Moisture Lesions

Tissue Viability Service

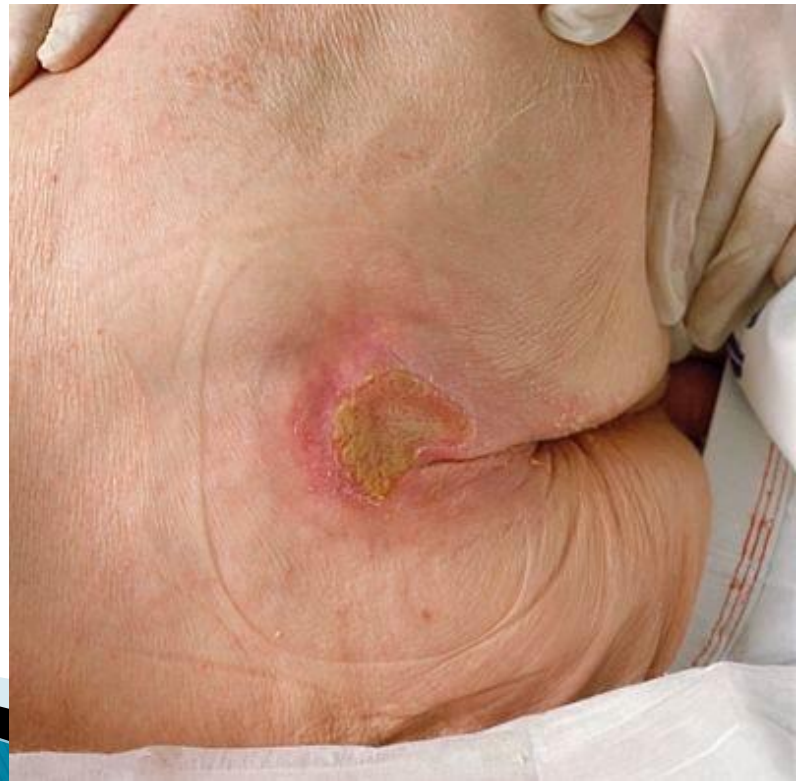
PRESSURE ULCERS & MOISTURE LESIONS

- 700,000 people affected by pressure ulcers and moisture lesions per year.
- This costs the NHS £3.8 million per day.
- NHS drive to reduce pressure ulcers & moisture lesions
- The skin is our biggest organ which we need to protect
- Moisture lesions are regularly identified incorrectly as pressure ulcers

What is a Pressure Ulcer

"A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".

(NHS Improvement 2018)



