

Title:	Skin Care Policy for Adult Patients Receiving Radiotherapy		
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Date	Version	Author	Comments
July 2017	1.1	Jean Smith	Changes made to existing policy and poster in light of new guidelines. Draft sent to all group members for comment.
July 2017	1.2	Jean Smith	Changes made following consultation with working group. Change of title for I Sturgess, pharmacist.
August 2017	1.3	Jean Smith	Update of personnel and job titles on the working group.
September 2017	1.4	Jean Smith	Insertion of statement on access to the information in the document as required by Equality Screening

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

A Multi professional working group has reviewed and revised the policy in line with current guidance and national practice. The information in this document is in response to new Society and College of Radiographers (SCoR) guidance that was published in 2015⁽¹⁾ following a UK survey on skin care ⁽²⁾ (a further survey was conducted by the Society in 2014 from which data is still being collated). Reference has also been made to the NHS Quality Improvement Scotland best practice statement 'Skincare of Patients receiving radiotherapy'⁽³⁾.

External Beam Radiotherapy is one of the treatment modalities used to treat cancer. Each year the radiotherapy department at the Cancer Centre, Belfast City Hospital, treats approximately 4000 new patients with radiotherapy.

Radiotherapy works by affecting DNA cells during mitosis. Cancer cells are damaged or destroyed during this process. Treatment is delivered in such a way that radiation will travel through tissue to deliver the relevant dose. In each case skin will be in the path of the radiation beam. As the skin is a large organ of radiosensitive tissue, it is acknowledged that there will be a certain amount of radiotherapy-induced skin damage, with 80-90% of patients experiencing erythema ⁽²⁾. In most cases the skin is able to repair itself.

Reference is made within the SCoR 2015 document that, although there have been great advances in radiotherapy treatment techniques, with some new modalities (such as IMRT) ⁽⁴⁾ having potential to reduce skin reactions, there has been little change in skin care advice over the years, and there is no consensus amongst centres ^(1,5,6).

Variation exists across departments in relation to washing instructions, during and after radiotherapy treatment and, in particular, the use of soap, creams and deodorant. Updated evidence shows that advising patients not to use soap, or to use water alone, can unnecessarily control their choices and preferences. As noted in the SCoR 2015 document, "expecting patients to follow traditional practice advice of "not to wash" and "not to use deodorant" may affect their social wellbeing". For example, breast cancer patients who are advised not to use a deodorant often cite this as one less area in which they have control in their life and they note concern regarding body odour⁽⁷⁾.

In the past it was felt that metallic compounds, particularly aluminium, within deodorants might cause a secondary radiation effect ⁽⁸⁾. However, more recent studies contradict this advice finding it unfounded and outdated ^(9, 10,11,12). Research, in this area, is ongoing across the UK.

The SCoR also state that "overall, the evidence base is not strong enough to either support or refute the use of any particular product for topical application".

Gosselin et al. (2010) noted, “patients prefer to take action rather than do nothing” so the focus for skin care should be on alleviating symptoms and providing comfort ⁽¹³⁾.

As research continues into all aspects of radiotherapy skin care, the Radiotherapy Department, in the Cancer Centre, Belfast City Hospital, will work within the boundaries of this policy; adhering to any new developments nationally, or locally, and taking into account the individual needs of each patient.

1.2 Purpose

The aim of the policy is to provide detailed information on the assessment and management of irradiated skin and to ensure that the advice and documentation is consistent across the professions within the Trust and wider community (primary care). Patients attend for radiotherapy treatment as either an outpatient or inpatient. The therapy radiographer will see the patient each time that they attend for treatment and will advise them about skin care during the course of treatment. A summary of the skin care policy is available in poster form and can be found in Appendix 1. The Radiotherapy Oncology Group (RTOG) scoring ⁽¹⁴⁾ has been used to grade skin reactions.

This policy has been referenced in the document ‘Guidance for the Management of Patients Who Become Ill Whilst Receiving Radiotherapy or Within 6 Weeks of Radiotherapy’.

1.3 Objectives

- To provide clear guidance around the management of skin care while patients are receiving radiotherapy treatment and up to three weeks following treatment.
- To deliver consistent and high quality care to patients.
- To encourage team working and seamless care.

2.0 SCOPE OF THE POLICY

This policy will apply to any professionals providing care to patients who have received radiotherapy in the Belfast Trust. Based on person centred care any information provided to patients will be provided in accessible/alternative formats as required. Accessible formats can include information in easy to read formats, audio when the patient has a learning disability or is visually impaired. If a patient does not speak English as a first language the information will be translated or an interpreter / sign language interpreter provided as appropriate.

3.0 ROLES/RESPONSIBILITIES

It is the responsibility of all professionals within the Belfast Trust who interact with patients to ensure that they have the correct information relating to skin care; giving it in a timely manner throughout and following their course of radiotherapy treatment. It is important that all professionals understand the

anatomy and physiology of the skin as well as how and when reactions may occur.

It is the responsibility of:

- Therapy radiographers to inform patients attending for treatment about their skin care regimen.
- All professionals involved in the patient's care to ensure that patients are aware of and follow their skin care regimen and that this is amended as skin reactions progress – see appendix 1.

4.0 KEY POLICY PRINCIPLES

4.1 During radiotherapy treatment patients are assessed daily by therapy radiographers. They are advised on skin care in the treated area from the first day of treatment and this advice should be in line with this policy. Other healthcare professionals coming into contact with the patient throughout the course of their treatment will also be aware of the necessary skin care advice. See Appendix 1 and for further information on creams etc see current BNF⁽¹⁵⁾.

4.2 There are a number of additional factors which may affect the patients' skin while having radiotherapy treatment. All healthcare professionals dealing with radiotherapy patients should, therefore, be aware of the main points of the skin care policy for patients receiving radiotherapy (see appendix 2), namely:

- The effects of radiotherapy on the skin.
- Risk factors for radiotherapy skin reactions.
- The effects of combined modality treatment.
- Skin assessment and management prior to, during and up to 3 weeks post radiotherapy.
- Delayed reactions to radiotherapy.
- Radiation recall reactions.
- Communication of best practice for Radiotherapy Skincare.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy is relevant to Therapy Radiographers, Radiotherapy Nurses, Cancer Centre Nurses, Medical staff, Pharmacists working with this group of patients and other Belfast HSC Trust professionals who come into contact with the patient during the course of their treatment.

5.2 Resources

No additional resources are required. Policy and guidelines will be available electronically via Belfast Trust Hub and within the Radiotherapy Department. All new staff will be informed of this policy during their induction to the Cancer Centre and each professional group will take responsibility for this training.

5.3 Exceptions

This policy will be used primarily in the Radiotherapy Department and Cancer Centre, Belfast City Hospital, for patients receiving radiotherapy treatment. It is also available to the wider Belfast HSC Trust for information.

6.0 MONITORING

Compliance will be measured by observation of patients and their skin reactions while attending for radiotherapy treatment on a daily basis. Nurses will review patients and provide wound management. The policy will be reviewed by the authors every 3 years or sooner if there is change in practice.

7.0 EVIDENCE BASE / REFERENCES

References

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8.0 CONSULTATION PROCESS

Cancer Centre Radiotherapy Development Group
 Section Manager, Radiotherapy Dept., Cancer Centre, BCH
 Radiotherapy Nurse Team Lead, Cancer Centre, BCH
 Radiotherapy Service Manager Cancer Centre, BCH.
 Information & Support Radiographer, Cancer Centre, BCH
 Clinical Oncologist/Senior Lecturer in Clinical Oncology, Cancer Centre, BCH
 Dermatology Consultant BCH.
 Lead Clinical Pharmacist Haematology/ Oncology, BCH.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 shows a summary of this protocol in poster form and can be used as an aide memoire on treatment units, wards or clinics. (See below).

Appendix 2 provides more detailed information for use with the policy.

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

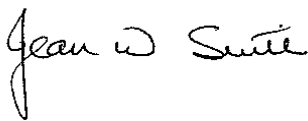
Major impact.

Minor impact

No impact. X

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



Author

Date: ____ October 2017 ____



Director

Date: ____ October 2017 ____






Basic Skin Care Guidelines – for staff use

(If there are any queries please contact a member of the Radiotherapy Skin Care Group – refer to main policy for details)

Assessment and management of irradiated skin while on treatment and up to 3 weeks post treatment

(RTOG = Radiation Therapy Oncology Group)

Appendix 1

RTOG score	Description	Appearance of skin	Treatment
RTOG 0	Normal	 No visible change	<ul style="list-style-type: none"> Diprobace cream to delay onset of reaction. Apply a thin layer of cream twice daily and then as required. Patient may continue to wash throughout treatment according to guidelines.
RTOG 1	Faint or Dull Erythema	 Skin becomes pink or slightly red	<ul style="list-style-type: none"> Frequent Diprobace cream to soothe and moisturize. Apply cream three times daily or as required.
RTOG 2A	Tender or Bright Erythema (Dry Desquamation)	 Skin red, dry and scaly, some itchiness and/or tingling	<ul style="list-style-type: none"> Frequent Diprobace cream. Apply cream four times daily. Diprobace ointment or white soft paraffin: liquid paraffin ointment (avoid excess build-up and do not apply directly before treatment). Hydrocortisone 1% cream may be used sparingly on itchy areas – apply twice daily. Patient should have written and verbal information regarding its application. Review hydrocortisone use after 7 days, discontinue if skin breaks. Refer to radiotherapy nurses for wound care.
RTOG 2B	Patchy Moist Desquamation, Oedema	 Skin inflamed with patches of epidermis broken down and moist	<ul style="list-style-type: none"> Principles of moist wound healing apply. Apply Hydrogel dressing to moist areas, with appropriate secondary dressing – Surgipad or foam dressing (avoid excess build-up and do not apply directly before treatment). Diprobace cream can still be applied to other parts of field treatment area but avoid in areas that are broken down. Medical assessment needed.
RTOG 3	Confluent Moist Desquamation	 Epidermis blisters and sloughs, underlying dermis is exposed and sore, oozing of serous fluid, increased risk of infection	<ul style="list-style-type: none"> Apply Hydrogel dressing to moist areas, with appropriate secondary dressing – foam dressing (avoid excess build-up and do not apply directly before treatment). Continual medical assessment.
Post Radiotherapy	<ul style="list-style-type: none"> Reactions may continue for several weeks post treatment. Continue with use of emollient creams until skin returns to normal. If RTOG2B/3 principles of moist wound healing apply (as above) OR Silicone dressing – ensure patient has no allergy to silicone. If infection suspected apply silver impregnated dressings OR Silver Sulfadiazine cream (prescription only medication). If using Silver Sulfadiazine cream apply daily for seven days, provided no known contraindications and with medical supervision. If further advice is required regarding the care of radiotherapy reaction then patients should contact the number provided on discharge. 		

Basic Skin Care Guidelines – for staff use

(If there are any queries please contact a member of the Radiotherapy Skin Care Group – refer to main policy for details)

All patients receiving radiotherapy, regardless of treatment field, should be advised of the following skincare guidelines.
The guidelines only apply to the area being treated, including both entry and exit sites.

When washing / bathing / showering on a daily basis:

(Use warm / tepid water, with unperfumed soap if desired.)

- Care should be taken regarding the use of showers particularly where there is no temperature control or where jets are very powerful.
- DO NOT use perfumed products on red or broken skin.
- Avoid the use of a washcloth.
- Use a soft towel to pat the area dry (avoiding friction).

Other skincare products:

- DO NOT apply perfume, aftershave or deodorant to the treatment area if the skin is red or broken.
- Only use creams or ointments advocated by the radiotherapy treatment centre.
- All gels, creams or lotions for skin application should be used at room temperature even if stored in a refrigerator.

Hair removal:

- If the face / neck is within the treatment field use an electric shaver instead of a wet razor when shaving.
- If the axilla is within the treatment area, shaving should be avoided where possible.
- DO NOT use wax or other hair removing creams within the treatment area.

Use of swimming pools:

- Caution should be taken as chlorinated water can have a drying effect on the skin. Our advice is that swimming should be avoided during radiotherapy and until any skin reaction has settled.

General advice

- Avoid direct application of heat or cold to the area.
- Friction is reduced with the avoidance of scratching, rubbing and massaging the skin.
- Loose natural fibre clothing will help avoid friction.
- Following mastectomy, if a permanent prosthesis causes increased moisture and/or friction, a soft prosthesis should be worn.
- Use of a mild detergent (fragrance-free if possible) for washing clothing to be worn next to the skin may reduce irritation.
- Adhesive tape should always be avoided within the treatment field during treatment and until any reaction has settled.
- Avoid sun exposure to the treatment area particularly in the first year following treatment and use a high SPF sunscreen or block. Irradiated skin will always be at risk of sun damage.
- Do not remove any skin markings during treatment unless advised to do so.
- Encourage good hand hygiene when applying creams to treatment area.

Skincare practices to avoid

- Do not use thick creams that cause a lot of friction to apply.
- Do not use adhesive dressings.

Steroid or cortisone creams should only be used following medical advice from the radiotherapy department. These creams should not be used on broken skin.

Appendix 2

Policy Principles of Skin care for patients receiving radiotherapy

1 The Effects of Radiotherapy on the Skin

Key Points

- Patients undergoing radiotherapy may experience skin changes and are at risk of skin damage.
- Individual patients' skin may react differently to radiotherapy and each patient should be made aware of possible changes.
- Patients should have their skin formally assessed prior to, during and post radiotherapy.
- Patients and carers should have written and verbal information.

