Managing skin issues for the bariatric patient

The purpose of this educational program is to provide information related to the cause and treatment of three common skin conditions related to the imbalance of skin moisture in the stratum corneum among patients of size. Healthcare providers will learn how to interpret information from their skin assessment and Braden scores and develop appropriate nursing interventions for this population at risk for skin problems and pressure ulcer development.

Objectives:

1. Identify two reasons for a full skin assessment
2. Describe two risk factors that can alter the skin integrity for the patient of size (bariatric population).
3. Discuss causes, prevention and management options needed to provide skin care for the patient of size

Patients of all sizes receive the same skin and pressure ulcer risk assessment

I. The goal of skin assessment is to gather and interpret information about the health of the integumentary system leading to a nursing diagnosis and plan of care.

II. The goal of pressure ulcer risk assessment is to gather information about specific pressure ulcer risk factors resulting in a nursing diagnose at risk for developing a pressure ulcer.

III. Full skin assessment
   A. Daily basic skin assessment
   B. Assess head-to-toe using visualization (good lighting), touching, smell (after cleansing), listening and documentation

IV. More than meets the eye
   A. Assessing a patient of size
   B. Skin folds upper back, lower legs, pannus, under breasts, sides etc.
   C. Common skin conditions
      1. Lymphedema
      2. Stasis dermatitis
   E. Redundant skin equals larger skin folds after weight loss
   F. Special skin care needs for the patients of size
      1. Use the same skin care products for xerosis, IAD and Intertrigo
      2. Difficult to inspect skin due to multiple layers of adipose tissue
      3. Use a long handled mirror to view deep skin folds etc.
      4. Multiple healthcare providers to lift heavy folds for inspection at the base of the skin fold or skin-to-skin area.
      5. Wear long gloves when performing incontinent procedures

IV. Common skin lesions (plaque, cyst, pustule, scar, crust, erosion)

V. Clinical photos of different skin conditions seen in patients of all sizes (skin tags, hyperkeratosis, nummular eczema, dry fissured heels, keloid, excoriation, black heel, basal cell carcinoma,

VI. What should you document?
   A. Alterations in skin moisture
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B. Changes in texture
C. Skin color changes
D. Changes in temperature
E. Persistent odor after cleansing
F. Consistency of skin (boggy, indurated)
G. Pressure ulcer locations assessing other areas than boney prominences

VII. Skin moisture
   A. Damage caused by lack of moisture (xerosis)
   B. Moisture associated skin damage (MASD)
      1. Perspiration and incontinence
      2. Different than pressure
      3. Pressure + friction + xerosis or moisture = increased risk of pressure ulcer

VI. Pressure ulcer risk assessment (Braden Scale)
   A. Initiate interventions
      1. Score of 18 or lower
      2. Braden score 19 or above evaluate sub score
         a. Sensory-perceptual, moisture, activity or nutritional score 3 or less
         b. Friction-shear score 2 or less
   B. Moisture subscale
      1. Perspiration in skin folds, skin to skin areas and under medical devices
      2. Urine, feces, gastric

Xerosis

I. NPUAP Pressure Ulcer Prevention points

Individualize bathing frequency. Use a mild cleansing agent. Avoid hot water and excessive rubbing. Use lotion after bathing. Use moisturizers for dry skin. Minimize environmental factors leading to dry skin such as low humidity and cold air. For neonates and infants follow evidence-based institutional protocols

II. Xerosis - a dermatosis described as dry scaly skin with or without erythema and pruritus
   A. Forgotten skin condition
   B. Overlooked until there is pain or a break in skin integrity
   C. Risk factors leading to an alteration of the natural moisturization process resulting in adult xerosis
   D. Symptoms – itch – scratch –itch cycle
   E. Clinical observations - Could the occurrence of heel pressure ulcers be greater than sacral coccyx pressure ulcers
   F. Clinical indicators of dry skin includes characteristics of dryness construct
   G. Braden score 21: Mobility sub score 3, Friction-shear 2
      1. Implement pillows to protect bony areas i.e. knees on knees,
      2. Float heels off bed
      3. Apply moisturizer to heels and other dry skin areas
   H. Case study poster presentation
Intertriginous Dermatitis

Prolonged water exposure, such as perspiration, can increase stratum corneum permeability facilitating permeability of potential irritants

I. Inter-tri-go—(inter, between + terr, to rub)
   A. Irritant dermatitis occurring between folds or juxtaposed surfaces of the skin.