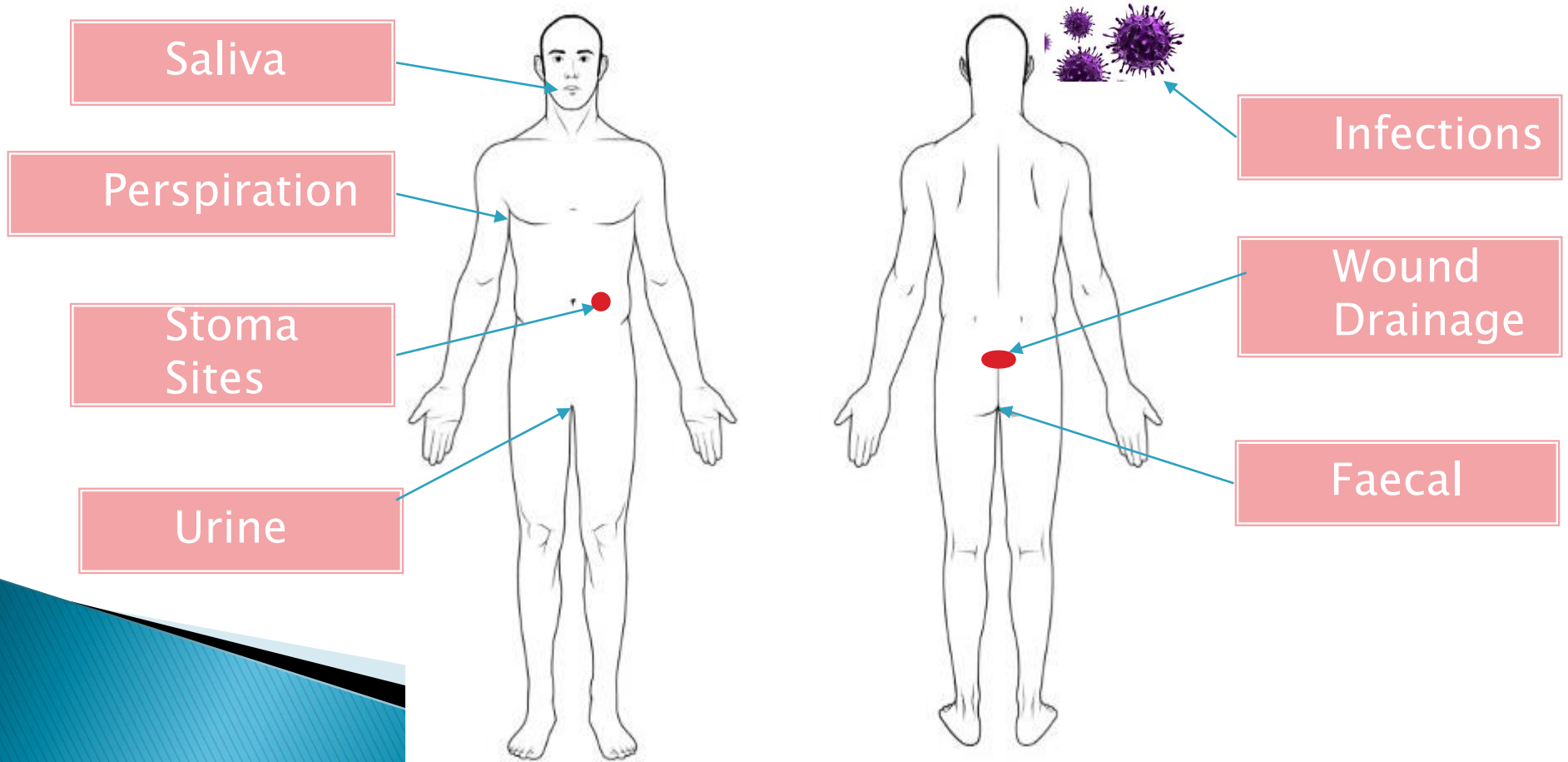
WHAT IS A MOISTURE LESION?