Table 1 – The effects of radiotherapy on the skin

Statement	How to Demonstrate Statement is Being Achieved
All healthcare professionals involved in the management of patients receiving radiotherapy should have access to resources which provide education on the anatomy and physiology of the skin.	Key reference relating to the anatomy and physiology of the skin: Burns T, Breathnach S, Cox N and Griffiths C. Rook's Textbook of Dermatology, 8 th Ed. Oxford; Wiley-Blackwell, 2010 ⁽¹⁶⁾ .
Before radiotherapy begins, a comprehensive assessment of the patient's current skin condition should be made and documented.	A skin assessment and evidence of an individualised radiotherapy skin care plan should be documented within the following documentation: <ul style="list-style-type: none">- The Radiotherapy Monitoring Form- Nurse assessment- Medical Notes
All involved healthcare professionals can identify the potential effects of radiotherapy on a patient's skin and the impact on skin regeneration ^(17,18,19) .	All healthcare professionals should document risk factors for individual patients. These should be recorded on the following documentation: <ul style="list-style-type: none">- The Radiotherapy Treatment Chart/Monitoring Form- Nurse assessment- Medical Notes

<p>During radiotherapy, a comprehensive assessment of the patient's skin should be made by healthcare professionals within the radiotherapy treatment area, using a valid and reliable assessment tool eg RTOG (see appendix 1)</p>	<p>Skin assessment during radiotherapy treatment should be recorded by healthcare professionals on the following documentation on a regular basis:</p> <ul style="list-style-type: none"> - The Radiotherapy Monitoring Form - Nurse assessment - Medical Notes
<p>Treatment centre staff will have primary responsibility for educating and preparing patients and carers, both prior to and during radiotherapy, with both verbal and written information⁽²⁰⁾.</p>	<p>Provision of written and verbal information for each patient is documented.</p> <p>There is also a radiotherapy patient information video on the BHSCT YouTube channel: https://www.youtube.com/watch?v=dxQbLwxMxF4&t=310s</p> <p>Pre radiotherapy patients receive verbal and written information (Trust produced 'Your Questions Answered' information booklet) about appropriate skin care. A record of the provision of this information is documented on the Radiotherapy Monitoring Form, the Consent Form for Examination, Treatment or Care. It may also be recorded within nursing notes and medical notes where appropriate.</p> <p>During radiotherapy healthcare professionals may reinforce the verbal/written information given to patients on a regular basis. This should be documented in the Radiotherapy Monitoring Form, within nursing notes and medical notes as appropriate.</p>

2 Risk Factors for Radiotherapy Skin reactions

Key Points

- Skin reactions can be influenced by factors which are extrinsic (treatment related) and intrinsic (patient related).
- Patients and their carers should be aware of preventative skincare measures and contact points for further information.
- There are direct and indirect factors that influence the risk of skin reactions.
- There is strong evidence that people who smoke are at risk of a more acute and prolonged skin reaction.

All risk factors should be documented on the Radiotherapy Monitoring Form at the beginning of treatment when the skin risk assessment is carried out.

Table 2 – Risk factors for radiotherapy skin reactions

Age	The epidermal turnover decreases with age resulting in extending healing times.
Chemical irritants	Applications of deodorant, perfume or aftershave could increase skin reactions to the treatment area. Research in this area is ongoing through the SCoR.
Chemotherapy	Some chemotherapeutic agents may cause increased skin reactions.
Co-existing disease	Illness or medication can have a direct effect on the skin's healing process, e.g. diabetes/steroids. Most co-existing diseases can be linked with an increase in age as well as changes in BMI and/or nutritional status.
Ethnic origin/skin diversity	There is a lack of evidence to support the theory that skin reaction increases in different ethnic groups.
Infection	Bacterial or fungal infection can damage basal cells and impede healing.
Inherited Radiosensitivity	Some genetic disorders such as ataxia telangiectasia can increase sensitivity to radiotherapy.
Mechanical irritants	Friction, e.g. clothing and shaving can increase skin reaction and cause delayed healing.
Nutritional status	Intake of adequate nutrients is required for optimum repair of tissue damage.
Obesity	Having excess adipose tissue can compromise healing due to poor vascularity and is linked with extra skin folds, friction, moisture and warmth which will increase skin reactions.
Previously treated area	These may be more at risk of acute skin reactions.
Smoking	Inhaling nicotine can impair the body's response to infection and healing. It limits the oxygen-carrying capacity by replacing oxygen with carbon monoxide.
Thermal irritants	Direct application of extremes of temperature onto the treatment area can cause irritation to the skin and thus delay healing, e.g. heat or ice packs.
Radiotherapy	Higher doses and increased volume of radiation will lead to greater risk of skin reactions, although advances in techniques may reduce this for some treatment sites ⁽⁴⁾ .
Energy of beam	Megavoltage (MV) photon energies deliver the maximum dose underneath the skin surface. Kilovoltage energies will deliver the maximum dose to the skin surface, therefore causing an increased skin reaction.
Entry and exit sites	Apparently 'unrelated' skin reactions may be due to the exit site dose of the beam.
Use of build up material	When tissue equivalent material is used in the treatment area it increases the dose to the skin and the skin reaction may be worse.
Site of treatment	Some sites will show an increased skin reaction following radiotherapy. Areas at risk may include the area under

	the breast, axilla, head and neck, perineum and groin.
Treatment regimes	Different treatment regimes may be associated with increased skin toxicities due to different treatment doses.

3 The effects of combined modality treatment

Key Points

- Combined modality treatment may include concurrent or sequential therapy with radiotherapy, chemotherapy and/or surgery.
- There is increasing use of chemo-radiotherapy, where the two treatments work together to improve response. This can affect the severity of skin reactions.

Table 3 – Combined modality

Statement	How to Demonstrate Statement is Being Achieved
Healthcare professionals within the treatment centre should be aware that combined modality treatment may lead to an increased risk of skin reactions. This information must be shared with the primary care team if relevant for an individual patient.	<p>Radiotherapy patients are seen by either a clinician or suitably qualified Therapy Radiographer at a weekly on-treatment review clinic. These professionals are aware of concurrent treatment that the patient may be receiving and will, therefore be vigilant regarding risk of early or severe skin reactions.</p> <p>Prompt treatment of skin reactions is documented in the following areas:</p> <ul style="list-style-type: none"> - The Radiotherapy Monitoring Form - Nurse assessment - Medical Notes
Healthcare professionals within the treatment centre should be aware of potential radiosensitisers used in their area, and this information must be shared within the primary care team if relevant for an individual patient.	<p>Risk of reaction due to combined modality treatment is documented in the following areas:</p> <ul style="list-style-type: none"> - The Radiotherapy Monitoring Form - Nurse assessment - Medical Notes

4 Skin assessment and management prior to, during and up to 3 weeks post radiotherapy

Key points

- It is acknowledged that there will be a certain amount of radiotherapy induced skin damage with 80 – 90% of patients experiencing erythema ⁽²⁾.
- Interventions and advice are aimed at minimising the severity of skin reactions; as they are not avoidable.
- Within the Belfast HSC Trust the RTOG Skin Assessment Tool will be used (Appendix A). This is a nationally accepted, validated tool.
- Skin reaction does not always occur immediately and may peak 10 days after completion of treatment.
- There are a number of practices that should be avoided. See appendix 1 – Basic Skin Care Guidelines.

Table 4 – Skin assessment and management

Statement	How to Demonstrate Statement is Being Achieved
<p>Patients care for the treated area in accordance with the basic skincare guidelines.</p>	<p>Pre radiotherapy patients receive verbal and written information (Trust produced 'Your Questions Answered' information booklet) about appropriate skin care. A record of the provision of this information is documented on the Radiotherapy Monitoring Form, the Consent Form for Examination, Treatment or Care. It may also be recorded within nursing notes and medical notes where appropriate.</p> <p>During radiotherapy healthcare professionals may reinforce the verbal/written information given to patients on a regular basis. This should be documented in the Radiotherapy Monitoring Form, within nursing notes and medical notes as appropriate.</p> <p>See Appendix 1 – Basic Skin care Guidelines</p>
<p>An assessment tool should be used to assess the degree of radiation toxicity.</p>	<p>The stage of toxicity is recorded within the relevant documentation using the RTOG Skin Assessment Tool (See Appendix 1).</p> <p>The RTOG grading should be recorded by healthcare professionals on the following documentation on a regular basis (see Appendix 1):</p> <ul style="list-style-type: none"> - The Radiotherapy Monitoring Form when the patient is reviewed at the review clinic. - Nurse assessment - Medical Notes

The poster in Appendix 1 - 'Assessment and Management of irradiated skin' provides a detailed summary of the recognition of the different degrees of radiation toxicity that may be experienced by patients receiving radiotherapy i.e. RTOG 0 – RTOG 3 and the management and treatment strategies adopted within the Belfast HSC Trust.

5 Delayed reactions to radiotherapy

Key Points

- Skin reactions may develop after treatment has been completed.
- Permanent skin changes may occur following treatment.

Table 5 – Delayed reactions

Statement	How to Demonstrate Statement is Being Achieved
At the end of treatment, patients will be reminded about the potential skin reactions which may follow treatment.	Verbal and written information will have been given prior to commencing radiotherapy. This information covers all aspects of potential skin reactions during treatment and after treatment. A record of the provision of this information is documented on the Radiotherapy Monitoring Form, within nursing notes and medical notes as appropriate.
Patients, carers and relevant staff will be aware of potential delayed skin reactions following radiotherapy such as ulceration (uncommon), dermal necrosis, dermal atrophy and telangiectasia (all rare).	On completion of radiotherapy a verbal reinforcement of this information is provided and is documented on the Radiotherapy Monitoring Form, within nursing notes and medical notes as appropriate.
Patients will be aware of any permanent radiotherapy-related side-effects to the skin e.g. dryness of skin, reduction of skin elasticity, increased skin sensitivity.	<p>Written information is also given in the form of the booklet 'Information for patients who have completed a course of Radiotherapy'. This contains contact information and patients are encouraged to phone if they have any problems after radiotherapy treatment.</p> <p>Patients have access to specialist advice on site, during radiotherapy treatment and this can continue after treatment if appropriate. Staff can also access this advice as needed.</p> <p>Additional information required by the primary care team can be sought from the appropriate professionals in the Cancer Centre.</p>

6 Radiation Recall Reactions

Key points

- Use of certain drugs may cause a radiation recall reaction.

Table 6 – Radiation recall

Statement	How to Demonstrate Statement is Being Achieved
Radiation recall can occur with any drug. These may be mainly chemotherapeutic agents but a few others such as statins; antibiotics etc. can also cause radiation recall reactions ^(21,22,23) .	Guidance is available on the types of drugs with the potential of causing these reactions ^(21,22,23) .
Healthcare professionals within the treatment centre should assess each individual patient in relation to past radiotherapy reactions and planned drug treatments.	<p>Clinicians will advise other professions should this be detected.</p> <p>Assessment of risk is documented for each individual patient where appropriate in the following documentation:</p> <ul style="list-style-type: none"> - The Radiotherapy Monitoring Form - Nurse assessment - Medical Notes

7 Communication of best practice for Radiotherapy Skincare

Key points

- Patients and their carers should be aware of preventative skin care measures and contact points for further information.
- Healthcare professionals in all care settings may be involved with patients receiving radiotherapy and should have ready access to expert advice.

Table 7 – Communication of best practice

Statement	How to Demonstrate Statement is Being Achieved
Patients are aware of possible skin reactions from radiotherapy both during and after completion of treatment, including the type of reaction, self-care measures and sources of more advice and information.	Patients are given skin care advice and information in their general and site specific information leaflets. This is reinforced verbally. Therapy Radiographers document on the patient's Radiotherapy Monitoring Form that information has been given both at the beginning and end of a course of Radiotherapy Treatment.

<p>The radiotherapy department should implement a strategy to ensure communication of best practice to the appropriate healthcare professionals, those involved before, during and after radiotherapy.</p>	<p>This policy will be communicated within the Directorate. It will also be communicated to the wider community by means of the BHSCT intranet and the Northern Ireland Cancer Network (NICAN).</p>
<p>A communication pathway is implemented for healthcare professionals between all care settings.</p>	

Title:	Cleansing of a baby's skin prior to invasive procedures in the Neonatal Intensive Care Unit (NICU), Royal Jubilee Maternity Service(RJMS)		
Author(s)	NICU Procedure Group; Muriel Millar (staff nurse) and Martina Fitzsimons (midwife) Mary-Grace Breslin (staff nurse)		
Ownership:	Mr Brian Barry, Specialist Hospitals and Women's Services		
Approval by:	Specialist Hospitals and Women's Services Standards and Guidelines Policy Committee Executive Team Meeting	Approval Date:	28/2/14 3/7/2013 20/1/2014 22/1/2014
Operational Date:	Jan 2014	Next Review:	Jan 2017
Version No.	V1	Supersedes	New
Key words	Skin cleansing invasive procedures NNU		
Links to other policies			

Version Control for drafts:			
Date	Version	Author(s)	Comments
19-June 2012	0.1	NICU Procedure Group	Draft commenced Sent to Dr. Una Robinson and Sharon Murray for comments
26-June 2012	0.2	NICU Procedure Group	Comments from Dr. Una Robinson addressed
04-July 2012	0.3	As above	Circulated to all staff for comments
23 July 2012	0.4	As above	Incorporated comments from NICU staff
04 Oct 2012	0.5	As above	Updated following Changes in clinical practice.
08-Oct-2012	0.6	As above	Updated
26 –Oct -2012	0.7	As above	Comments from Mary Hanrahan (Senior Infection Prevention and Control Nurse)and Dr. Robins on (Staff Grade) NICU addressed
31-Jan-2013	V1	As above	Received by A. King, formatted and scrutinised Widely circulated amongst Excellence and Clinical Governance Committee, Supervisors of Midwives and all key workers. End date for comments 28/02/2013
17-June-2013	V1	As above	Forwarded to S&G
24- Sept -2013	V1	As above	Comment from Majella Moohan, Clinical Pharmacist, NICU
13-May-2014	V2	As above	Procedure updated due to change in one product and sent to A. King
16-May-2014	V2	As above	Resubmitted on 20/5/2014 to S&G for uploading onto the intranet.
21-May-2014	V2	As Above	Appendix 2 changed (returned to Anne King)
22-May-2014	V2	As above	Forwarded to S&G

1.0 INTRODUCTION

Neonates especially the most preterm/ sick babies will have numerous invasive procedures performed while in the neonatal unit. Nosocomial infections are a common cause of neonatal morbidity and all precautions should be taken to prevent this. The skin is the largest organ of the body and the most common site of entry of bacteria, for this reason skin cleansing is of the utmost importance.

