases the skin's:
  - Permeability of irritants.
  - Friction coefficient.
  - Physiological pH.

Maceration Protection

- High-risk sites.
  - Perineal skin.
  - Abdominal / breast folds.
  - Tube sites.
  - In between toes.
  - Skin around wound sites and fistulas.
- Protection.
  - Moisture barriers and/or absorbent dressing on all areas of the skin prone to excessive moisture.

Skin Care Experts

- Routine care.
  - Bathing.
  - Incontinent care.
  - Protecting from trauma.
  - Protecting from pressure.
  - Protecting from maceration.
- Skin treatments (RNs and LPNs)
  - Assessments.
  - Documentation.
  - Treatment.

Risk Assessments

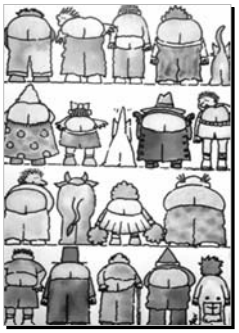
- Risk assessments.
  - Upon admission.
    - Pressure ulcers, trauma and maceration.
  - Quarterly / upon mobility or nutritional changes.

Risk Assessments

- Skin assessments.
  - During every bath.
    - Everyone.
  - Routine skin assessments.
    - Incontinent patients - upon cleaning.
    - High risk patients - daily.

No Butts About It!

Prevention !



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Alabama Department of Public Health

(334) 206-5618

alphtn@adph.state.al.us

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