MOISTURE LESIONS

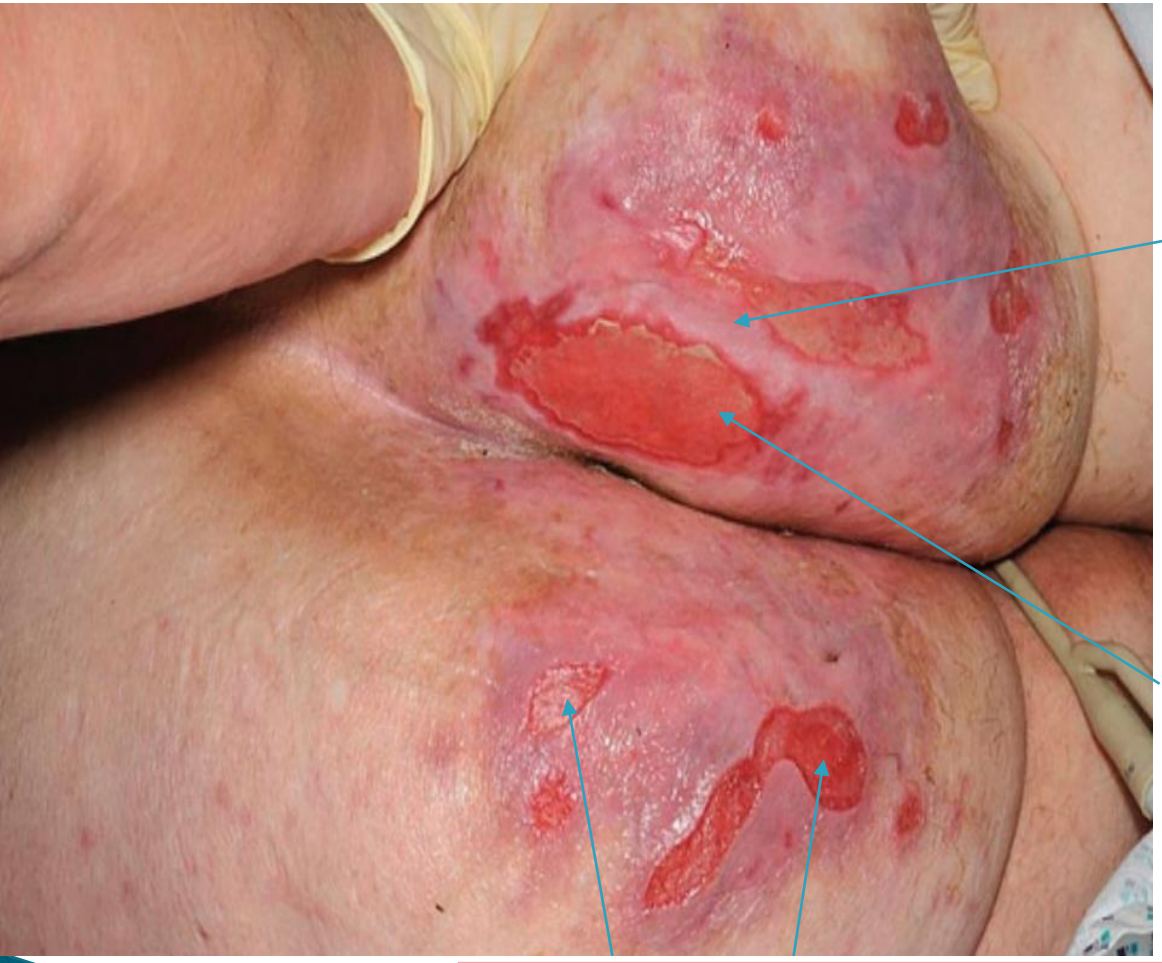
Skin damage due to exposure to urine, faeces or other body fluids (sometimes referred to as a ‘kissing ulcer’)

FACTORS THAT CAUSE MOISTURE LESIONS?

Moisture-associated skin damage is the general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture



Characteristics of Moisture Lesions



Pink or white surrounding skin
maceration due to moisture

Red skin
If redness is not uniformly distributed, the lesion is likely to be a moisture lesion.

Moisture lesions are superficial
(not deep)
If it becomes infected, it will extend to full thickness skin loss.

Different superficial spots are likely to be moisture lesions

In kissing ulcers at least one of the wounds is moist likely caused by moisture urine, faeces, perspiration, skin fold and wound exudate.

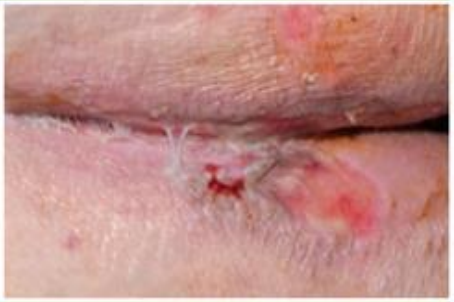
Scottish Excoriation & Moisture Related Skin Damage Tool

Moisture Lesions:

Skin damage due to exposure to urine, faeces or other body fluids

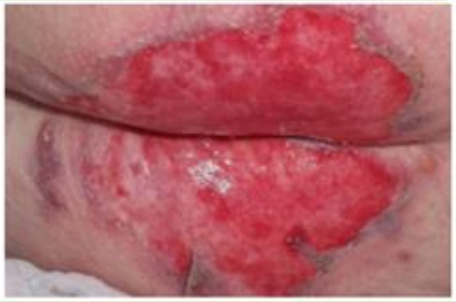
Location

Located in peri-anal, gluteal, cleft, groin or buttock area. Not usually over a bony prominence.