This guideline provides best practice in preparing the baby's skin before undertaking the specified invasive procedure(s) to minimise the risk of infection.

2.0 SCOPE OF THE POLICY

- Medical, midwifery and nursing staff carrying out or assisting with invasive procedures in NICU
- All babies who require the procedure(s)

3.0 ROLES/RESPONSIBILITIES

All medical, midwifery and nursing staff carrying out or assisting with invasive procedures in NICU should use these guidelines in order to provide the highest standard of evidence based care to babies.

4.0 PROCEDURE SEE APPENDIX 1

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This guideline will be circulated amongst all key workers, Excellence and Clinical Governance Committee and Supervisors of Midwives. Once ratified by the standards and guidelines Committee it will be displayed on the BHSCCT intranet site.

Following ratification by the Standards and Guidelines Committee and Policy Committee this guideline will be published on the Belfast Trust Intranet Site and staff will be informed. Guidelines are regularly accessed by staff.

6.0 Resources

New product training

6.0 MONITORING

This guideline contains the current evidenced based thinking on skin cleansing for invasive procedures in babies. However, as new research and clinical experience evolves, changes may be necessary and should the need arise the guideline may be updated.

7.0 EVIDENCE BASE / REFERENCES

- 1) Epic2: (2007) National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England. Pratt RJ, Pellowe CM, Wilson JA, Loveday HP, Harper PJ, Jones SR, Mc Dougall C, Wilcox MH
- 2) Carefusion (2010) Product education and usage information. [www.chloraprep.co.uk/using ChloraPrep.html](http://www.chloraprep.co.uk/using-ChloraPrep.html)
- 3) Northern Ireland Regional Infection Prevention and Control Manual. (Oct 2008) Standard Precautions. www.infectioncontrolmanual.co.ni
- 4) NMC Guidelines Nursing and Midwifery Council (2010) for record and record keeping : London.
- 5) BNF for children (2012-2013) page 599 BMJ Group London

8.0 CONSULTATION PROCESS

Excellence and Clinical Governance Committee, Supervisors of Midwives and all key workers within the maternity service of the Belfast Trust

9.0 APPENDICES / ATTACHMENTS

Appendix 1- Procedure
Appendix 2 - Skin Cleansing Guidelines

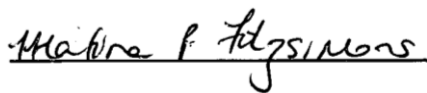
10.0 EQUALITY STATEMENT

Major impact

Minor impact

No impact.

SIGNATORIES:



Author



Director

_____ Jan 2014 _____
Date

_____ Jan 2014 _____
Date

Appendix 1

PROCEDURE

4.0 KEY POLICY PRINCIPLES

1. Infection prevention and control measures must be carried out throughout the procedure; this includes hand washing and the use of alcohol gel using the seven step technique.
2. Two different preparations of skin cleansing agents are used in the NICU to cleanse the baby's skin prior to invasive procedures (see appendix 2)
3. ChloroPrep used in NICU is available in **2** applicators - 0.67mL **ChloroPrep Sepp** and 1.5mL **ChloroPrep** . Both are single use applicators.
4. Follow guidelines for gestation, age and the method of application (see appendix 2)
5. Where possible try to prevent the solution from pooling under the baby (e.g. during umbilical catheter insertion). (See Appendix 2)
6. ChloroPrep is contraindicated in babies with congenital skin disorders.
7. **Do not use on** eyes, ears, mouth or genital areas.
8. When using ChloroPrep to cover a larger area of skin for example insertion of a long line or an umbilical catheter (See Appendix 2) do not use a repeated application of ChloroPrep to the same area of skin within a 24 hour period.
9. For optimal effect, clean the skin and allow to dry for 30 seconds.
10. If sensitivity to any of the skin cleansing preparations is observed, report and record, also complete an incident report.

Skin Cleansing Preparations used in the NICU.

Chlorhexidine gluconate 2% in aqueous solution is used for babies born less than 26 weeks gestation and less than one week old

ChloroPrep Sepp 0.67 ml is used for babies born at less than 26 weeks gestation and who are more than one week old or babies born at more than 26 weeks gestation.

Both preparations will be used for the following procedures:

- Venepuncture
- Capillary gas sampling
- Venous cannulation
- Peripheral arterial cannulation
- Supra pubic aspiration
- Long line insertion
- Lumbar puncture
- Needle aspiration of the chest
- Chest drain insertion
- Cerebral Function Monitor (CFM) electrodes

Procedure for chlorhexidine gluconate 2% in aqueous solution (Babies born <26 weeks gestation and are less than week of age)

1. Prepare as per aseptic non-touch technique(ANTT)
2. Check the product name and contents and that it does not exceed use by date.
3. Decant appropriate solution into a sterile gallipot
4. Apply solution with sterile cotton wool or gauze squares by dabbing
5. Allow to dry for 30 seconds
6. Clean skin again with sterile water
7. Discard unused chlorhexidine gluconate 2% in aqueous solution 1 week after opening

N.B.Do not allow the solution to pool under the baby – if pooling occurs, wash the area immediately with sterile Sodium Chloride 0.9% BP and sterile gauze. Dry with sterile gauze.

Procedure for ChloraPrep Sepp 0.67ml (Babies < 26 weeks gestation and are more than 1 week old or babies born > 26 weeks gestation)

- A. Prepare as per aseptic non-touch technique(ANTT)
- B. Check that the applicator is sealed, intact and in date
- C. Remove the applicator from the packaging
- D. Hold the applicator (**0.67mL**) between the thumb and forefinger , sponge side down (do not touch the tip)
- E. Immediately prior to use, pinch the sides of the applicator once only (in the middle of the ampoule) until you feel the inner ampoule break and allow the solution to flow naturally through to the tip
- F. Press the applicator against the identified area of skin and apply gently
- G. Leave the area for at least 30 seconds to air dry before proceeding with the procedure
- H. Discard the applicator after single use into the sharps box

N.B.Do not allow the solution to pool under the baby – if pooling occurs, wash the area immediately with sterile Sodium Chloride 0.9% BP and sterile gauze. Dry with sterile gauze.

ChloroPrep 1.5mL (Babies < 26 weeks gestation and are more than 1 week old or babies born > 26 weeks gestation)

Use in the following procedures

- Umbilical arterial catheter (UAC) insertion
- Umbilical vein catheter (UVC) insertion
- Long Line insertion
- Lumbar puncture
- Ventricular tap
- Chest drain Insertion
- Needle aspiration of the chest

Procedure

1. Prepare as per aseptic non-touch technique(ANTT)
2. Check that the applicator is sealed, intact and in date
3. Remove the applicator from the packaging
4. Immediately prior to use, firmly pinch the wings of the 1.5 applicator breaking the glass ampoule inside
5. Ensure the chloraprep 1.5 ml applicator is primed and moist prior to use
6. Press the sponge part of the applicator onto the baby's skin and gently apply the solution to the identified area of skin
7. Allow the area to air dry for at least 30 seconds
8. Discard the applicator after single use into the sharps box

N.B.Do not allow the solution to pool under the baby – if pooling occurs, wash the area immediately with sterile Sodium Chloride 0.9% BP and sterile gauze. Dry with sterile gauze.

New Skin Cleansing Guidelines

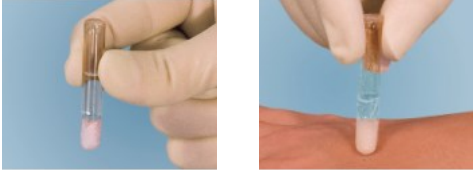
- ChloraPrep (2% chlorhexidine and 70% Isopropyl Alcohol) – 0.67ml and 1.5ml applicators
- Chlorhexidine Gluconate 2% w/v sterile aqueous solution – 20ml bottle

	Age	Application
Approach 1 (Chlorhexidine Gluconate 2% in aqueous solution)	Babies born less than 26 weeks gestation and are <u>less than</u> a week old	<ul style="list-style-type: none"> • decant solution into a sterile gallipot • apply solution with cotton wool ball / gauze square by dabbing • allow to dry for 30 seconds • clean skin again with sterile water <p>**Do not allow solution to pool under infant – if pooling occurs wash area immediately with sterile saline and gauze**</p>
Approach 2 (ChlorPrep)	Babies born: <ul style="list-style-type: none"> (a) Less than 26 weeks gestation and who are <u>more than</u> a week old (b) More than 26 weeks gestation <p>(BUT if concerned about skin integrity in any baby use approach 1)</p>	<ul style="list-style-type: none"> • apply ChlorPrep by back and forth method • allow to dry for 30 seconds

ChloroPrep Applicator

ChloroPrep Sepp

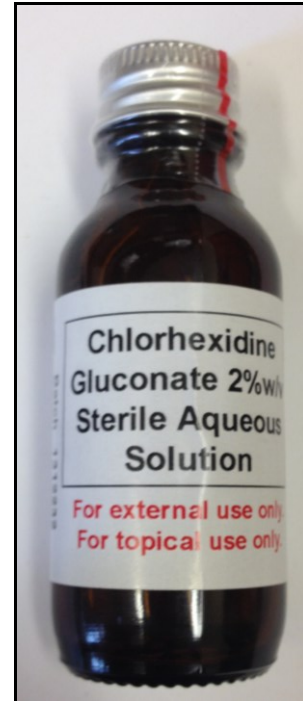
(0.67ml 2% Chlorhexidine Gluconate w/v and 70% isopropyl alcohol v/v)



ChloroPrep Frepp

(1.5ml 2% Chlorhexidine Gluconate w/v and 70% isopropyl alcohol v/v)

Ensure Frepp is primed and moist prior to use



Title:	Cleansing of a baby's skin prior to invasive procedures in the NICU, RJMS		
Author(s)	Gemma Carter, NICU Procedure Group [REDACTED] Kathryn McCullagh, NICU Procedure Group [REDACTED] Claire McIlwaine, NICU Procedure Group [REDACTED] Natalie Trimble, NICU Procedure Group [REDACTED]		
Ownership:	Mr Aidan Dawson, Specialist Hospitals and Women's' Health Director		
Approval by:	Specialist Hospitals and Women's Services Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting	Approval date:	19/11/2019 11/12/2019 06/02/2020 12/02/2020
Operational Date:	February 2020	Next Review:	February 2025
Version No.	2	Supersedes	V1 – January 2014 – January 2017
Key words:	Neonate, baby, skin cleansing, invasive procedure		
Links to other policies	BHSCT Aseptic Non-Touch Technique Policy (2016) SG 01/14 BHSCT Hand Hygiene Policy (2047) SG 34/09		

Date	Version	Author	Comments
07/11/2017	1.01	NICU Procedure Group	Reformatting commenced
30/11/2017	1.02	NICU Procedure Group	Further reformatting and updating of references
05/12/2017	1.03	NICU Procedure Group	Reviewed and sent to Dr Alison Verner, Dr Una Robinson, Sally Hamilton and Maureen O'Dowd for comment.
22/02/2018	1.04	NICU Procedure Group	Comments from Dr Una Robinson addressed.
29/11/2018	1.05	NICU Procedure Group	Resent to Maureen O'Dowd to forward to all staff for comment.
23/05/2019	1.06	NICU Procedure Group	Sent to Maureen O'Dowd to complete screening form

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Sick and premature babies will potentially have numerous invasive procedures performed while in the neonatal unit. Nosocomial infections are a common cause of neonatal morbidity and all precautions should be taken to prevent this. The skin is the largest organ of the body and the most common site of entry of bacteria, for this reason skin cleansing is of the utmost importance.

This guideline provides best practice in preparing the baby's skin before undertaking the specified invasive procedure(s) to minimise the risk of infection.

1.2 Purpose

To provide clear guidance to medical, nursing and midwifery staff involved in the cleansing of a baby's skin prior to an invasive procedure.

1.3 Objectives

To ensure safe practice, which is appropriate to the baby's gestational and postnatal age, when cleansing a baby's skin prior to an invasive procedure

2.0 SCOPE OF THE POLICY

- Medical, midwifery and nursing staff carrying out or assisting with invasive procedures in NICU
- All babies who require the procedure(s)

3.0 ROLES/RESPONSIBILITIES

All medical, midwifery and nursing staff carrying out or assisting with invasive procedures in NICU should use these guidelines in order to provide the highest standard of evidence based care to babies.

