Company Name:

Policy No: 03-3607	Authorised:	Date:
SKIN CARE ***MANAGEMENT OF SKIN INTEGRITY***		

This Policy describes the effects that the ageing process has upon the skin, and how this is assessed, managed and treated for the benefit of the older service user.

A: THE SKIN & THE AGEING PROCESS:

1. The skin is made up of 3 layers – the dermis, the epidermis, and a subcutaneous fatty layer which contains the major nerves and blood vessels. During ageing, the layers of the skin and the junction between the dermis and epidermis become thin and flatten, and circulation is reduced.

2. Older skin is also subject to drying out due to reduced intake of fluids (drinking less), general reduced mobility, and co-morbidities, all of which can render the skin susceptible to infection. This also renders the skin vulnerable to wounding resulting from trauma such as a knock or bump, or from sustained unrelieved pressure over bony prominences, shear and friction.

3. Acute illness and high temperatures associated with fevers, and moisture from diaphoresis and incontinence can contribute to the vulnerability of ageing skin.

B: ASSESSMENT OF SERVICE USER SKIN INTEGRITY:

1. *Common Skin Conditions associated with Medium to Long-term Care:*

   During the course of any shift, the Organisation's Nursing / Care Staff may come across a variety of skin conditions in the service users. The following are typical skin conditions for which vigilance is required:

   - Irritant reactions to dressing adhesives and stoma appliances;
   - Blisters due to dressing adhesives or fixation tapes;
   - General rashes from latex allergies;
   - Eczema associated with dermatitis;
   - Thick scaly skin (hyperkeratosis) associated with lymphoedema or venous stasis disease;
   - Paper-thin skin and purpura due to long-term steroid therapy;
   - Dehydrated skin due to acute illness, inadequate nutrition and / or hydration etc;
   - Excoriated skin conditions from prolonged exposure to urine, moisture, faeces or acidic effluent from enterocutaneous fistulae.

2. *Skin Integrity Assessment:*

   2.1 The Baseline Assessment of a prospective service user's needs for care will include an assessment of existing skin integrity in order to identify future risks of skin failure. This will focus upon issues such as existing wounds, pressure injuries / vulnerable pressure points, rashes and excoriation.

   2.2 Skin Assessment will involve inspection of the skin for the following 6 attributes:

   2.2.1 Colour - specify what is normal for the service user.
   - colours present - red / purple / unusual pigmentation of lower limbs.
   - colours present - blue / grey hues of distal limbs (lower limbs / feet).
   - instances of bruising and / or purpura.

   2.2.2 Temperature - skin feels cool to touch (possibly due to poor peripheral perfusion).
   - skin feels hot due to fever or infection.

   2.2.3 Texture - skin feels dry / moist / papery / thin / leathery.

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