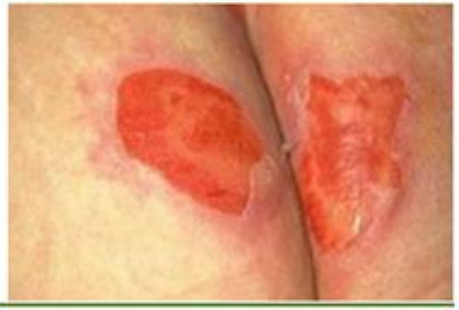
Necrosis

No necrosis or slough.
May develop slough if infection present.



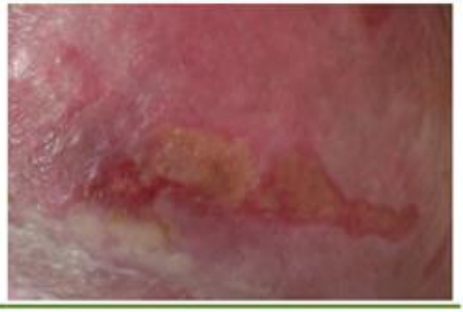
Shape

Diffuse often multiple lesions. May be 'copy', 'mirror' or 'kissing' lesion on adjacent buttock or anal-cleft.
Linear



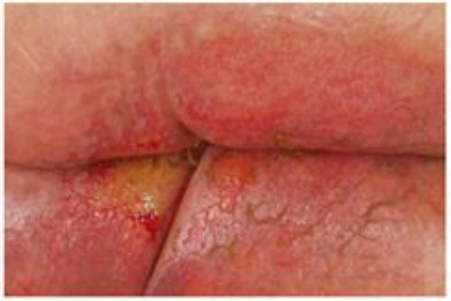
Depth

Superficial partial thickness skin loss.
Can enlarge or deepen if infection present.



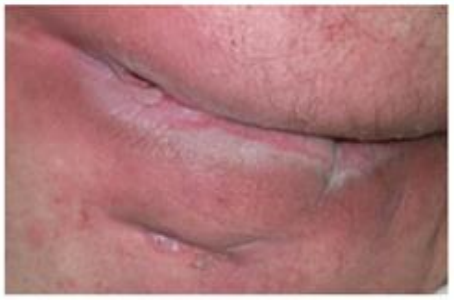
Edges

Diffuse irregular edges.

