



Skin Cares Procedure

Procedure Number
WCDHB-PN-0101

Version Nos:
4

1. Purpose

This Procedure is performed as a means of:

- preventing damage to the health skin of the patient; and
- preventing secondary infection; and
- stimulating blood supply in pressure areas.

2. Application

This Procedure is to be followed by all nursing staff throughout the West Coast District Health Board (WCDHB).

3. Definitions

There are no definitions associated with this Procedure.

4. Responsibilities

For the purposes of this Procedure:

Clinical Nurse Leaders/Unit Managers are required to:

- oversee all aspects of this Procedure
- monitor the performance of WCDHB Nursing staff members in relation to this Procedure;

Nursing Staff Members are required to:

- ensure they abide by the requirements of this Procedure;

5. Resources Required

This Procedure requires:

- i) Warm water, soap and towel or oasis bed bath pack
- ii) Sterile dressings

6. Process

1.00 As part of the admission process, all Inpatients will be assessed for the risk of developing pressure sores. This assessment is to be documented on the WCDHB General Nursing History/Assessment Form.

1.01 Daily bathing cleanses refreshes and soothes the patient and aids in the prevention of decubiti. For older patients whose skin is particularly fragile, bathing every other day rather than daily may be sufficient.

1.02 For bed-bound patients, turning and positioning every second hour (**unless contraindicated**), with back care and attention to avoiding pressure on bony prominences is vital in the prevention of decubiti.



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- 1.03 Special care is required with the management of incontinent patients to ensure that the patient and their bed are kept dry and clean, to avoid injury/infection to the skin.
- 1.04 Any pressure or friction caused by any medical device/equipment is to be reported immediately, and documented in the patient's medical record, as well as actions taken.
- 1.05 Any break in the skin, or signs of pressure are to reported immediately, and documented in the patient's medical record, as well as actions taken. A WCDHB Pressure Sore Notification Form is also to be completed.
- 1.06 Where a skin problem has been identified and documented, a plan for the monitoring, investigation and correction of the skin problem is required, which is to include:
- i) planning for the patient's requirements;
 - ii) clear communication amongst all clinical staff caring for the patient;
 - iii) type of treatment(s) to be provided.
- 1.07 Skin condition reflects the overall health of an individual. With some patients, (e.g. elderly) skin can be more easily damaged and take longer to heal. Therefore, the following preventative measures need to be followed:
- i) observation and assessment during delivery of care e.g. bathing so as to identify any possible skin problems as early as possible;
 - ii) careful unhurried dressing and removal of garments;
 - iii) use of non-restrictive clothing;
 - iv) maintaining the nutritional and hydration status of the patient;
 - v) controlling (as much as is reasonably possible) the external environment:
 - a) removal of dangerous objects from the patient's immediate area;
 - b) using appropriate staff and equipment to reposition and assist patients so as not to drag skin on surfaces; using sliding sheets
 - c) correct positioning of patients when using wheelchairs and taking care when transferring patients from wheelchairs (using appropriate lifting aids);
 - vi) keeping the skin dry and clean;
 - vii) initiating passive/active exercise for patients within their limitations;
 - viii) when patients are going outside, ensure that the patients use sun block and/or hats for protection.

7. Precautions And Considerations

- Any break in the skin, or signs of pressure are to reported immediately, and documented in the patient's medical record, as well as actions taken.
- For bed-bound patients, turning and positioning every second hour (unless contraindicated).

8. References

Gauntlett, P. & Myers, J. (eds) Adult Health Nursing, 3rd edition (1988), Mosby St Louis



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9. Related Documents

WCDHB General Nursing History/Assessment Form

WCDHB Pressure Area Notification Form

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	Developed By:	Quality Improvement Co-Ordinator
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