4.0 KEY POLICY PRINCIPLES

Definitions

Key Policy Statement(s)

Policy Principles

- 1. Infection prevention and control measures must be carried out throughout the procedure; this includes hand washing and the use of alcohol gel using the seven step technique.**
2. Two different preparations of skin cleansing agents are used in the NICU to cleanse the baby's skin prior to invasive procedures (see appendix 2)

- a. Babies born at < 26 weeks gestation and less than 1 week old, Chlorhexidine Gluconate 2% in aqueous solution is used.
- b. Babies born <26 weeks gestation and who are more than a week old, or babies born at more than 26 weeks gestation, ChloraPrep® (2% Chlorhexidine and 70% Isopropyl alcohol) is used
3. If concerned about skin integrity in any baby use Chlorhexidine Gluconate 2% in aqueous solution.
4. ChloraPrep used in NICU is available in **2** applicators - 0.67mL **ChloraPrep Sepp** and 1.5mL **ChloraPrep Frepp**. Both are single use applicators.
5. Follow guidelines for gestation, age and the method of application (see appendix 2)
6. Where possible try to prevent the solution from pooling under the baby (e.g. during umbilical catheter insertion). If however, pooling should occur wash the area immediately with sterile water and sterile gauze.
7. ChloraPrep is contraindicated in babies with congenital skin disorders.
8. **Do not use on** eyes, ears, mouth or genital areas.
9. When using ChloraPrep **Frepp** to cover a larger area of skin for example insertion of a long line or an umbilical catheter (See Appendix 1) do not use a repeated application of ChloraPrep **Frepp** to the same area of skin within a 24 hour period.
10. For optimal effect, clean the skin and allow to dry for 30 seconds.
11. If sensitivity to any of the skin cleansing preparations is observed, report and record, also complete an incident report.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This guideline will be circulated amongst all key workers.

5.2 Resources

None

5.3 Exceptions

None

6.0 MONITORING

This guideline contains the current evidenced based thinking on skin cleansing for invasive procedures in babies. However, as new research and clinical experience evolves, changes may be necessary and should the need arise the guideline may be updated.

7.0 EVIDENCE BASE / REFERENCES

1. Loveday, H.P, Wilson, J.A, Pratt, R.J, Golsorkhi, M. Tingle, A., Bak, A., Browne, J., Prieto. J. and Wilcox, M. (2014) epic3: National Evidence- Based

Guidelines for Preventing Healthcare- Associated Infections in NHS Hospitals in England. Journal of Hospital Infection, 86(1) S1-S70.

2. Carefusion (2010) Product education and usage information
3. Northern Ireland Regional Infection Prevention and Control Manual. (2015) Contact Precautions. www.infectioncontrolmanual.co.ni
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5. Sathiyamurthy. S, Banerjee,J. and Godambe, S V. (2016) Antiseptic use in the neonatal intensive care unit- a dilemma in clinical practice: An evidence based review World Journal of Clinical Pediatrics 5(6) 159-171
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4857229/>
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8.0 CONSULTATION PROCESS

Excellence and Clinical Governance Committee, Supervisors of Midwives and all key workers within the maternity service of the Belfast Trust

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Procedure for the cleansing of skin prior to invasive procedures in the Regional Neonatal Intensive Care Unit
Appendix 2: Skin Cleansing Guidelines

10.0 EQUALITY STATEMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if this policy/proposal has potential impact and if it should be subject to a full impact assessment. This process is the responsibility of the policy or service lead - the template and

guidance are available on the Belfast Trust Intranet. Colleagues in Equality and Planning can provide assistance or support.

The outcome of the Equality screening for this policy is:

Major impact

Minor impact

No impact

11.0 **DATA PROTECTION IMPACT ASSESSMENT**

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this [link](#).

The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved

A full data protection impact assessment is required

A full data protection impact assessment is not required

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 **RURAL IMPACT ASSESSMENTS**

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services. It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 **REASONABLE ADJUSTMENTS ASSESSMENT**

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people

face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).



Dr Clifford Mayes
Clinical Director

12/02/2020

Date: _____



Author

12/02/2020

Date: _____



Catherine Shannon
Maternity Services Manager/
Head of Midwifery

12/02/2020

Date: _____



Dr Stan Craig

12/02/2020

Date: _____



Sally Hamilton
Lead Midwife / Assistant Service Manager

12/02/2020

Date: _____

**Procedure for the cleansing of skin prior to invasive procedures in the
Regional Neonatal Intensive Care Unit**

Skin Cleansing Preparations used in the NICU.

Chlorhexidine gluconate 2% aqueous solution is used for babies born less than 26 weeks gestation and less than one week old

ChloraPrep Sepp 0.67 ml is used for babies born at less than 26 weeks gestation and who are more than one week old or babies born at more than 26 weeks gestation.

Both preparations will be used for the following procedures:

- Venepuncture
- Capillary gas sampling
- Venous cannulation
- Peripheral arterial cannulation
- Supra pubic aspiration
- Long line insertion
- Lumbar puncture
- Needle aspiration of the chest
- Chest drain insertion
- Cerebral Function Monitor (CFM) electrodes

Procedure for Chlorhexidine Gluconate 2% aqueous solution

- A. Decant solution into a sterile galipot
- B. Apply solution with sterile cotton wool ball/ gauze square, squeezing out any excess liquid, using a **dabbing** motion for 30 seconds.
- C. Apply to the smallest area required to provide adequate skin preparation for the procedure.
- D. Allow to dry for 30 seconds

Do not allow solution to pool under infant – if pooling occurs wash area immediately with sterile water and sterile gauze. Dry with sterile gauze.

Procedure for ChloroPrep Sepp 0.67ml (Babies < 26 weeks gestation and are more than 1 week old or babies born > 26 weeks gestation)

- A. Prepare as per aseptic non-touch technique(ANTT)
- B. Check that the applicator is sealed, intact and in date
- C. Remove the applicator from the packaging
- D. Hold the applicator (**0.67mL**) between the thumb and forefinger , sponge side down (do not touch the tip)
- E. Immediately prior to use, pinch the sides of the applicator once only (in the middle of the ampoule) until you feel the inner ampoule break and allow the solution to flow naturally through to the tip
- F. Press the applicator against the identified area of skin and, once the solution is visible on the skin, apply gently in a **dabbing** motion, or if a more mature baby, by gentle back and forth strokes for 30 seconds.
- G. Leave the area for at least 30 seconds to air dry before beginning the procedure
- H. Discard the applicator after single use into the sharps box

ChloroPrep Frepp 1.5mL (Babies < 26 weeks gestation and are more than 1 week old or babies born > 26 weeks gestation)

Use in the following procedures

- Umbilical arterial catheter (UAC) insertion
- Umbilical vein catheter (UVC) insertion
- Long Line insertion
- Lumbar puncture
- Ventricular tap
- Chest drain Insertion
- Needle aspiration of the chest

Procedure

1. Prepare as per aseptic non-touch technique(ANTT)
2. Check that the applicator is sealed, intact and in date
3. Remove the applicator from the packaging
4. Immediately prior to use, firmly pinch the wings of the Frepp applicator breaking the glass ampoule inside
5. Ensure the Frepp is primed and moist prior to use
6. Press the sponge part of the applicator onto the baby's skin and, once the solution is visible on the skin, apply gently in a dabbing motion or by gentle back and forth strokes, in a bigger baby, to the identified area of skin for 30 seconds.
7. Allow the area to air dry for at least 30 seconds
8. Discard the applicator after single use into the sharps box

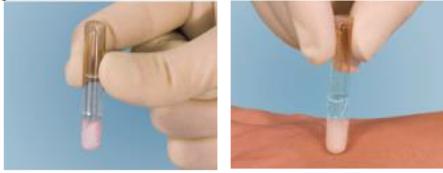
Do not allow the solution to pool under the baby – if pooling occurs, wash the area immediately with sterile water and sterile gauze. Dry with sterile gauze.

Appendix 2 Skin Cleansing Guidelines

- ChloroPrep (2% chlorhexidine and 70% Isopropyl Alcohol) – 0.67ml and 1.5ml applicators
- Chlorhexidine Gluconate 2% w/v sterile aqueous solution – 20ml bottle

	Age	Application
Approach 1 (Chlorhexidine Gluconate 2% in aqueous solution)	Babies born less than 26 weeks gestation and are <u>less than</u> a week old	<ul style="list-style-type: none"> • decant solution into a sterile gallipot • apply solution with cotton wool ball / gauze square by <u>dabbing</u> • allow to dry for 30 seconds • clean skin again with sterile water <p>*Do not allow solution to pool under infant – if pooling occurs wash area immediately with sterile water and gauze*</p>
Approach 2 (ChloroPrep)	<p>Babies born:</p> <p>(a) Less than 26 weeks gestation and who are <u>more than</u> a week old</p> <p>(b) More than 26 weeks gestation</p> <p>(BUT if concerned about skin integrity in any baby use approach 1)</p>	<ul style="list-style-type: none"> • apply ChloroPrep by <u>dabbing</u> or back and forth method • allow to dry for 30 seconds

**ChloroPrep Sepp applicator
(0.67ml 2% Chlorhexidine Gluconate w/v and 70% isopropyl alcohol v/v)**



**ChloroPrep Frepp applicator
(1.5ml 2% Chlorhexidine Gluconate w/v and 70% isopropyl alcohol v/v)
*Ensure Frepp is primed and moist prior to use***



Title:	Skin Care Policy for Staff		
Policy Author(s)	Dr Noeleen Boyd. Occupational Health Specialist Doctor [REDACTED] Dr Keith Armstrong, Dermatology Consultant, [REDACTED]		
Responsible Director:	Jacqui Kennedy, Director of Human Resources (including Occupational Health)		
Policy Type: (tick as appropriate)	*Directorate Specific <input type="checkbox"/>	Clinical Trust Wide <input type="checkbox"/>	Non Clinical Trust Wide <input checked="" type="checkbox"/>
If policy type is confirmed as *Directorate Specific please list the name and date of the local Committee/Group that policy was approved			
Approval process:	Trust Policy Committee Executive Team Meeting		Approval date: 05/08/2021 25/08/2021
Operational Date:	August 2021		Review Date: August 2026
Version No.	3	Supersedes	V2 – February 2016 – November 2018
Key Words:	Skin care, staff		
Links to other policies	BHSCT General Health and safety policy (2018) TP 50/08 BHSCT Occupational health procedures for respiratory health surveillance (2014) TP 39/08 BHSCT first aid at work policy (2018) TP 74/11 BHSCT Policy and procedural arrangements relating to the prevention and management of latex sensitisation (2018) TP 67/10 BHSCT Hand hygiene policy (2017) SG 34/09		

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

This policy and procedure describes how the health, safety and welfare issues specific to skin care should be identified, assessed and managed within the Belfast Health and Social Care Trust (BHSC).

Skin diseases, of which dermatitis forms the largest proportion, are one of the most commonly reported occupational disorders in most developed countries. It is estimated that occupational skin diseases make up 20% of all reported work related diseases. Occupational Dermatitis comprises 70 - 90% of all reported occupational skin disease in the UK. During the COVID-19 pandemic there have been increasing reports, in the literature, of irritant contact dermatitis and pressure related facial dermatitis secondary to wearing personal protective equipment (PPE) in frontline healthcare workers (HCWS). At risk groups are frontline HCWS and those employed in the cleaning, food/catering industries..

Risk factors for occupational dermatitis include exposure to irritant and allergenic chemicals, frequent hand washing or wet work and frequent or persistent glove wearing and the wearing of facial PPE.

Occupational dermatitis, if left untreated, can have a high impact on quality of life and lead to work loss. Early identification, assessment, investigation and treatment are therefore recommended.

Dermatitis is a term which is used to describe inflamed skin. The area of skin involved becomes red and swollen, sometimes with tiny blisters that weep and form a crust. The skin can become itchy, scaly and flaky and if it persists for a long time, thickened and cracked.

The most commonly reported symptoms caused by increased wearing of facial PPE for extended periods are itching, irritation, pain, dryness and swelling of the skin. Staff can also report exacerbation of underlying skin conditions e.g: eczema, acne vulgaris, acne rosacea and seborrheic eczema.

The mainstay of treatment of dermatitis is a skin care regime with emollients. Topical steroids and topical immune modulators (e. g. Tacrolimus) are also used. If an occupational cause is identified, intervention to reduce exposure to irritants, allergens or to minimise wet work will be necessary to control symptoms.

Psoriasis, although not work related can have significant effects on fitness for work in certain clinical occupations or food handling occupations. Severe or uncontrolled psoriasis on exposed skin can become colonised with bacteria and due to the scaling nature of the condition, can become a cross infection risk due to the shedding of scales. An employee with acute psoriasis on exposed skin such as the forearms, ears, face, scalp or hands should not undertake clinical work with patients at high risk from hospital-acquired infection and would not be fit for food handling duties.

1.1.1 Prevention of occupational dermatitis and friction induced facial changes secondary to wearing PPE.

The British Occupational Health Research Foundation (BOHRF review in March 2010) considered the evidence on the effectiveness of a number of preventative Actions.

Symptoms related to the wearing of facial PPE may be lessened by application of a barrier cream (e.g. Cavilon) at least 30 minutes before starting a shift to ensure that the barrier cream is absorbed and does not damage the material of the mask. Cavilon should be applied sparingly to the nose, cheeks and chin. A moisturiser should be applied after each shift e.g. Epaderm or Cetraben cream. Guidelines are available from NHS England on helping prevent facial damage beneath PPE via this [link](#)

Makeup should not be worn under facial PPE. Comfort breaks from wearing masks should ideally be taken every 2 hours for 5 minutes if this is possible. The HSE recommends that FFP2 & FFP3 masks should not be worn for longer than one hour continuously. The same mask should not be worn for 8 hours. It is important to stay well hydrated throughout the day. If skin symptoms do not resolve staff should inform their line manager. Exacerbation of underlying skin conditions may require referral to the Occupational Health Service (OHS).

Health education is the most important aspect in the prevention of occupational skin disease. It is important that skin is kept in good condition and excessive drying is prevented by the regular application of an emollient cream. Any breaks in the skin should be covered by an occlusive dressing. Hand washing technique is important.

Hands should be thoroughly rinsed, to remove residual soap. Hands must be dried properly, paying careful attention to drying between fingers and underneath wedding rings. Wearing cotton glove liners can prevent the development of impaired skin barrier function that can be caused by prolonged wearing of occlusive gloves.