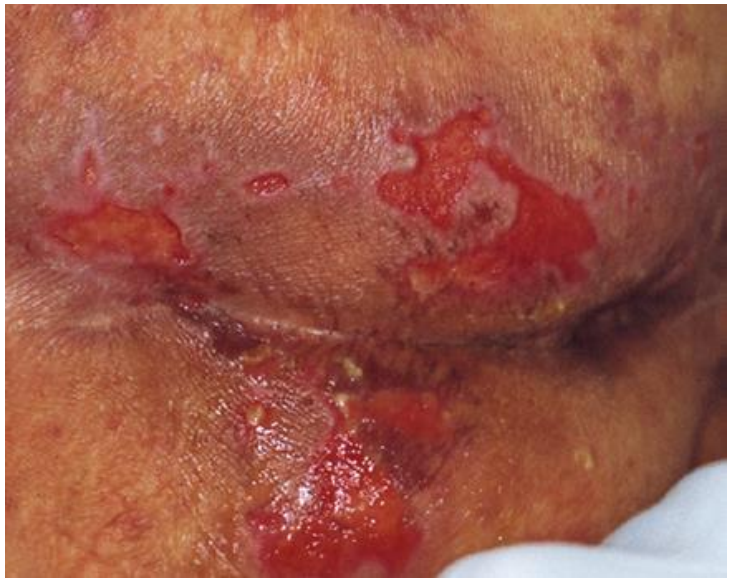


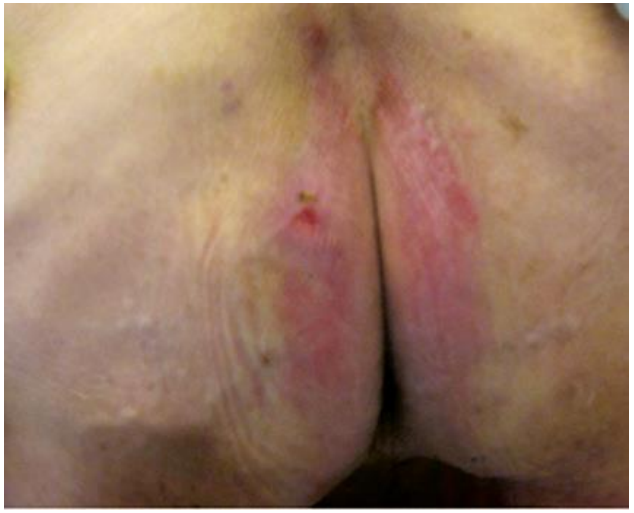
Colour

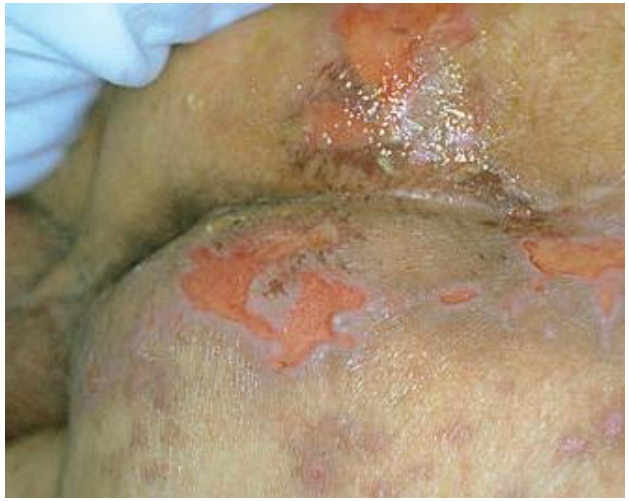
Colour of redness may not be uniform. May have pink or white surrounding skin (maceration). Peri-anal redness may be present.



