

## Chapter 21

### SKIN CARE

#### **What You Will Learn**

- Age related changes affecting the integumentary system
- Observations to make while giving skin care
- Specific measures related to skin care
- The main cause of pressure ulcers
- Pressure areas on the body
- Types of clients prone to formation of pressure ulcers
- Stages of pressure ulcers
- Ways the In-Home Aide can help prevent pressure ulcers
- Observations that should be made about a pressure ulcer
- How to give Stage I pressure ulcer care according to proper procedure

#### **Age Related Changes Affecting the Integumentary System**

As we age our skin becomes thinner and more fragile. The skin loses elasticity and wrinkles develop. Loss of subcutaneous fat causes the older person to feel cold even when you do not. Blood vessels become fragile and skin bruises more easily. Production of oil decreases resulting in dry skin. The older person perspires less and may need to bathe less often. Discoloration and spotting of the skin is common. Hair grays due to loss of pigment and nails become brittle.

#### **Purposes of Skin Care**

We sometimes get so busy feeding, bathing, and toileting our clients that we tell ourselves we don't have time to give skin care. Skin care is important to our clients. Good skin care stimulates circulation, helps prevent skin breakdown, relaxes muscles, and relieves tension.

The client who is bedridden should receive skin care to bony areas at the time of each position change. Remember that the skin of the elderly is fragile and easily damaged. Skin care given improperly can cause discomfort, so be gentle.

## **Observations to Make While Giving Skin Care**

While giving skin care you should observe the condition of the client's skin. You should observe for:

- Irritation or redness
- Rashes
- Bruises
- Swelling
- Excessive dryness
- Sores, lumps, or growths
- Cuts, abrasions, burns
- Mottled skin that is cool to touch
- Condition of skin over bony prominences

Remember to report your observations for the nurse/supervisor.

## **Specific Measures Related to Skin Care**

Treat the client's skin gently. The client must be handled with extreme gentleness to prevent bruising and skin tears. Keep the skin clean and dry at all times and apply lotion frequently. The skin of the elderly is usually dry and needs the moisturizing effect of lotion. Lotions at room temperature are 20° F colder than normal skin temperature. Before applying, warm the lotion by placing the bottle in a pan of warm water or rubbing a small amount in your palms. Apply lotion after bathing a client. To prevent skin breakdown, clients who cannot position themselves must be repositioned at least every two (2) hours; more frequently if indicated by the service plan.

Be cheerful when giving skin care. It is a chance to communicate with your client and should be a pleasant experience.

## **Causes of Pressure Ulcers**

Pressure Ulcers are also called bedsores, pressure sores, decubitus ulcers, and decubiti. A pressure ulcer is an inflammation, sore, or lesion that develops over areas where the skin and tissue underneath are injured. This is due to a lack of blood flow and oxygen supply to an area of the body. Lack of circulation usually results from continuous pressure on the skin over a bony prominence. This can be from the way or length of time a client is positioned. Other things such as heat, moisture, stool, urine, wrinkles from linen, and irritating substances, such as crumbs, can hasten the development of skin breakdown.

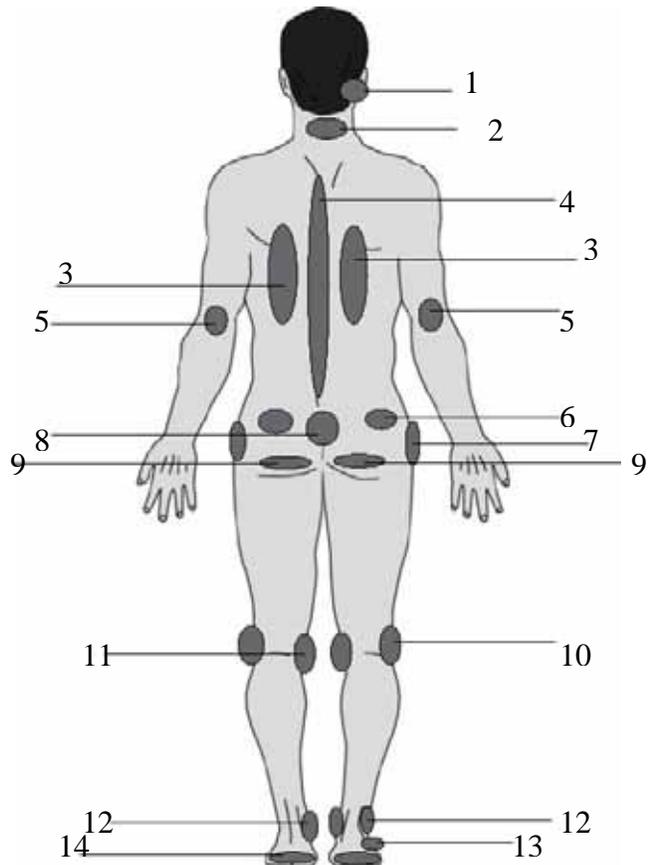
Shearing occurs when the body slides on a surface that moves the skin in one direction and the underlying bones in the opposite direction causing skin breakdown. Most pressure ulcers are preventable with appropriate nursing care.