Periodic health surveillance for occupational contact dermatitis and urticaria aims to identify cases at an early and reversible stage of disease. There is no direct evidence base, derived from studies in working populations, to address the question of the effectiveness of health surveillance in the early detection of occupational contact dermatitis or urticaria, or the comparative effectiveness of different screening methods.

In relation to the education of employees, appropriately targeted and sustained educational intervention induces important behavioural changes.

1.2 Purpose

To provide a suitable skin care and skin health surveillance programme, ensuring the protection of employees' health during their employment with the BHSCT.

1.3 Objectives

- To ensure all prospective employees, including those in temporary posts, have a pre-employment health assessment carried out by the Occupational Health Service. Prospective employees may be assessed remotely by telephone consultation with the aid of photographs of skin conditions. Face-to-Face (F2F) consultations with an Occupational Health nurse Advisor or an Occupational Health Doctor will be arranged if required. Particular attention should be paid to those staff who wear occlusive gloves for prolonged periods and those who will be involved in "wet work". This is any job that involves frequent hand washing, having wet hands either frequently or for long periods.
- To assess whether a pre-existing skin condition will be aggravated by exposure to allergens / irritants, wet work or the wearing of PPE in the proposed work.
- To assess whether there is a potential cross infection hazard due to colonisation of existing abnormal skin and increased shedding of skin scales.
- To assess whether there is an increased risk of infection / contamination of an individual due to penetration of microbiological agents e.g. blood-borne viruses.
- To ensure all new staff involved in "wet work" receive new induction training in skin care
- To increase understanding among staff of the risk of skin problems in certain work and the importance of good skin care.
- To encourage Ward, Department and Facility Managers to use the risk assessment process to identify and control areas of risk within their own areas of responsibility.
- To identify, at an early stage, anyone with a skin disorder, through a skin health surveillance programme undertaken by a responsible person / line manager.
- To implement investigation and treatment and, where appropriate, arrange early specialist referral, in cases of occupational skin disease.
- To monitor the incidence of occupational skin disease among Belfast HSC Trust employees and target problem areas.

2.0 SCOPE OF THE POLICY

This is a corporate policy applicable to all staff who are employed or work in contracted services, within the BHSCT.

3.0 ROLES AND RESPONSIBILITIES

The ultimate responsibility for ensuring the health, safety and welfare of BHSCT staff and others who may be affected by the Trust's work activities rests with the Chief Executive.

The Medical Director (as Lead Director for Health and Safety and Occupational Health) is responsible for co-ordinating compliance with the requirements in this policy in conjunction with the Trust's Managers, Health and Safety Managers, Infection Prevention and Control professionals and Occupational Health Professionals.

However this responsibility cascades down through the line management structure to Directors, Co-directors, Senior Managers, Ward, Department and Facility managers and to all staff who should familiarise themselves with this policy.

3.1 The responsibilities of Belfast Health and Social Care Trust Directors, Co Directors and Ward, Department and Facility Managers are to:

- 3.1.1** Identify activities and tasks which are likely to cause dermatitis, to undertake a General Health and Safety Risk Assessment of these activities/tasks and to prevent or where this is not reasonably practicable to put in place appropriate control measures. (Any specific controls relating to potential skin exposure, for particular products, will be covered in COSHH Risk Assessments.)
- 3.1.2** Reduce the risk of skin problems as far as is reasonably practicable, by preventing or controlling exposure to substances that are known to cause irritation or allergy.
- 3.1.3** Inform staff undertaking such jobs / tasks about the risk of dermatitis.
- 3.1.4** Ensure staff receive appropriate skin care advice as part of their induction and ongoing training programme, and receive a skin care advice handout and sign the Declaration form to confirm they have received this advice (Appendix 1).
- 3.1.5** Supervise staff to ensure compliance with skin care instructions.
- 3.1.6** As far as reasonably practical, rotate staff between duties to try to prevent their hands being in constant / prolonged contact with water.
- 3.1.7** Give consideration to the mechanisation of as many wet procedures as possible e.g. use of dishwashing machines.
- 3.1.8** Select and provide suitable gloves for each work task. The risk assessment for the task should determine the glove material and the physical qualities required (e.g. durability).

- 3.1.9** Ensure the provision of adequate supplies of suitable gloves and cotton liners as necessary. For further information, see the Trust policy on the prevention and management of latex sensitisation.
- 3.1.10** Ensure the provision of emollient creams in pump action dispensers or in individual tubes for each employee. Barrier creams are not recommended as a substitute for the use of protective gloves.
- 3.1.11** where skin health surveillance is a requirement of a job, prospective and existing employees must be made aware that this is a condition of employment.
- 3.1.12** Appoint a local responsible person to perform regular health surveillance of skin by simple inspection. This person should be trained in how to detect early problems and how to access further advice from the Occupational Health Service. Health surveillance should be carried out with the informed consent of the employee and records should be kept for 40 years (Appendix 3).
- 3.1.13** Maintain meticulous records on skin care training (Appendix 1); health checks by simple skin inspection (Appendix 3) and any disciplinary action, which is taken for failure to follow the skin care policy.
- 3.1.14** Refer staff who report with skin irritation or skin rashes to the Occupational Health Service.
- 3.1.15** Ensure that any contracts with Agency or Locum staff should specify that all such staff supplied to the Trust undergo screening for skin problems and are advised about skin care.
- 3.1.16** if workplace adjustments or redeployment is recommended by an Occupational Health Professional, all reasonable efforts will be made to secure appropriate job adjustment, redeployment or retraining. Temporary restrictions may be placed on clinical work with patients who are at high risk of hospital acquired infection (e.g. high-dependency and immuno-compromised patients, patients undergoing surgical procedures or post-operative patients and neonates).
- 3.1.17** To be aware that in healthcare workers with dermatitis or active psoriasis, particularly in exposed skin, any areas of skin that are affected are more likely to be colonised with bacteria than normal skin.
- 3.1.18** To complete the Skin Care e-learning programme available on the BHSCCT intranet HUB. This is a mandatory course for managers and responsible persons.

3.2 The responsibilities of all staff are to:

- 3.2.1** Participate fully in skin care training and sign a declaration confirming this training / advice has been received (Appendix 1).
- 3.2.2** Adhere to good skin care practices at all times, co-operating with measures which have been put in place for their protection, including safe systems of work and protective clothing. It is important that staff recognise that skin care also applies outside of the workplace.
- 3.2.3** Participate fully in health surveillance programmes by consenting to a responsible person undertaking skin health checks by simple inspection (Appendix 3).
- 3.2.4** Wear appropriate Personal Protective Equipment as instructed.
- 3.2.5** Report skin symptoms, which may be work-related, to a designated responsible person in their work area or to the Occupational Health Service.
- 3.2.6** Attend the Occupational Health Service if referred by their manager.

3.3 The responsibilities of the Occupational Health Service are as follows:

- 3.3.1** To carry out health assessments on clients being employed in the BHSCT, paying particular attention to existing skin conditions and any relevant history of hand rashes or allergies (e.g. latex) which may indicate a propensity to develop significant skin problems. Existing skin problems may be a bar to employment if the job is likely to aggravate the candidate's skin condition, or place them at unacceptable risk from exposure to hazardous substances such as blood, body fluids or chemicals. Skin conditions affecting exposed areas (hands, arms, face, scalp) may present a cross-infection risk in certain clinical areas and in food production.
- 3.3.2** To assess employees who are referred to the OHS, arrange early investigation and treatment. This may include referral to the employee's GP or the Trust's Dermatology Department. The aim is to optimise the clinical management of the skin condition as soon as possible.
- 3.3.3** To identify possible work-relatedness of any presenting skin problems in employees so that risk assessments can be performed and control measures can be initiated.
- 3.3.4** To advise management about the fitness for work, the elimination or reduction of perpetuating or exacerbating factors or any other job adjustments, which are, required facilitating fitness for work. In cases of deteriorating dermatitis, this may include a recommendation for redeployment.

- 3.3.5** To advise management about adjustments to the work of clinical healthcare workers with acute or severe rashes on exposed skin where cross infection may be a risk.
- 3.3.6** To identify any adjustments which may facilitate an employee at work whose skin condition may come under the provision of The Disability Discrimination Act 1995 and advice management of these adjustments.
- 3.3.7** To assist managers as required, in carrying out their responsibilities under this policy e.g. implement an e-learning training programme “Skin Care Training for Managers / Responsible Persons” is available on the BHSCT intranet HUB that assists managers to give skin care advice and carry out regular skin checks by inspection.
- 3.3.8** To report new cases of occupational dermatitis to the Health and Safety Executive under RIDDOR.

4.0 CONSULTATION

This policy was devised by the Occupational Health Service. Consultation has involved the Trust Health & Safety Managers, Central Nursing, Theatres, Business Services Organisation, Patient & Client Safety, Allied Health Professionals, Infection Control, Pharmacy, Patient and Client Support Services, Estates and the Trade Union side.

The Trust’s Joint Health & Safety Committee, HSENI, BMA, JNC and Service Groups have been consulted on this Policy.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Key Policy Statements

- 5.1.1** Belfast HSC Trust recognises that occupationally related skin conditions are a common occupational health problem and that early identification, diagnosis and treatment facilitates the effective management of such conditions.
- 5.1.2** The Trust has a duty to identify skin hazards and eliminate or control risks, provide/maintain personal protective equipment, arrange for health surveillance and to inform and train staff on the risks and the importance of good skin care.
- 5.1.3** To ensure compliance with statutory obligations, in particular The Personal Protective Equipment Regulations (NI) 1992, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997, the Management of Health & Safety at Work Regulations (NI) 2000, the COSHH Regulations (NI) 2003.

5.1.4 Ward, Department and Facility Managers will maintain appropriate health surveillance as identified through the COSHH risk assessment process for staff exposed to skin irritants, skin sensitisers or undertaking wet work.

5.1.5 Occupational health advice / referral should be sought for staff who exhibit new skin rashes which are potentially work related or if an existing skin problem deteriorates which may interfere with ability to perform work or increase infection risk.

5.2 Policy Principles:

5.2.1 All prospective employees, including those in temporary posts, will have a pre-employment health assessment carried out by the Occupational Health Service. Particular attention will be paid to those staff who will wear occlusive gloves for prolonged periods and those who will be involved in “wet work”. This is any job that involves frequent hand washing, having wet hands either frequently or for long periods.

5.2.2 An assessment will be made as to whether a pre-existing skin condition could be aggravated by exposure to allergens / irritants, wet work or the wearing of gloves in the proposed work.

5.2.3 An assessment will be made as to whether there is a potential increased risk of spreading infection between staff and patients due to potential colonisation of existing abnormal skin and increased shedding of skin scales or a risk to the individual due to penetration of microbiological agents e.g. blood borne viruses.

5.2.4 All new-staff involved in “wet work” will receive induction training in skin care as part of their local induction programme including an understanding of the risk of skin problems in certain work and the importance of good skin care. New staff will be required to sign Appendix 1

5.2.5 Ward, Department and Facility Managers will use the risk assessment process to identify and control areas of risk within their own areas of responsibility.

5.2.6 Management will appoint a responsible person to undertake regular skin checks and identify, at an early stage, anyone with a new skin disorder or an exacerbation of an existing skin disorder. Referral to occupational health will then be appropriate.

5.2.7 Following referral, occupational health professionals will implement investigation and treatment and, where appropriate, arrange early specialist referral, in cases of occupational skin disease.

5.2.8 The incidence of occupational skin disease will be monitored among Belfast HSC Trust Employees.

5.3 Dissemination

This policy is to be implemented by management of all directorates All employees must comply with this policy.

5.4 Resources

Managers will be provided with information and training, via an e-learning programme, to cascade to staff. Policy will be available on the Belfast HSCT intranet hub. Advice and training about mechanisms for prevention, early recognition and management of skin disease at work are available through Occupational Health (screening, induction, health surveillance).

5.5 Exceptions

There are no exceptions.

6.0 MONITORING AND REVIEW

Managers are primarily responsible for identifying employees who develop skin problems in the workplace through a skin health surveillance programme. Occupational Health will maintain statistics on the number of employees referred with skin problems.

7.0 EVIDENCE BASE/REFERENCES

Legal Requirements:

- **Health and Safety at Work (NI Order) 1978** which requires employers, as far as is reasonably practicable, to make provision for securing the health, safety and welfare of employees and the public.
- **Personal Protective Equipment at Work Regulations (NI) 1993**
- **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR)** The Trust has a duty to report incidents of occupational dermatitis and asthma attributable to latex to the appropriate enforcing authority (HSENI or Local Council Environmental Health Department) and keep a record of such incidents. Such incidents are reportable through the Occupational Health Department.
- **The Management of Health & Safety at Work Regulations (NI) 2000** These Regulations require that health surveillance is provided for staff who are exposed to significant risk of respiratory sensitizers, skin sensitizers and irritants.
- **The Control of Substances Hazardous to Health (COSHH) Regulations (NI) 2003, as amended 2005.** There is a duty on the Trust to assess any substances used at work that are hazardous to health.

Evidence Base:

- British Occupational Health Research Foundation, March 2010 – Occupational Contact Dermatitis Evidence Review.
- NHS Plus, occupational health clinical effectiveness unit, 2009 – Dermatitis, Occupational aspects of management – evidence based guidance. **Sources of Further Information:**

Health and Safety Executive resources on occupational skin disease - www.hse.gov.uk/skin

8.0 APPENDICES

Appendix 1 Skin Care Policy 3 Point Prevention Plan

Appendix 2 Guidelines on emollient creams

Appendix 3 Health Check for Occupational Skin Problems

Appendix 4 Guidance on common skin conditions and fitness for work

Appendix 5 COVID Addendum

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **skin care for staff policy** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this [link](#).