Moisture lesions are NOT graded

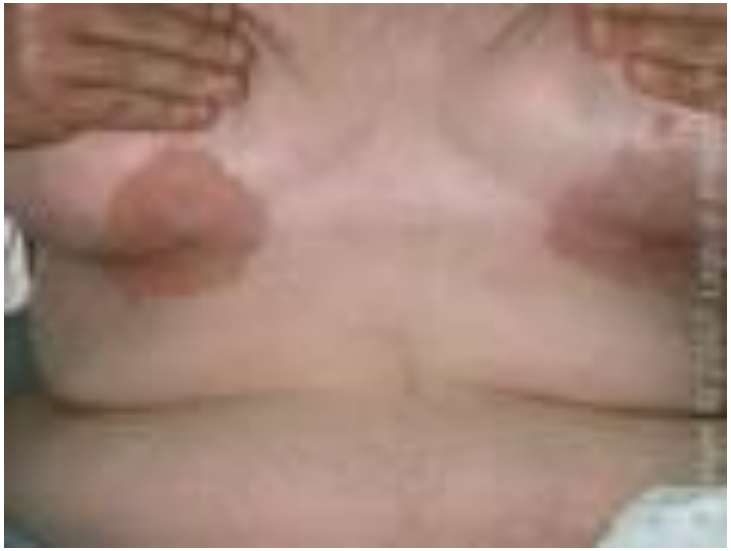


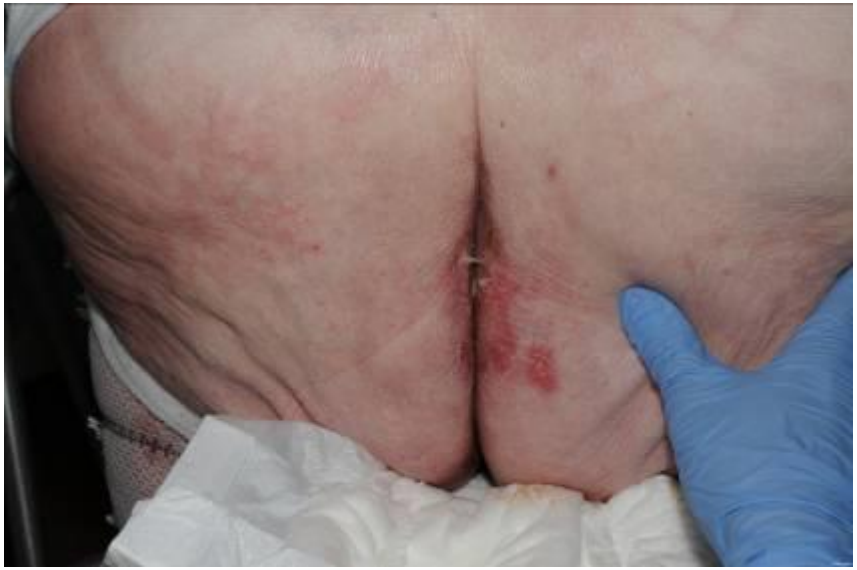




Pictures courtesy of 3M

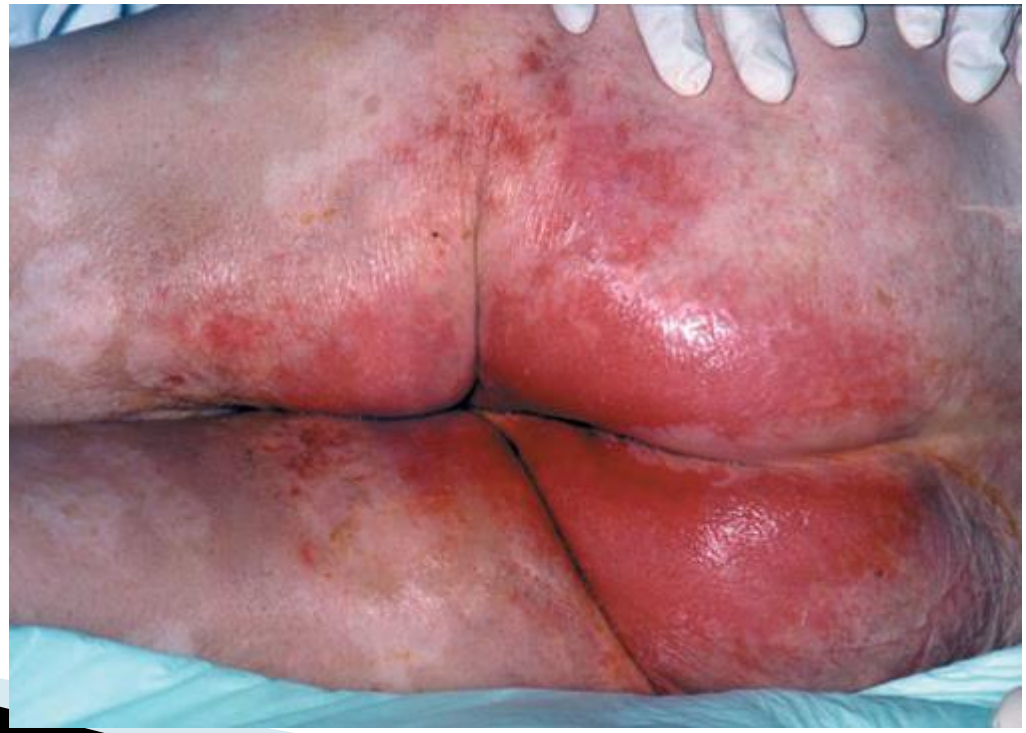
Moisture Lesions-note the mirrored image on the surrounding skin





Incontinence related Dermatitis (IRD)

- Incontinence dermatitis : note that the skin is red and moist, the lesion presents as a “kissing lesion” in that the peri-anal area is mirrored image.