## **Pressure Areas**

Figure 20.1 shows the areas of the body at highest risk for pressure ulcers. These areas include:

*Figure 20.1, Pressure Areas*

1. Back of the ear.
2. Back of the head.
3. Shoulder blade.
4. Backbone.
5. Elbow.
6. Crest (top) of the pelvis.
7. Hipbone.
8. Coccyx (tailbone) region.
9. Buttocks.
10. Knee Cap.
11. Inside and outside of knee.
12. Inside and outside of ankle.
13. Heel.
14. Sides of feet



### **Clients Prone to Forming Pressure Ulcers**

Some clients have a higher risk of getting pressure ulcer than others. Elderly clients may be a higher risk due to poor circulation, hydration, and nutrition. Clients who are unable to move about freely due to paralysis are a higher risk. Paralyzed clients also have a loss of sensation so they may not feel uncomfortable when there is pressure on their skin.

Clients who are thin and malnourished clients have bony prominence closer to skin's surface. Clients who are obese are at risk of skin breakdown in areas where the skin comes in contact with other skin such as underneath the breasts, between legs and under abdominal folds. Chemicals in stool and urine cause skin irritation. This makes the client who is incontinent at higher risk. Clients with chronic diseases (e.g., diabetes, renal disease, cancer) and clients who are immunocompromised also have an increased risk.

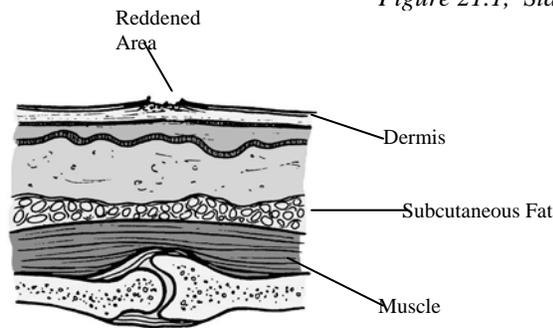
### **Stages of Pressure Ulcers**

NOTE: ALL STAGES OF PRESSURE ULCERS MUST BE REPORTED AND DOCUMENTED

Pressure ulcers develop in stages. They are classified as Stage I, II, III or IV with a Stage IV being the most severe.

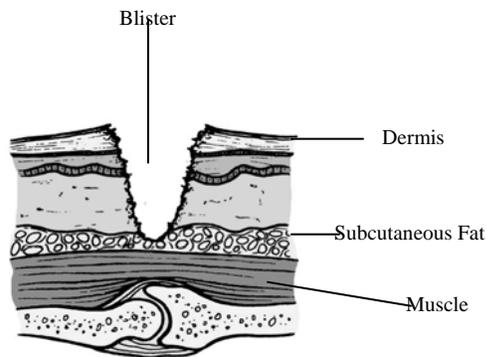
A Stage I (Figure 21.1) pressure ulcer may be superficial or a sign of deeper tissue damage. The client has non-blanchable redness of skin, warmth, redness, or swelling. Stage I pressure ulcers may be difficult to assess especially in a client with darkly pigmented skin. If pressure is reduced or removed, the stage I pressure ulcer can be prevented.

Figure 21.1, Stage I



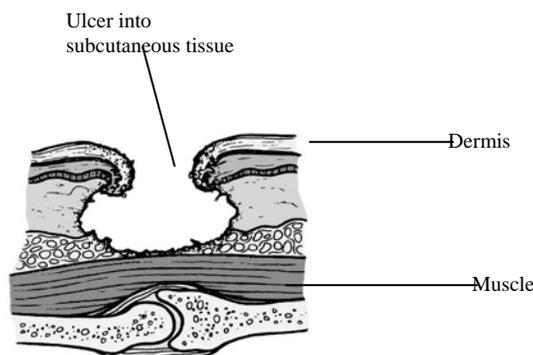
A Stage II (Figure 21.2) pressure ulcer involves partial thickness skin loss involving the epidermis, dermis, or both. It may appear as a blister, abrasion, or shallow crater.

Figure 21.2, Stage II



The Stage III (Figure 21.3) pressure ulcer has full thickness skin loss involving damage to or death of subcutaneous tissue that may extend down to, but not through underlying fascia (muscle or bone). It appears as a deep crater with or without undermining of adjacent tissue.

Figure 21.3: Stage III



A Stage IV (Figure 21.4) pressure ulcer is the most severe form. There is full thickness skin loss with extensive destruction; tissue death; damage to muscle, bone, tendons, or joints. It may include undermining or sinus tracts (tunneling).

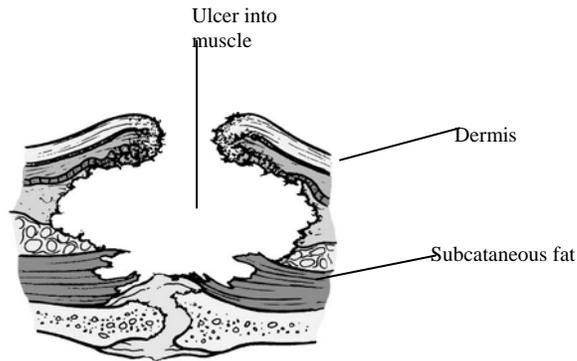


Figure 21.4: Stage IV

Dead (necrotic) tissue may be seen in stages III and IV. Dying tissue may appear black, brown, grey, or yellow and may be either moist or dry.