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact
Minor impact
No impact

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this [link](#).

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved
A full data protection impact assessment is required
A full data protection impact assessment is not required

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this [link](#).

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

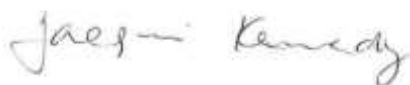
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



01/07/2019

Date: _____

Dr Noeleen Boyd
Speciality Doctor



14/05/2021

Date: _____

Director

Skin Care Policy: 3 Point Prevention Plan

Dermatitis means inflammation of the skin. It is characterised by a dry, itchy, red rash which usually affects the hands. Small blisters may appear later. It is not infectious. Dermatitis can be prevented.

AVOID

- Avoid chemicals that are known to irritate the skin where possible. Read labels and relevant literature on all chemicals carefully.
- Avoid wearing jewellery other than a wedding ring.
- Avoid wearing gloves or facial PPE for any longer than needed.
- Avoid spilling liquids over gloves.
- Avoid sharing gloves
- Avoid wearing makeup under facial PPE
- Avoid wearing disposable facemasks for longer than 2 hours continuously and FFP2 and FFP3 masks for longer than one hour
- Avoid wearing the same mask for longer than 8 hours
- Avoid becoming dehydrated

PROTECT YOUR SKIN BY

- Using appropriate gloves for the task and replacing damaged gloves.
- Washing, rinsing and drying your hands thoroughly after washing and after wearing gloves.
- Using a moisturising hand cream several times a day.
- Covering cuts and wounds with a waterproof plaster while at work.
- Application of a facial barrier cream e.g. Cavilon 30 minutes before shift and moisturiser e.g. Epaderm or Cetraben cream after a shift.

ENSURE YOU

- Check for signs of dryness, itching, redness, flaking, scaling, cracks, swelling and blisters on your hands.
- Report the above signs immediately to your Line Manager.
- Ensure early referral to Occupational Health.

SKIN CARE ADVICE DECLARATION

I agree that I have been advised about how to care for my skin, including appropriate use of gloves and moisturiser. I understand and agree to follow the advice of which I have been given a copy and understand disciplinary action may be taken by management if I do not comply with this advice.

NAME _____ **Signed** _____

Date _____

Witnessed by _____

Name / Title _____

Copy to employee / Manager

Guidelines on Emollient Creams

The following guidelines are intended to assist managers in the provision of emollient creams to their staff in line with the Skin Care Policy.

1. Clinical and Non- Clinical Staff

This group includes Ward Bedside Hygiene Operatives, Catering Staff, Laundry and CSSD staff, home helps and all others whose work may put them at risk of dermatitis.

For these staff emollients recommended by the Trust are available. Where large dispensers are provided in washing and changing rooms, instructions on appropriate use should be prominently displayed.

2. Special Areas

Areas including Intensive Care and Neonatal Units and Infectious Disease wards require different provision.

Only selected emollients recommended by the Trust are suitable. These must be non-ionic in nature as anionic creams may interfere with the antibacterial effect of chlorhexidine.

Normally staff are advised to apply emollients to their hands and forearms at least four times daily at work, break times and at the end of shifts. More frequent applications are recommended, where practical, for staff who wash their hands frequently, preferably after each wash.

An estimate of the amount of emollient required to cover the hands and forearms is 1g. Therefore a 30g container should last about 7 working days if used 4 times daily.

Further advice can be obtained from Occupational Health and a list of suggested emollients with costs and suppliers is available from the Pharmacy department

Health Check for Occupational Skin Problems

Introduction

In some workplaces, substances are in use which may give rise to skin problems in certain individuals. As a result, a programme of regular skin checks has been set up for the employees in these workplaces.

Consent

I understand that a programme of regular skin checks is required in my employment, to verify that I am not developing skin problems in relation to my work. It has been explained to me that this programme will involve examination of my hands by a supervisor and that the results of the examination will be recorded.

I know that my manager will need to be informed whether or not the results of my skin check has been satisfactory. If a problem is detected, I understand that I will need to be referred to the Occupational Health Service for further advice, which may include recommendations regarding changes to my work or workplace.

I therefore *consent /do not consent to the above. (*delete as appropriate).

Signature of employee _____ Date: _____

DETAILS OF SKIN CHECK DATE OF ASSESSMENT: _____

NAME OF RESPONSIBLE PERSON CARRYING OUT ASSESSMENT _____

EMPLOYEE DETAILS:

NAME _____ SEX _____

N.I. NO. (if available) _____ DOB _____

JOB TITLE _____ SERVICE GROUP _____

DATE OF COMMENCEMENT IN CURRENT EMPLOYMENT _____

HAZARDS TO WHICH EMPLOYEE MAY BE EXPOSED IN THIS POST (tick appropriate box)

Y N Y N

**WET WORK CLEANING
AGENTS OILS**

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

SOAPS/DETERGENTS
DISINFECTANTS
SOLVENTS

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

OTHERS (please list)

IS EMPLOYEE EXPOSED TO ANY OF THE ABOVE OUTSIDE WORK ? (Y / N)

RESULTS OF SKIN CHECK

Y N

NOTHING FOUND – FIT FOR WORK RASH NOTED – REFERRED
TO OCCUPATIONAL HEALTH

SIGNED: DATE:

Guidance on Common Skin Conditions and Fitness for Work

Psoriasis

Mild, controlled psoriasis is not usually a bar to employment, unless it involves the hands or exposed sites which cannot be covered. Individuals with moderate to severe psoriasis, particularly with scaling and involvement of exposed sites require careful assessment by an occupational physician for reasons of: -

- Cross infection risk.
- Risk of worsening of hand psoriasis under occlusion from gloves.
- Infection risk from BBVs (Blood Borne Viruses) due to splashes on lesional skin.

Any associated psoriatic arthropathy also requires careful consideration.

Due to the scaling nature of psoriasis, cross infection concerns relate to lesions of exposed skin, particularly the hands, forearms, scalp and outer ears (otitis externa). Risk of cross infection is maximal in Operating Theatres and surgical wards and Augmented care areas such as Intensive care units, / burns / renal units and with immune-suppressed patients. The risk of food contamination with skin scales is also significant.

Anyone with active psoriasis on exposed skin will not be fit to undertake the above clinical duties or for food handling duties until their skin condition comes under control and stability is sustained.

Atopic Eczema

In a review of the evidence undertaken by BOHRF in March 2010, no conclusions can be drawn regarding atopy as an independent risk factor for the development of occupational contact dermatitis, since there are studies of the same quality whose findings contradict one another.

Individuals with persisting moderate or severe atopic eczema (regardless of whether it affects the hands), particularly in adulthood, appears to be an independent risk factor for the development of occupational contact dermatitis. Careful consideration of fitness for work is required for employment involving “wet work”.

Those with active eczema involving the hands, distal forearms or other exposed sites will be found unfit for clinical work with patients at high risk from hospital acquired infection until the rash is controlled.

People with mild eczema that has settled are more at risk if involved in “wet work” and care must be taken in considering their employment in high risk areas (domestic assistants, caterers, nursing staff).

Contact Eczema

A previous history of contact irritant dermatitis may be a bar to employment in “wet work”. If contact eczema is due to a specific allergen then it is essential to avoid further harmful exposure. Bacterial colonisation may be very high and clearing of MRSA can be difficult. Employees who are suffering from active skin conditions on exposed areas are medically fit for non-clinical duties only. Food handlers will not be employed unless lesions are away from exposed areas and can be covered appropriately

Nickel Allergy

Nickel allergy is common and affects 10% of women and 1% of men. It should not usually be a bar to employment. Occasionally nickel allergy can present at a site distant from contact with the metal (the wandering effect). Individual assessment should be made in such cases.

Type 1 latex allergy

A potential employee with type 1 latex sensitisation / allergy will require individual assessment of suitability for placement in work. They will require placement in an area without latex exposure. See the Belfast Health & Social Care Trust Policy and Procedural Arrangements relating to the Prevention and Management of Latex Sensitisation

Covid-19 Addendum

The COVID-19 pandemic has resulted in increased frequency of handwashing and use of PPE by healthcare workers.

The British Association for Cutaneous Allergy and British Association of Dermatology has issued guidance regarding Occupational Skin Disease during the Coronavirus pandemic:

Title:	Guideline on use of a Hairdryer in Stoma Care		
Author(s)	Karen Boyd, Stoma Nurse Specialist Audrey Steele, Stoma Nurse Specialist Stoma Department, 2 North, Belfast City Hospital, XXXXXXXXXX		
Ownership:	Caroline Leonard, Surgical and Specialist Services Director		
Approval by:	Standards and Guideline Committee Trust Policy Committee Executive Team Meeting	Approval date:	10/05/2019 06/06/2019 12/06/2019
Operational Date:	May 2019	Next Review:	May 2024
Version No.	1	Supercedes	None
Key words:	Stoma, excoriated peristomal skin, hairdryer.		
Links to other policies	Regional Infection Prevention and Control Manual Medical Devices policy (TPO16/08) Medical Devices Procedures and Guidelines (TPO41/07) Waste Policy Belfast Trust		

Date	Version	Author	Comments
01/04/2014	0.1	K Boyd	Initial Draft
01/09/2014	0.2	K Boyd	Following consultation with Infection Prevention and Control Team, Tissue Viability Team, Northern Ireland Stoma Care Nurse Forum
10/12/2014	0.3	K Boyd	Following consultation with Association Of Stoma Care Nurses UK
22/11/2016	0.4	K Boyd	Following further consultation with Infection Control Team, Medical Devices Team, Health and Safety Belfast Trust, Estates Fire Safety Officer. Colorectal Consultants Belfast Trust
10/05 2019	1	K Boyd	Final version- comments added. Updated following Standards and Guideline Committee meeting

skin continues to become damaged, adhesion of the stoma bag is reduced and this can cause further leakage, resulting in skin damage, pain and anxiety. It can quickly become a vicious circle (Collet, 2002; Taylor 2012). Patients with an ileostomy are more likely to experience excoriation due to the corrosive nature of the output. The main signs and symptoms are areas of erythema, denuded skin; bleeding; blisters; burning sensation; oedema; pain; and wet weeping skin (Vujonovich, 2008).

4.2 Assessment of stoma and peristomal skin

Careful history taking by the stoma care nurse can establish an understanding of the problem with leakage and will help to establish any predisposing factors. Careful assessment of the stoma's size and shape, consistency of output, and examination of the baseplate when removed can reveal possible causes of leakage (ASCN 2016). Also, assessment of the abdominal contours, creases, muscle tone, and skin turgor can indicate if additional support is needed. This information will help the Stoma Care Nurse decide whether a convex appliance is needed. Adding a seal or soft convex pouch can reduce leakage by exerting pressure onto the skin around the stoma and creating a better seal (Boyd et al, 2004).

Normal output from an ileostomy is about 800mls per day. The height of the stoma should be 2.5 cms to prevent contact of faeces with the skin, thus preventing appliance leaks (Cottam et al, 2007). Poorly spouted stomas are one cause of severe skin excoriation. The highly corrosive nature of ileostomy effluent is to blame (Smith, 2013).

4.3 Treatment of excoriated peristomal skin

Small areas of affected skin are commonly treated with a stoma powder e.g. Orahesive powder (Convatec Ltd), Brava ostomy powder (Coloplast), which is lightly dusted over the area. However, this is not suitable over large areas of skin, as it can also prevent the pouch from adhering if applied too liberally. The use of a silicone barrier film, in a spray or a wipe form, such as Brava skin barrier (Coloplast), Skinsafe Non-Sting Protective Film (Opus Healthcare), can protect damaged skin from further contact with effluent (Burch 2003; Rudoni, 2011). The ASCN Stoma Care Clinical Guidelines (ASCN 2016) also suggest use of calamine lotion to dry wet damaged peristomal skin.

For larger areas of excoriated skin, a hydrocolloid wafer can be applied over the peristomal area with an opening cut for the stoma, and a pouch can then be placed on top.

4.4 Use of a hairdryer

In extreme cases when the peristomal skin is very broken and wet it needs to be dried before applying a pouch, as it will not adhere otherwise. A hairdryer with a cool setting can be used to dry any wet or oozing skin (Burch 2003).

The hairdryer should be kept moving and not positioned too close to the skin; it can be used for up to five minutes, which is usually adequate. However, this

A general health and safety risk assessment on the use of a hairdryer needs to be completed by the Stoma Nurse Team.

4.6 Conclusion

The management of severely excoriated peristomal skin needs the skills and expertise of an experienced SCN to guide the hospital ward team in swiftly reversing the damage of leaking stoma appliances, recognising and acting on the signs of stomal complications, and initiating appropriate treatment plans (Stoma Care Nurses High Impact Action Steering Group, 2010). The SCN needs to provide solutions to complex and unusual problems, such as appliance management, thus helping to reduce the anxiety and psychological distress experienced by patients (RCN 2010).

The guideline in appendix 1 is aimed to guide the Stoma Care Nurse and ward nursing team to safely use a hairdryer to resolve severely excoriated peristomal skin and prevent appliance leakage.

The hairdryer in this instance would not be classed as a Medical Device. However, taking into consideration the manner in which it is to be used, the guidance outlined in the Trust's Medical Devices Policy and the Medical Devices Procedure and Guidelines should be followed in relation to use / storage / disposal etc.

Each hairdryer should be for single patient use only and disposed of according to the Trusts Waste Policy.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Nursing staff in EmSU (Emergency Surgical Unit) in the RVH.
Nursing staff ward 6A and ward 6B Colorectal RVH
Nursing staff in Wards 2 North and 2 South Colorectal in BCH.
Nursing staff Ward F Mater Hospital.

