CLINICAL PROTOCOL FOR SKIN CARE USING EMOLLIENTS AND OINTMENTS

RATIONALE

This clinical protocol has been developed in response to an alert from the National Patient Safety Agency (2007) regarding the potential risks for patients when using paraffin based skin products. The clinical protocol is also underpinned by Best Practice in Emollient Therapy (2007) by the British Dermatological Nursing Group to promote the highest standards of care for patients across all settings by all health professionals.

TARGET GROUP

All community nurses who provide clinical care to patients.

TRAINING

All staff in the Trust are required to comply with mandatory training as specified in the Trust’s Mandatory Training Matrix. Clinical Staff are also required to comply with service specific mandatory training as specified within their service training matrix.

All Community Nurses are required to attend an in house 2 day Tissue Viability training course, which is to be updated every two years.

In addition, Community Nurses are required to attend an in house 2 day leg ulcer training course, updated every two years.

This training is not mandatory for bank staff. When training has not been accessed, bank staff must always work within their scope of practice and competency levels in the assessment, management and ongoing care of leg ulcer patients.

DELEGATION AND SCOPE OF PRACTICE

The delegation of nursing care must be appropriate, safe and in the best interests of the patient at all times and the decision to delegate must always be based on an assessment of their individual needs (NMC 2008). Where Trust staff have the authority to delegate clinical tasks to other members of staff, they will retain accountability and responsibility for that delegation.
Trust staff should only delegate clinical tasks to other members of staff whom they deem clinically competent and able to fully understand the nature of the delegated task and also what is required of them.

Trust staff should not delegate to other members of staff if they believe that it would be unsafe to do so or if they are unable to provide or ensure adequate supervision. It is important that the member of staff, to whom an aspect of care is being delegated, understands their limitations and when not to proceed should the circumstances within which the task has been delegated change.

When health care assistants are undertaking the role of cleansing leg ulcers, the delegating person must assess the person performing the clinical task has the competence to undertake this duty, as the delegating nurse remains accountable for the delivery of the care plan and for ensuring that the overall objectives for that patient are achieved.

Health care assistants should be encouraged to understand their limitations and recognise when it would be unsafe to proceed with a clinical task which has been delegated to them. In this instance, the member of staff should contact the Community Nursing team and liaise with the most appropriate member of staff.

**RELATED POLICIES**

Please refer to relevant Trust policies and procedures

**DEFINITIONS OF TOPICAL SKIN APPLICATIONS**

Emollients: also known as moisturisers. These are grease-based substances which, when applied to the skin, either tap water in or allow water to be pulled from the dermis to the epidermis (Loden, 2003). Emollients can be used as wash products in the form of soap substitutes and bath oils. Once washing is complete, emollients can be applied to the skin in the form of lotions, creams or ointments to seal water into the skin.

Lotions: these are the lightest and least greasy emollients. They are less effective as they contain less oil.

Creams: these have a higher oil content than lotions, allowing the oil to sink into the skin. They are good for daytime use. Ointments: these have the highest oil content and are very greasy. They can leave the skin looking shiny and clothes greasy. However, if the skin is very dry, ointments should be used and may be best applied at night.

*Emollients/ointment must only be used on a named patient basis / the person it has been prescribed for, not for multi patient use. This is essential for best practice in infection control procedures. It is recognised that communal use of products are linked to outbreaks of infection. Please refer to the Trust’s Policy for the Safe Handling and Administration of Medicines as this refers to the legal requirements associated with sharing prescribed products.*
## MANAGEMENT OF DRY, VULNERABLE TISSUE

**Key points:**

- If identified as having dry, vulnerable skin, the skin should be frequently assessed.
- Regular treatment with a moisturiser will maintain skin integrity.