### **Prevention of Pressure Ulcers**

Most pressure ulcers can be prevented with good care. Check the client's skin condition at least once a day or more often if indicated in the service plan. Promote good circulation by encouraging ROM exercises. A pressure ulcer can be as stressful to the human body as major surgery. For every minute it takes to cause a pressure ulcer, it takes weeks to heal.

Prevent pressure by changing the client's position at least every two hours or more frequently if indicated in the service plan. Use a turning sheet/lift sheet to reduce friction to the skin. Do not position the paralyzed client on his affected area. Encourage clients sitting in a geri-chair or wheelchair to raise themselves every 10-15 minutes.

Use anti-pressure devices as indicated in the service plan. A waterbed distributes pressure evenly over the entire body. Alternating air pressure mattresses keep pressure off half the body at a time. They should be covered with only one sheet and lift sheet to avoid additional layers of material between client and mattress. Do not use pins or any sharp objects near mattress to avoid punctures. Mattress overlays and wheelchair pads cushion the client with foam, gel, water, or air. Pillows provide support and can help when positioning clients in bed. An overbed cradle keeps the weight of top linens off the client's feet and lower legs. Heel and elbow protectors reduce friction and rubbing against bed sheets. A foot elevator reduces pressure on heels. Keep bed linens dry and free of wrinkles and any other irritating substances. Avoid over padding the bed.

Promote good skin condition by keeping the skin clean and dry. Change wet or soiled linens immediately. Treat the skin gently during cleaning and apply lotion or moisture barrier according to the service plan. Avoid vigorous massage of bony areas which can injure the tissue. If used, apply a light dusting of powder or cornstarch. Do not use lotion and powder together. When mixed they can form a thick glue-like paste which can damage the skin.

**CAUTION: DO NOT GET POWDER ON A TILE FLOOR BECAUSE IT CAN CAUSE A SLIPPING HAZARD**

Encourage good nutrition and fluid intake. Provide nutritional supplements as ordered.

### **Observations to Make about Pressure Ulcers**

If the client develops a pressure ulcer or open area on the skin, you will need to make the following observations:

- Location of the pressure ulcer – e.g., “right inner ankle.”
- Condition of the skin – e.g., “reddened area” or “open.”
- Skin temperature – e.g., “warmer to touch than the surrounding skin.”
- Size – compare to familiar objects such as a pea, dime, quarter, or hand.
- Drainage present, amount, and color.
- Odor.

Notify the supervisor/nurse of your observations or if a dressing becomes soiled or dislodged.

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#### PROCEDURE FOR GIVING STAGE I PRESSURE ULCER CARE:

NOTE: IF DRAINAGE IS PRESENT, DO NOT PROCEED. NOTIFY THE SUPERVISOR/ NURSE.

1. Gather necessary equipment.
2. Wash your hands. Put on gloves.
3. Explain what you are going to do.
4. Observe reddened area.
5. Rub the skin around reddened areas with warmed lotion.
6. Wash skin area very gently with soap and water if soiled.
7. Place clean linen on bed if necessary.
8. Tighten linen (must be free from wrinkles).
9. Remove, clean, and store equipment.
10. Wash your hands.
11. Record observations and report anything unusual to the charge nurse.

#### **Chapter Review**

1. What age related changes affect the integumentary system?
2. What observations can you make while giving skin care?
3. What are some specific measures related to skin care?
4. What causes pressure ulcers?
5. What are the pressure areas on the body?
6. What types of clients are prone to formation of pressure ulcers?
7. What are the four stages of pressure ulcers?
8. What are some ways the In-Home Aide can help prevent pressure ulcers?

9. What observations should be made about a pressure ulcer?
11. How do you give Stage I pressure ulcer care according to proper procedure?

## **Student Exercise**

**Complete the following short-answer questions.**

1. List four age-related changes that occur in the integumentary system.
  - a.
  - b.
  - c.
  - d.
2. List the three purposes of skin care.
  - a.
  - b.
  - c.
3. List five observations you could make while giving skin care.
  - a.
  - b.
  - c.
  - d.
  - e.
4. What is the main cause of skin breakdown?
5. List four pressure areas.
  - a.
  - b.
  - c.
  - d.

**Mark the correct answer(s) with a check.**

6. Which of the following describes a client prone to developing pressure ulcers?

\_\_\_a. Independently ambulatory client.

\_\_\_b. Thin and malnourished client.

\_\_\_c. Paralyzed client.

\_\_\_d. Incontinent client.

\_\_\_e. Obese client.

7. What four observations should be made when caring for a client with a pressure ulcer?

a.

b.

c.

d.

**Circle the letter that corresponds to the correct answer.**

8. Which of the following is a necessary measure to prevent pressure ulcers?

a. Elevate the head of bed to 60°.

b. Promote friction on the client's skin.

c. Change the client's position frequently.

d. Avoid the use of pillows as an anti-pressure device.