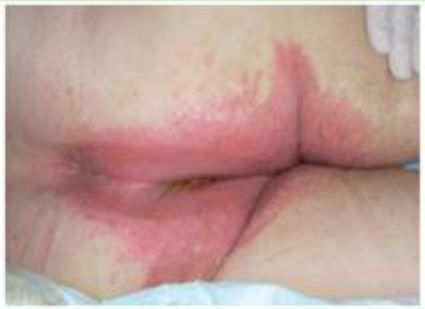


Scottish Excoriation & Moisture Related Skin Damage Tool

Incontinence Related Dermatitis (IRD)

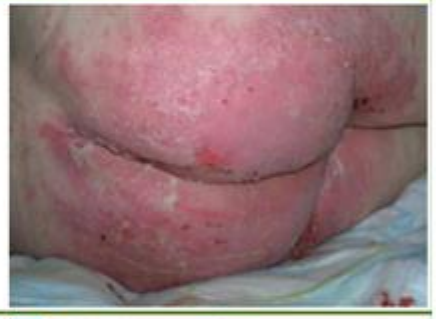
Mild

Erythema (redness) of skin only. No broken areas present.



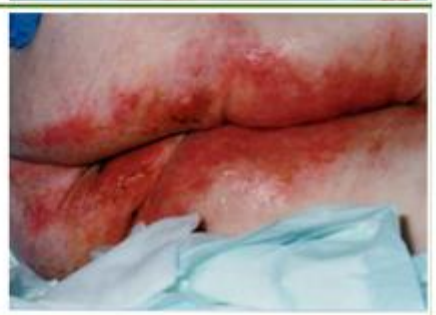
Moderate

Erythema (redness), with less than 50% broken skin.
Oozing and/or bleeding may be present.



Severe

Erythema (redness), with more than 50% broken skin.
Oozing and/or bleeding may be present.



Treatment:

Prevention/Mild IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply Moisturiser +/or skin protectant e.g. barrier cream/film which does not affect absorbency of continence products.

Moderate-Severe IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply liquid/spray skin protectant, OR barrier preparation, if no improvement refer to local guidelines or seek specialist advice.

NB:
Observe for signs of skin infection, e.g. candidiasis, and treat accordingly (do not use barrier films as this will reduce effectiveness of treatment)

Maintaining Healthy Skin

- REGULAR Assessment and document skin condition
- Encourage mobility
- Pressure relief
- Nutrition
- Hydration

Maintaining Healthy Skin

- Skin Care Top Tips
  - Ensure skin is cleansed (warm water only)
  - dried thoroughly (pat dry – avoid rubbing)
  - Use non soap cleanser
  - Ensure incontinence pads are checked and changed regularly
  - Use appropriate barrier cream or film

- AVOID TALCUM POWDER
  - This combines with the water to make a paste which can cause more damage


SUREPREP
RAPID DRY


SORBADERM
Barrier Cream
3028 1x92g Tube
CREAM
92g
SORBADERM
CREAM
28g

PREVENTION IS KEY!

- To prevent pressure damage, the most important factor is to **reduce or relieve pressure**.

- To prevent moisture damage, the most important factor is keeping the skin **clean, dry and well hydrated.**

CONSIDER introducing a barrier cream early if your patient is high risk before the skin breaks down!


QUESTIONS?
COMMENTS?
CONCERNS?