MOISTURE LESION GUIDELINES

Version Number	3	Version Date	December 2020
Author's Name & Title	Tissue Viability Nurse Specialist		
First approval or date last reviewed	2nd July 2014		
Staff/Groups Consulted	Pressure Ulcer Steering Group: Ward Sisters Physiotherapy Dietetics Equipment Library Infection Prevention Control/Tissue Viability Team		
Approved by PUSG	17 December 2020		
Next Review Due	17 December 2023		

1. INTRODUCTION

1.1. Incontinence is the difficulty or inability to control your bladder (urine) or bowel (stool). Incontinence is common, but those who experience incontinence are often too embarrassed to ask for help.

1.2. Incontinence is one of the major risk factors for the development of skin breakdown. The effects of age on the physiology of skin, combined with incontinence in the older population, can result in the skin becoming increasingly vulnerable to damage, resulting in incontinence dermatitis.

1.3. Skin provides our first line of defence against germs and infection. Long-term exposure to moisture from urine and/or stool can cause the skin to soften. This can weaken the skin's ability to be a protective barrier. With frequent incontinence, skin problems can occur. Typical symptoms are redness, burning and irritation around the buttocks, rectum, groin or between the thighs. If there is persistent moisture from urine and/or stool, it increases the risk for infection or skin breakdown.

2. DEFINITION

2.1. Moisture lesions are a skin condition that affects people who are incontinent. This can result in inflamed, excoriated, infected and damaged skin that causes pain and discomfort. Combined with friction and shearing forces they can increase patients' risk of developing pressure ulcers.

3. SSKIN ASSESSMENT TOOL

3.1. YDH have adopted "Your skin matters" as one of the national High Impact Actions to improve patient care.

- **S**kin inspection
- **S**urface
- **K**eep moving
- **I**ncontinence
- **N**utrition

4. ASSESSMENT

4.1. A tissue viability risk assessment should be carried out on all patients on admission to hospital and reassessments performed at regular intervals depending on individual needs. Good skin care is the single most important factor in preventing moisture lesions.

4.2. Clear, concise documentation in the nursing records.

4.3. Discuss your intervention with patient and/or carer.

4.4. Map wound in conjunction with the Wound Assessment tool.

4.5. If skin continues to deteriorate, contact Continence Lead Nurses or Tissue Viability Lead Nurses for further advice.

4.6. Tissue Viability Nurses may photograph, with gained verbal/written consent.

4.7. This guideline will be discussed during the pressure ulcer mandatory training sessions throughout the Trust.

5. GENERAL SKIN HYGIENE FOR PATIENTS WITH HEALTHY/INTACT SKIN

5.1. Wash using a mild unperfumed soap to minimise the risk of irritation to the skin.

5.2. Derma S products, barrier wands and cream should be used as a barrier against bodily fluids - these are available on all ward twin bins.

5.3. Derma Pro barrier cream is available on request from the Tissue Viability team. Ext 4401.

5.4. Both of the above are for single patient use only.

6. FLOW CHART DEMONSTRATING THE CONTINUUM FROM HEALTHY SKIN TO SKIN BREAKDOWN