II. Intertrigo Symptoms
    A. Maceration
    B. Erythema – varying degrees of redness with or without areas of erosion or fissuring
    D. Itching and burning and pain
    E. Odor

III. Patients at risk for intertrigo
    A. Immobilized patients
    B. Disease processes that alters body images
    C. Patients of size
    D. Transplant patients
    E. Weight loss
    F. Patients using medical devices (splints, blood pressure cuffs, foley catheters)

IV. Complications from untreated intertrigo
    A. Bacterial and fungal skin infections
    B. Pressure ulcers in skin folds related to weight of a pannus
    C. Braden Score 21: Moisture sub score 2 (Perspiration in skin folds)
       1. Moisture intervention (perspiration and skin to skin friction)
          a. Assess are between skin folds every shift
          b. Cleanse area between skin folds with no rinse cleanser
          c. Mange moisture with wicking textile

V. Poster Presentations/Case Stories

Incontinence Associated Dermatitis (IAD)

I. NPUAP pressure ulcer prevention points

Establish a bowel and bladder program for patients with incontinence. When incontinence cannot be controlled, cleanse skin at time of soiling, and use a topical barrier to protect the skin. Select under pads or briefs that are absorbent and provide a quick drying surface to the skin. Consider a pouching system or collection device to contain stool and to protect the skin.

II. Inflammation of the skin in the genital, buttock, or upper leg areas: often associated with changes in the skin barrier (redness, a rash or vesiculation), and adverse symptoms such as pain or itching.

III. Differential diagnosis
    A. Erythema with or without erosion
    B. Candidiasis vs. Herpes zoster

IV. “Fecal incontinence (diarrhea) increases the risk for pressure ulcers”
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37% pressure ulcers located on sacrum

V. Etiology related to effluent
A. Intensity and duration of irritant, skin condition and contributing factors
B. Fecal incontinence increase risk of pressure ulcers
C. Braden Score 20: Moisture sub score 2, Mobility score 3
   1. Incontinent urine and feces
      a. Moisture intervention (perspiration and skin to skin friction)
      b. Assess are between skin folds every shift
      c. Cleanse are between skin folds with no rinse cleanser
      d. Mange moisture with wicking textile
   2. Slightly limited movement makes frequent though slight changes in body position
      a. Assess and inspect skin every shift and PRN
      b. Ensure appropriate patient turns/repositions

VI. Case studies and poster presentations adults and infants

Skin assessment Nursing Diagnosis

Nursing diagnosis: Left lower leg is at risk for a break in skin barrier due to hemosiderin staining, dry skin (xerosis) and pruritus.

Plan of care:
1. Cleanse skin with no-rinse cleanser once-daily
2. Apply 24 hour moisturizer once-daily
3. Assess skin every shift (observe for scratching)

Braden scale assessment Nursing Diagnosis

Braden score 22: Moisture subscale 3. Perspiration under breasts

Nursing diagnosis
The area under breasts is at risk for pressure ulcers due to perspiration and skin to skin friction.

Plan of care
1. Cleanse area under breasts with no-rinse cleanser.
2. Manage moisture with wicking textile

Summary
The goal of a skin assessment is to determine skin health and establish a plan of care.
- The goal of a pressure ulcer risk assessment is to identify risk factors and interventions.
- A head-to-toe skin assessment should be performed daily.
- A Braden risk score should be completed daily and on patient change of status.
- Untreated xerosis may result in a skin infection or a pressure ulcer.
- Untreated intertrigo and incontinence-associated dermatitis may result in cutaneous infection or pressure ulcers.
- A Braden score above 18 with a moisture sub-score of 3 indicates an intervention for moisture.
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