SKIN INTEGRITY: A CLINICAL GUIDE TO ‘BEST PRACTICE’

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Introduction: Maintenance of good skin integrity is everyone’s business. To distinguish the difference between a pressure ulcer (PU) and other forms of skin damage can be extremely challenging for all Clinicians. Wounds to the sacrum are often classified as a PU without any consideration to other causes. There are other reasons why wounds occur in this area which are often related to moisture, either from wound exudate or more significantly unresolved incontinence. Inaccurate diagnosis is imperative as prevention & treatment strategies differ largely and the patient consequences of the outcome are extremely important. Bianchi & Johnstone (2011) indicated that despite guidelines and grading tools being available to staff across NHS GGC, uptake was poor, only 38% of patients who should have been assessed for use of a Faecal Management System actually were. Although this percentage is low, it is not unusual. In a literature review literature, Gethin et al (2011) also found use of guidelines for patient care was limited to between 17% - 54%. Gethin also indicated dissemination should be multifaceted, and clinicians want a simple tool. With this in mind a group of lead Clinicians in collaboration with ConvaTec decided to develop a ‘simple easy to use’ guide to ‘refine and build on the latest EPUAP documentation’ and assist in management and the differential diagnosis between healthy skin, excoriation, moisture lesions and pressure damage.

Method: A focus group meeting was sponsored by ConvaTec to explore current clinical challenges in the identification and management of skin damage caused by moisture, pressure, shear, friction, & or a combination of these factors. Results: A table to illustrate differences between Excoriation (E), Moisture Lesion (M), Pressure Ulcer (P). Combined Lesion (C) has been developed: [Fig. 1] to educate and encourage ‘Best Practice’ Skin Integrity management. Conclusion: The overall objective was to develop a clinical differential diagnosis tool which is simple & easy to use to promote good skin integrity and assist in the prevention of excoriation and timely intervention of moisture induced skin damage management. Clinicians often wait until excoriation is very severe, sometimes with pending before optimal intervention is considered incurring increased costs and patient associated problems. A recommendation made by the group is if the associated moisture problem is due to faecal incontinence (FI) to assess the suitability of the patient and then consider use of a faecal management system eg: Flexiseal. It is widely known FI can be debilitating and intensively embarrassing to those affected and in many cases it has a profound impact on the patients’ quality of life. Early intervention is essential to prevent further deterioration and induce increased management costs for all.

**Definition**

**Excoriation (E)**: Erythema (redness), no broken skin
- Superficial lesions caused by irritant fluids i. e: urine, faeces, wound exudate.
- Area of localised damage to the skin & underlying tissue caused by pressure, shear, friction, & a combination of these factors.

**Moisture Lesion (M)**: Irritant fluids / Moisture is present, eg: urine, shining wet
- Irritant fluids / Moisture is present, eg urine, faeces, wound exudate.
- Pressure, shear, friction, & a combination plus moisture

**Pressure Ulcer (P)**: Area of localised damage to the skin & underlying tissue caused by pressure, shear, friction, & & a combination of factors plus moisture

**Combined Lesion (C)**: Area of localised damage to the skin & underlying tissue caused by pressure, shear, friction, & & a combination of factors plus moisture

**Causess**

- Irritant fluids / Moisture is present, eg: urine, faeces, wound exudate.
- Irritant fluids / Moisture is present, eg urine, faeces, wound exudate.
- Pressure, shear, friction, & a combination plus moisture

**Location**

- Skin folds, anal, cliet, peri-anal area
- Skin folds, anal cliet (sharp edge), peri-anal area
- Bony prominences
- Bony prominences & peri wound area (i.e.: peri-anal area)

**Shape**

- Diffuse, irregular shape
- Diffuse superficial spots, ‘kissing’ ulcers, irregular wound edges
- One spot, circular or regular wound edges
- One spot, circular or regular wound edges combined with diffuse superficial spots

**Depth**

- No broken skin
- Diffuse/ partial thickness skin loss (infection)
- Partially – full thickness from Category I - Grade 2 – Generally deeper than moisture wounds
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**Necrosis**

- No necrosis or eschar
- Necrosis likely
- Necrosis likely
- Necrosis likely

**Edges**

- Diffuse or irregular edges
- Diffuse edges and irregular lesions
- Distinct edges, clear demarcation
- Distinct edges over bony prominence, irregular margins to satellite lesions

**Colour**

- Red but not uniformly distributed, pink or white skin (macerated), red with white (fungal infection)
- Red but not uniformly distributed, pink or white surrounding skin (macerated), red with white (fungal infection), green (infect)
- Non-blanchable erythema, necrosis, and slough, Red, yellow, green (infected, black)
- Non-blanchable erythema, necrosis, and slough, Red, yellow, green (infected, black)

**Management**

**Complete assessment:**
- Review Bristol Stool Chart*
- Clean skin with pH balanced cleanser
- Manage moisture: Use skin protectors: E.g: durable barrier cream or barrier film spray.
- Control urinary & faecal incontinence: use of pads.

**Clinical recommendations:**
- If Bristol stool 6 or 7 & prolonged (i.e: more than 3 episodes): Intervene early - consider use of faecal management system eg: Flexiseal®
- If patients medical status &lor; medication is known to cause diarrhoea: Intervene early - consider use of faecal management system eg: Flexiseal®
- If severe excoriation is present due to faecal incontinence: consider use of faecal management system eg: Flexiseal®

**Controlled intervention:**
- Refer to local wound care formulary guidelines
- Ensure all assessments are completed and pressure relieving equipment is provided.

**Complete wound assessment:**
- Refer to EPUAP 2009 Pressure Ulcer Definitions*
- Refer to local wound care management system eg: Flexiseal®
- Refer to EPUAP 2009 Pressure Ulcer Definitions*
- Refer to local wound care formulary guidelines
- Ensure all assessments are completed and pressure relieving equipment is provided.

**Combined Lesion (C)**

- Complete wound assessment:
- Review Bristol Stool Chart*
- Clean skin with pH balanced cleanser
- Manage moisture: Use skin protectors: E.g: durable barrier cream or barrier film spray.
- Control urinary & faecal incontinence: use of pads.

**Clinical recommendations:**
- If Bristol stool 6 or 7 & prolonged (i.e: more than 3 episodes): Intervene early - consider use of faecal management system eg: Flexiseal®
- If patients medical status &lor; medication is known to cause diarrhoea: Intervene early - consider use of faecal management system eg: Flexiseal®
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**References:**
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