5.2 Resources

The Stoma Care Nurse will educate nursing staff in areas identified above during Stoma Care Teaching sessions and as patients present with severely excoriated peristomal skin.

The Stoma Care Team will keep a small number of Hairdryers with a cool button available for use as required.

Hairdryers will be ordered through E procurement. Current cost is £20.00 per hairdryer.

5.3 Exceptions

Any patient with a multidrug resistant microorganism or infectious disease the Infection and Prevention Control Team should be informed first.

Hairdressing Training (2019) Blow-drying techniques. Start. <http://hairdressing.jisc.ac.uk> (accessed 2 April 2019)

London Fire Brigade (2013) Brigade issues 'beauty blaze' warning after hairdryer fire: <http://www.london-fire.gov.uk/news> (accessed 2 December 2014)

Lyon C, Smith A (2001) *Abdominal Stomas and Their Skin Disorders*. Martin Dunitz, London.

McNaughton V; Canadian Association for Enterostomal Therapy ECF Best Practice Recommendations Panel, Brown J et al (2010) Summary of best practice recommendations for management of enterocutaneous fistulae from the Canadian association for enterostomal Therapy ECF Best practice Recommendations Panel. *J Wound Ostomy Continence Nurse* **37**(2): 173-84.

Rolstad S, Boarini j (1996) Principles and techniques in the use of convexity. *Ostomy Wound manage* **42** (1):24-6, 28-32

Royal Collage of Nursing (2002) *Caring for people with Colorectal problems*. Report of the RCN/Coloplast competencies Project. RCN. London

Rudoni c (2011) Peristomal skin irritation and the use of a silicone –based barrier film. *Br J Nur* **20**(16): s12-16

Schwarzkopf (2014) Tricks of the trade: Proper Blow-drying. <http://www.schwarzkopf.co.uk/en/hairstyle/proper-blow-drying.html> (accessed 2 April 2019)

Smith L (2013) High Output stomas: ensuring safe discharge from hospital to home. *Br J Nurs* **22**(5): s14-18

Stoma Care Nurses High Impact Action steering group (2010) *High Impact Actions For Stoma Care* Coloplast Ltd, Peterborough

Taylor L (2012) Peristomal sore skin: Assessing the effect of an alginate wafer. *Br j Nurs* **21**(16): s41-6

Thompson MJ, Epanomeritakis E (2008) An accountable fistula management treatment plan. *Br J Nurs* **17**(7): 434-40

Vujonovich A (2008) Pre and post-operative assessment of patients with a stoma. *Nurs Stand* **22** (19): 50-6

8.0 CONSULTATION PROCESS

Lead Nurse Infection Prevention and Control BHSCT
Tissue Viability Lead Nurse BHSCT
Medical Devices Team BHSCT

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services. It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



10/05/2019

Author

Date: _____



10/05/2019

Date: _____

Full Description

Reference No: SG 07/09

1 Policy for measuring and recording physiological observations

2 Introduction

Physiological abnormality is associated with adverse patient outcome. Track and trigger scoring systems have been designed to identify and monitor ward patients who are, or who may become unwell.

Physiological 'track and trigger' systems rely on periodic observation of selected basic physiological signs ('tracking') with predetermined calling or response criteria ('trigger') for requesting the attendance of staff who have specific competencies in the management of acute illness and/or critical care.

If track and trigger systems are to alter outcome the following are required;

- Measurement of the defined physiological parameters must be accurate.
- The measurement must be frequent enough to identify trends and changes in physiology.
- The calculation of the track and trigger score with each set of observations must be accurate.
- The response to an abnormal score must be prompt.

3 Purpose:

To ensure the safety of patients in accordance with the NICE clinical guideline CG50 - *Acutely ill patients in hospital - Recognition of and response to acute illness in adults in hospital.* (July 2007).

4 The scope:

This policy will apply to all BHSCT nursing / midwifery staff working with adult patients in the acute hospital setting.

It does not address care that should be provided to:

- children,
- patients in critical care areas directly under the care of critical care consultants
- outpatients
- certain areas where the chart might be used to record observations but the escalation algorithm may not be applicable e.g. dying patients receiving palliative care or patients being cared for in a recovery ward.

5 Objectives:

This policy outlines the steps to be taken in regard to the measuring and recording of patient's physiological observations.

6 Roles and Responsibilities:

It is the responsibility of all BHSCT nursing / midwifery employees to adhere to this policy.

7 The definition and background of the policy:

Patients on general adult wards and emergency departments who are at risk of deteriorating may be identified before a serious adverse event by changes in

Royal Marsden Hospital Manual of Clinical Nursing Procedures 6th Ed

10. References, including relevant external guidelines:

1. NICE clinical guideline CG50 - *Acutely ill patients in hospital - Recognition of and response to acute illness in adults in hospital. (July 2007).*
<http://www.nice.org.uk/nicemedia/pdf/CG50FullGuidance.pdf>
2. Guidelines for records and record keeping: April 2002
<http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=4008>
3. Royal Marsden Hospital Manual of Clinical Nursing Procedures 6th Ed

11. Consultation Process:

Trust Service Group Directors, Staff Side & Standards and Guidelines Committee

12. Equality and Human Rights screening carried out:

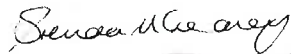
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

√ Screening completed
No action required.

Full impact assessment to be carried out.

13. Procedure

Standard Observation Chart



Director: Brenda Creaney

Date: August 2011



Author: Joanna McCormick

Date: August 2011

Early Warning Score (EWS) Algorithm

Total EWS score	Action	Variance
0-1	Continue with current management	
2-3	Inform nurse in charge Hourly observations	Document rationale if action not taken
>4 or 3 for any parameter	Inform nurse in charge Half hourly observations Contact Doctor - to attend within 30 minutes	Document rationale if action not taken

Pain score			Nausea score
Visual analogue	Numerical	Verbal descriptor	
A = None	0	0	0 = No nausea
B = Mild	1	1-3	1 = Mild nausea
C = Moderate	2	4-6	2 = Severe nausea
D = Severe	3	7-10	3 = Vomiting

Full Description

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<http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=4008>
3. Royal Marsden Hospital Manual of Clinical Nursing Procedures 6th Ed

11. Consultation Process:

Trust Service Group Directors, Staff Side & Standards and Guidelines Committee

12. Equality and Human Rights screening carried out:

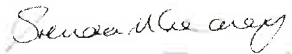
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√ Screening completed
No action required.

Full impact assessment to be carried out.


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Director: Brenda Creaney

Date: August 2011



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Pain score			Nausea score
Visual analogue	Numerical	Verbal descriptor	0 = No nausea
A = None	0	0	1 = Mild nausea
B = Mild	1	1-3	2 = Severe nausea
C = Moderate	2	4-6	3 = Vomiting
D = Severe	3	7-10	

Title:	Policy for the Early Recognition and Management of a Suspected Head Injury		
Author(s)	Colin Williamson, Head Injury Liaison Nurse		
Ownership:	Brenda Creaney, Nursing and User Experience Director		
Approval by:	Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting	Approval date:	03/10/2018 04/10/2018 10/10/2018
Operational Date:	October 2018	Next Review:	October 2023
Version No.	4	Supersedes	V3
Key words:	Head Injury, Head, Trauma, Management, Brain		
Links to other policies	<ul style="list-style-type: none"> - Provision of Head Injury Discharge Advice (Adult) - BHSCT Guidelines for Safe Warfarin Management - A practical guide for the acute management of haemorrhage, emergency surgery and overdose in patients receiving rivaroxaban, apixaban and edoxaban - Out of hours care for patients with congenital bleeding disorders under the care of the Northern Ireland Haemophilia Comprehensive Care Centre at Belfast City Hospital 		
Date	Version	Author	Comments
28/07/2008	0.1	O Macleod	Draft 1
24/08/2008	0.2	JR Johnston	Amendments
16/02/2009	0.3	O Macleod	Amendments
6/03/2009	0.4	JR Johnston	Formatting; Rationalisation
31/03/2009	0.5	O Macleod	Amendments
07/04/2009	0.6	JR Johnston	After Russell McLaughlin comments
08/05/2009	0.7	JR Johnston	RBHSC changes
18/05/2009	0.8	JR Johnston	Modified Paediatric GCS changes
22/06/2009	0.9	H Steen	After Heather Steen comments
01/04/2009	2.0	O Macleod	Final version 2009
26/01/2014	2.1	CD Williamson	2014 Policy review and amendments incorporating safety and quality learning letters and updated NICE 2014 guidelines.
16/04/2014	2.2	CD Williamson	B Bartholome Comments: Policy adjusted to age fourteen plus attending the adult hospital. Inference to RBHSC removed from policy.
30/09/2014	2.3	CD Williamson	Standards and Guideline Committee comments: Policy readjusted to include

			paediatrics. Confirmation of ED observation frequency sought.
24/10/2014	2.4	CD Williamson	Hyperlink added to Warfarin – Safe Management policy and links to NOACA’s policies included. Final version 2014.
04/07/2018	3.1	CD Williamson	Policy review and minor adjustments to reflect current head injury pathway. POC testing removed for RBHSC in consultation with J Maney. Inclusion of Congenital Bleeding Disorders.

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

“Head injury” is defined by NICE (2014) as any trauma to the head, other than superficial injuries to the face.

A head injury can occur as a result of blunt trauma such as, a road traffic collision, sports injury, fall, workplace accidents, assaults or penetrating trauma e.g. gunshot or explosion. The most significant consequence of a head injury is traumatic injury to the brain.

This document is aimed at the large number of patients admitted to Clinical Assessment Units, Short Stay and medical wards, rather than those admitted to critical care or neurological settings, with more severe injuries. It uses NICE Clinical Guideline 176 as the basis for its recommendations.

As a result, it is imperative that registered nursing staff are able to accurately perform a basic neurological assessment, including the Glasgow Coma Scale, understand the significance of the findings and, if required, take prompt and appropriate action.

The Glasgow Coma Scale is a standardised system for evaluating the level of consciousness, through the use of an objective scoring system. It provides a framework for describing the state of a patient in terms of three aspects of responsiveness: eye opening, verbal response, and best motor response, each stratified according to increasing impairment.

The Glasgow Coma Score is an artificial index; obtained by adding scores for the three responses.

Neurological observations incorporating the GCS are the primary tool used by nurses to make quick, repeated evaluations of several key indicators of neurological status including:-

- Level of consciousness by evaluating: eye opening, verbal response and motor response (Glasgow Coma Scale)
- Pupil size and response to light.
- Limb movements (motor and sensory function).
- Vital signs.

- Other signs indicative of cerebral pathology.

1.2 Purpose

This policy is based on the provision of safe, effective, timely care and treatment to patients requiring observation following a known or suspected head injury.

It relies on registered nursing staff being able:-

- To accurately perform a basic neurological assessment including the Glasgow Coma Scale.
- To understand the significance of the findings and take prompt and appropriate action.

1.3 Objectives

1. To ensure accurate recording of a patient's neurological observations, including the Glasgow Coma Scale.
2. To ensure there is a clear record of what observations have been carried out, when and by whom.
3. To monitor, through regular and accurate observations, the progress of the patient's condition by staff and ensure they understand their clinical relevance.
4. To ensure staff are aware of the immediate and subsequent steps to be taken when deterioration in the patient's condition is noted.
5. To ensure that relevant staff are kept informed of the patient's condition.
6. To ensure the patient's next of kin are kept informed of the patient's condition.

2.0 SCOPE OF THE POLICY

This document is aimed at the large number of patients with admitted to Clinical Assessment Units, Short Stay and medical wards, rather than those admitted to critical care or neurological settings with more severe injuries.

This policy applies to all registered nursing & midwifery staff, including those contracted through an agency. The tasks described should never be delegated to an unregistered member of staff or to a member of staff not deemed competent in this task.

Student nurses undertaking a placement may undertake neurological observations providing they are directly supervised by a registered member of nursing or medical staff when carrying out the task.

This policy applies to adults, children and infants.

3.0 ROLES/RESPONSIBILITIES

It is the role and responsibility of registered nurses and midwives to be aware and adhere to this policy.

Recording of the Glasgow Coma Scale is the responsibility of the registered nurse/midwife and should never be delegated to an unregistered member of the nursing team or to a member of staff not deemed competent in this task.

4.0 KEY POLICY PRINCIPLES

Definitions

Head injury is defined, by NICE (2014), as any trauma to the head, other than superficial injuries to the face.

Policy Principles

4.1 Observation

The nurse responsible for the patient's care must introduce him/herself to the patient and family. They should briefly explain the purpose of neurological observations.

4.1.1 Patients with a known or suspected head injury must immediately commence on neurological observations, as documented in section 4.3.

Any patient aged over fourteen years of age who is attending either of the adult emergency departments should commence on neurological observations if they

- Present with a GCS<15/15 at any stage since injury
- Have suffered a loss of consciousness
- Have vomited since injury
- Reporting headache of 7/10 or higher
- Suffered a post traumatic seizure or have a neurological deficit
- On anticoagulant or antiplatelet agents.
- History of bleeding or clotting disorder
- Felt dazed at the time of injury

4.1.2 When patients require head injury observation the minimum acceptable documented neurological observations are:

- Glasgow Coma Score;
- pupil size and reactivity;
- limb movements;
- respiratory rate;
- heart rate;
- blood pressure;
- temperature;
- blood oxygen saturation.

4.1.3 The Belfast Trust Neurological Observation Chart must be used to record and display these assessments. All of the aforementioned parameters must be recorded on a single observation chart. Likewise, record keeping in the nursing notes should reflect the continuous care of the patient and should be maintained in chronological order.