### Statement | Reason for Statement | How to demonstrate statement is being achieved
--- | --- | ---
- All individuals are assessed to determine condition of skin (dry*, flaky, excoriated, discoloured, etc)  
- Emollient soap substitutes should be used in individuals with dry, vulnerable skin, or skin determined to be vulnerable when washing/cleansing during routine personal hygiene  
- Skin should be thoroughly dried to prevent further dehydration. Drying should involve a light patting and not rubbing, as rubbing may lead to abrasion and/or weakening of the skin  
- All individuals with dry, vulnerable skin should have a bland moisturiser or barrier cream applied at least twice daily to prevent the adverse effects of dry skin  
- Application of the moisturiser or barrier cream should follow the direction of the body hair, and be gently smoothed into the skin  
- Assessment enables the correct and suitable preventative measures to be initiated and maintained  
- Washing skin with an emollient soap substitute reduces the drying effects associated with soap and water  
- If the skin is left damp, it is vulnerable to excess drying from the environment and at risk from bacterial and fungal contamination  
- Application of a bland moisturiser or barrier cream rehydrates the skin and reduces the irritant effects from perfumes and additives  
- Excessive rubbing of moisturiser or barrier cream into the skin can lead to irritation  
- The health records of all patients who are unable to self care must include evidence of skin condition assessment  
- Health records include evidence that the appropriate emollient is used, if required  
- Health records have evidence that all individual’s skin is dried in an appropriate manner  
- There is evidence within the health records that the appropriate moisturiser and amount is used, if required (see table one, page 3)  
- If there are any clinical concerns regarding skin integrity, the appropriate intervention and actions are to be recorded in the patients records  
- The care plan will reflect the advice given to patients/carers as required, as it will not always be a community nurse providing the care
Table One
QUANTITIES OF DERMATOLOGICAL PREPARATIONS PRESCRIBED FOR SPECIFIC AREAS OF THE BODY

<table>
<thead>
<tr>
<th>Area</th>
<th>Creams and Ointments</th>
<th>Lotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>15–30 g</td>
<td>100 ml</td>
</tr>
<tr>
<td>Both Hands</td>
<td>25–50 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Scalp</td>
<td>50–100 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Both Arms or Legs</td>
<td>100–200 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Trunk</td>
<td>400 g</td>
<td>500 ml</td>
</tr>
<tr>
<td>Groins and genitalia</td>
<td>15–25 g</td>
<td>100 ml</td>
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For further clinical advice contact the Tissue Viability Service on 0151 643 5330.
ALLERGIES
Always ask the patient or carer if the patient has any allergies/hypersensitivity before applying any creams or emollients.

Contact dermatitis is a medical diagnosis given to adverse inflammatory changes in the skin caused by contact with a product. This can be irritant or allergic in nature. To determine whether this is an immune-mediated allergic response or an irritant response often requires an assessment by a health care professional who specialises in allergic skin disease. Contact the Tissue Viability Team if you need clinical advice and guidance.

Common culprits with topical products are perfumes and preservatives (De Groot, 2000). As ointments usually do not contain preservatives they have a lower irritant sensitising potential than creams or lotions. The British National Formulary lists common inert ‘carriers’ found in topical preparations which may be rarely associated with sensitisation.

Some common emollients such as Aqueous cream have constituents e.g. phenoxyethanol, which can lead to dermatitis (Lovell et al, 1984). Aqueous cream which is commonly prescribed as a leave on emollient was originally designed as a soap substitute. Its high water content makes it an effective leave on emollient for those with dry skin.

Furthermore previous audits have illustrated that aqueous cream caused stinging and discomfort in a significantly higher proportion of children with atopic eczema than other emollient products when used as a leave on product.

Although lanolin has often been reported in literature as a potent sensitisier, newer, more highly refined hypo-allergenic types of lanolin are very rarely the cause of adverse reactions (Stone, 2000). The over use of very greasy ointments can block the hair follicles which can lead to irritation and inflammation. This can usually be avoided by stroking rather than rubbing the emollient into the skin following the directional lie of the hair and using a lighter less occlusive product.

Occasionally blockage of the hair follicle may lead to painful pustules and infection, causing folliculitis. Topical antibiotics or, rarely, oral antibiotics, may be needed. However, stopping the product is often sufficient to resolve the problem.

RISK ALERT

Paraffin-based emollients such as 50/50 white soft paraffin/liquid, do pose a fire risk as they are easily ignited by a naked flame when soaked into dressings or
clothing. The risk is especially high if used in large quantities. Those using paraffin-
based emollients should be advised not to smoke or come into contact with fire while
using the preparations (NPSA 2007).

When using substantial quantities of petroleum based emollients and particularly where
bandaging is also being used to increase the moisture holding capacity of the skin,
there may be a risk of fire in the presence of naked flames. Therefore, Staff must
complete a specific Trust risk assessment entitled ‘Use of Topical Products
Containing Paraffin’ as part of the patient’s care plan (available on the Trust intranet
site)

- Patient/carers must be given NPSA Leaflet “Fire Hazard” with paraffin based
skin products on dressings and clothing on every admission (available through Trust
online ordering) and this must be documented in the patient’s notes.

- Patients and significant others should be informed of the significant risks of using
moisturisers and creams.

Ensure consideration is given to patients using disposable containment products. It is
good practice to avoid emollients or oil based creams unless absolutely necessary. If
further advice is required, please contact the Integrated Continence Service.

REDUCING THE LIKELIHOOD OF SENSITIVITY
A product can be considered an irritant when the skin reacts adversely to it in a non-
immune mediated way. This usually occurs within minutes or hours, i.e. the skin
produces an almost immediate inflammatory or cumulative response (where the skin
reacts after a number of exposures to a product). An allergic reaction is an immune
mediated response where the individual was previously exposed to the allergen and
has been sensitised to a substance. The individual will always react to it no matter how
small the contact, however, the reaction can be greater with greater exposure. Thus,
the reaction will not occur on the first exposure, but on subsequent exposures the
allergic response may occur immediately or be delayed for about 48 - 96 hours after
exposure (Nicol et al, 1995). The least potentially sensitising products are those that
contain the least number of ingredients. Ointments, therefore, are likely to produce
fewer adverse reactions than creams and lotions. Fragrances are known sensitisers
with an estimated 1% of the general population being allergic to them. This figure
may be as high as 14% when considering people with eczema (De Groot, 2000). Thus,
products without perfume are preferable for those who have sensitive skin.

SKINCARE FOR THE OLDER ADULT
The skin of the older adult tends to be drier through increased permeability of the skin.
It is also more sensitive as the ageing process diminishes the effectiveness of the
hydrolipid layer and less sebum is produced. In order to prevent poor skin health, a
regime of routine emollient therapy is recommended along with other preventive
measures, such as avoiding over-heating of the ambient environment and maintaining
effective nutrition (Ersser 2000).
A best practice document relating to caring for the older person’s skin can be found at:

www.woundsuk.com

WHERE TO GET ADVICE FROM

Trust staff should contact their own Line Manager if further advice is needed. When more comprehensive advice is required, please contact the Tissue Viability Service.

INCIDENT REPORTING

Clinical incidents or near misses must be reported and a Trust Incident Form must be completed using the Trust’s incident reporting system.

SAFEGUARDING

In any situation where staff may consider the patient to be a vulnerable adult, they need to follow the Trust Safeguarding Adult Policy and discuss with their line manager and document outcomes.

EQUALITY ASSESSMENT

During the development of this protocol the Trust has considered the clinical needs of each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation). There is no evidence of exclusion of these named groups.

If staff become aware of any clinical exclusions that impact on the delivery of care a Trust Incident form would need to be completed via the Trust’s incident reporting system and an appropriate action plan put in place.

REFERENCES

Best Practice in Emollient Therapy (2007)


### CONTROL RECORD

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Status – New / Revised / Trust Change