4.1.4 Recording of the neurological observations is the responsibility of the registered nurse/midwife. It must not be delegated to an unregistered member of the nursing team or to a member of staff not deemed competent in this task. The same staff member must complete all parts of the assessment. **It is not acceptable for an unregistered member of staff to measure vital signs and a registered practitioner to conduct the neurological aspect of the assessment.** A Student Nurse, undertaking clinical placement, may conduct neurological observations under the direct supervision of a registered health care professional.

4.1.5 It should be remembered that a patient may present with a GCS of 15/15 but still have experienced significant trauma and will require close monitoring.

4.1.6 The minimum frequency of observations for patients with GCS of 15/15 should be as follows, starting at initial assessment in the emergency department:

- half hourly for 2 hours
- *then 1 hourly for 4 hours
- *then 2 hourly thereafter.

**Where a patient has not achieved a Glasgow Coma Score of 15/15 after two hours they should remain on a minimum of half hourly observations. This should continue until such time as a CGS of 15/15 has been achieved or a supervising doctor advises otherwise. The need for more frequent observation should be decided in collaboration between nursing and medical staff.*

Neurological observations should only be reduced beyond this in consultation with supervising medical staff.

4.1.7 Monitoring and exchange of information about individual patients should be based on the three separate responses on the Glasgow Coma Scale (for example, a patient scoring 13 based on scores of 4 on eye-opening, 4 on verbal response and 5 on motor response should be communicated as E4, V4, M5).

Always score the best response if there is a difference between right and left sides in terms of motor response.

4.1.8 Where possible, neurological observations should be carried out by the same member of staff throughout a shift. When a patient is transferring, between units, neurological observations should be recorded, shortly before the patient leaves the referring department and, immediately on arrival to the receiving department. The most recent Glasgow Coma Scale must be

verbally handed over to the receiving unit. Likewise, a recent coma scale should be handed over during staff handovers within the same unit.

4.1.9 Any of the following examples of neurological deterioration should prompt urgent reappraisal by the supervising doctor:

- Development of unexplained confusion, agitation or abnormal behaviour.
- A sustained (that is, for at least 30 minutes) drop of one point in GCS (greater weight should be given to a drop of one point in the motor response score of the Glasgow Coma Scale).
- Any drop of three or more points in the eye-opening or verbal response scores of the Glasgow Coma Scale, or two or more points in the motor response score.
- Development of severe or increasing headache or persisting vomiting.
- New or evolving neurological symptoms or signs such as
- Seizures;
- pupil inequality;
- asymmetry of limb or facial movement.

Staff should be vigilant in observing for these symptoms and signs which could be indicative of a rise in intracranial pressure.

4.2 **Patients presenting with a history of clotting disorder or are receiving anticoagulant/antiplatelet agents.**

Patients who are at particular risk of intracerebral bleeding, such as those with a history of coagulation problems, may require more regular observations. This should be decided through collaboration between nursing and medical team.

4.2.1 Any patient presenting to ED on anticoagulants are at high risk of intracranial bleeding. They must be flagged, at the point of triage, to a senior member of medical staff. Patients aged 14 and over, attending the adult Emergency Departments should have a point of care INR recorded.

4.2.2 If anticoagulant / antiplatelet reversal treatment or clotting factors are prescribed they must be given without delay.

4.2.3 Patients on anticoagulants, non steroid anti-inflammatory drugs and/or medication known to cause drowsiness should have an early medical review to decide if these medicines should be continued. Patients on warfarin should be managed in accordance with the trust policy "BHSCT Guidelines for Safe Warfarin Management".

4.2.4 Likewise patients presenting on Rivaroxaban, Apixaban or Endoxaban should be managed in accordance with the trust policy, "A practical guide for the acute management of haemorrhage, emergency surgery and overdose in patients receiving rivaroxaban, apixaban and edoxaban.

4.2.5 If there is doubt as to the patient's medications history, or the patient is confused, then the Northern Ireland Electronic Care Record should be consulted.

4.2.6 Where available the trust guidelines for reversal of specific anticoagulants should be held in the Emergency Departments' resuscitation areas.

4.2.7 Patients presenting with a congenital bleeding disorder (CBD), such as Haemophilia, are considered to be at higher risk of intracranial bleeding. Any patient who has sustained a head injury, with a history of a CBD, must be managed in accordance with the trust policy, "Out of hours care for patients with congenital bleeding under the care of Northern Ireland Haemophilia Comprehensive Care Centre at Belfast City Hospital." This is located on the Belfast Trust Hub under keywords, "Haemophilia" and "Von Willebrand's disease."

Key safety issues and guidelines are contained at Appendix 4.

4.3 Principles for General Management

4.3.1 Patients who normally have a low baseline Glasgow Coma Scale due to underlying chronic pathology require careful consideration and management depending on the presenting clinical scenario.

4.3.2 If a patient has a deteriorating GCS and needs an urgent CT scan, anaesthetic advice should be sought early as the patient may need airway management during imaging and/or immediate surgery afterwards.

4.3.3 It is essential that staff consider the mechanism of injury to determine the possibility of an associated cervical spine injury, which would necessitate spinal stabilization/ immobilization. This should be maintained until such an injury has been safely excluded.

4.3.4 Patients presenting who have consumed alcohol and/or illicit drugs require particularly close monitoring. Likewise, patients with a history of alcohol abuse may develop hypoglycaemia. As such blood glucose should be measured on presentation with a depressed level of consciousness. **"A depressed consciousness level should be ascribed to intoxication only after a significant brain injury and hypoglycaemia have been excluded."** (NICE 2014).

4.3.5 Patients should have their pain managed effectively as failure to do so may lead to an increase in intracranial pressure. Where a patient is unable to void urine and has a full bladder a urinary catheter should be inserted where needed. (NICE 2014).

4.3.6 Patients with seemingly minor head injuries often present with cognitive issues after discharge from hospital. Where patients aged over fourteen years, are admitted for observation following a minor/moderate head injury, consideration should be given to a head injury liaison nurse referral at an

early stage of admission. The head injury liaison nurse will assist in the management of the patient, where appropriate s/he will liaise with neurosurgery and work to facilitate input from rehabilitation services on discharge.

It should be noted this is not intended to act as a replacement for any services offered by rehabilitation medicine or the neurosurgical department. Therefore, direct referral to these services can still be made particularly in the case of the more seriously injured patient.

4.3.7 These guidelines are not intended to cover the acute management of non-accidental injury in a child. Nevertheless, it is important that healthcare professionals are aware that the head injury examination is an important opportunity to identify this problem. Minor head injury is relatively common in young children. A head injury in any child, especially under two years of age, should have a full examination. If there are concerns raised regarding non-accidental injury the child should be discussed with a consultant paediatrician and the child admitted for safeguarding follow up.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

It is the role and responsibility of registered nurses and midwives to be aware of and adhere to this policy.

Recording of the Glasgow Coma Scale is the responsibility of the registered nurse/midwife and should never be delegated to an unregistered member of the nursing team or to a member of staff not deemed competent in this task.

5.2 Resources

Neurological observations must be recorded on the approved Belfast Trust neurological observation chart.

Staff undertaking neurological observation must be competent in obtaining the observations described in section 4.1.

6.0 MONITORING

Standards and Guidelines Committee
Policy Committee

7.0 EVIDENCE BASE / REFERENCES

1. [NICE \(2014\) Clinical Guidelines, 'Head injury: Triage, assessment, investigation and early management of head injury in infants, children and adults.](#)

2. SIGN 46 - Early management of patients with Head Injury
<http://www.sign.ac.uk/guidelines/fulltext/46/index.html>
3. Waterhouse, C (2005) The Glasgow Coma Scale and other neurological observations. Nursing Standard. 19, 33, 56-64.
4. Hickey, J.V (2003). The Clinical Practice of Neurological and Neurosurgical Nursing. (5th ed). Philadelphia: J.B Lippincott, Co.
5. National Neuroscience Benchmark Group, Benchmark No. 1 Neurological Assessment
6. G Teasdale and B Jennett; Assessment of Coma and Impaired Consciousness; Lancet(1974) ii 81-84
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8. Head Injuries; 3e pp4044-50
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10. ROYAL MARSDEN NEUROLOGICAL ASSESSMENT (Section 26)
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8.0 CONSULTATION PROCESS

Belfast Trust Emergency Department Staff
 Belfast Trust Neurosciences Staff
 Standards & Guidelines Committee
 Belfast Trust Rehabilitation Medicine
 Royal Belfast Hospital for Sick Children Emergency Department
 Belfast Trust Haematology Department

9.0 APPENDICES / ATTACHMENTS

Glasgow Coma Scale for adults = Appendix 1
 Glasgow Coma Scale for infants of child <5 years old = Appendix 2
 Glasgow Coma Scale for children >5 years old = Appendix

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact

Minor impact

No impact.

SIGNATORIES



Author

31/08/2018

Date: _____



Director

31/08/2018

Date: _____

The Glasgow Coma Scale for adults

The Glasgow Coma Scale is scored between 3 and 15, 3 being the worst, and 15 the best.

It is composed of three parameters: Best Eye Response, Best Verbal Response and Best Motor Response.

The definition of these parameters is given below.

Feature	Scale Responses	Score Notation
Best Eye Response.	No eye opening.	1
	Eye opening to pain.	2
	Eye opening to verbal command.	3
	Eyes open spontaneously	4
Best Verbal Response.	No verbal response	1
	Incomprehensible sounds.	2
	Inappropriate words.	3
	Confused	4
	Orientated	5
Best Motor Response	No motor response.	1
	Extension to pain.	2
	Abnormal flexion to pain.	3
	Normal flexion to pain. (Withdrawal)	4
	Localising pain.	5
	Obeys Commands	6
TOTAL COMA 'SCORE'		3/15 - 15/15

* From

NICE clinical guideline 176 - Head injury: Triage, assessment, investigation and early management of head injury in infants, children and adults.

SIGN 110 - Early management of patients with Head Injury

Appendix 2

The Glasgow Coma Scale for infants or child (<5 years old)

The Glasgow Coma Scale is scored between 3 and 15, 3 being the worst, and 15 the best.

It is composed of three parameters: Best Eye Response, Best Verbal Response and Best Motor Response.

Communication with the infant or child's caregivers is required to establish the best usual verbal response. A 'grimace' alternative to verbal responses should be used in pre-verbal patients or if there is no verbal (audible) response i.e. if silent or intubated.

The definition of these parameters is given below.

Feature	Scale Responses		Score
Best Eye Response	No eye opening.		1
	Eye opening to pain.		2
	Eye opening to verbal command.		3
	Eyes open spontaneously		4
Best Verbal Or Grimace Response	No verbal response	No response to pain	1
	Whimpers and/or Moans in response to pain	Mild grimace to pain	2
	Cries in response to pain	Vigorous grimace to pain	3
	Less than usual ability or spontaneous irritable cry.	Less than usual spontaneous ability or only response to touch stimuli	4
	Alert, babbles, coos, words or sentences to usual ability.	Spontaneous normal facial/oro-motor activity e.g. sucks, cough.	5
Best Motor Response	No motor response.		1
	Responds to pain with decerebrate posturing (abnormal extension)		2
	Responds to pain with decorticate posturing (abnormal flexion)		3
	Withdraws in response to pain		4
	Withdraws to touch		5
	Moves spontaneously and purposefully		6
TOTAL GLASGOW COMA 'SCORE'		3/15 - 15/15	

Appendix 3

The Glasgow Coma Scale for Children > 5 years old

The Glasgow Coma Scale is scored between 3 and 15, 3 being the worst, and 15 the best.

It is composed of three parameters: Best Eye Response, Best Verbal Response and Best Motor Response.

Communication with the infant or child's caregivers is required to establish the best usual verbal response. A 'grimace' alternative to verbal responses should be used in pre-verbal patients or if there is no verbal (audible) response i.e. if silent or intubated.

The definition of these parameters is given below.

Feature	Scale Responses		Score
Best Eye Response	No eye opening.		1
	Eye opening to pain.		2
	Eye opening to verbal command.		3
	Eyes open spontaneously		4
Best Verbal Or Grimace Response	No verbal response	No response to pain	1
	Incomprehensible words or nonspecific sounds	Mild grimace to pain	2
	Inappropriate words	Vigorous grimace to pain	3
	Confused	Less than usual spontaneous ability or only response to touch stimuli	4
	Oriented, appropriate (person, place or address)	Spontaneous normal facial/oro-motor activity e.g. sucks, cough.	5
Best Motor Response	No motor response		1
	Responds to pain with decerebrate posturing (abnormal extension)		2
	Responds to pain with decorticate posturing (abnormal flexion)		3
	Withdraws to painful stimuli		4
	Localizes to painful stimulus		5
	Obeys commands		6
TOTAL GLASGOW COMA 'SCORE'			3/15 - 15/15

Emergency Treatment for People with Haemophilia and Related Bleeding Disorders.

If you have a patient attending E.D. or minor injuries with one of the above conditions, please take the following steps.
Any delay in giving the appropriate treatment may have serious consequences.

Recognising a Bleed

Intracranial Bleed

Treat all symptoms as a serious episode whether there is an obvious injury or not.
If a patient shows any of the following signs there is a risk of intracranial haemorrhage:

- Persistent or worsening headache
- Nausea and /or vomiting
- Drowsiness or abnormal behaviour
- Weakness of limbs
- Clumsiness or poor coordination
- Blurred vision
- Neck stiffness
- Loss of balance
- Fits or convulsions

Muscle and Joint Bleeds

- Pain
- Swelling of the affected joint or muscle
- Heat over the affected joint or muscle
- Tightness/stiffness
- The limb may appear unequal in appearance
- Loss or impairment of movement

Useful Advice

DO NOT GIVE ANTICOAGULANTS, ANTIPLATELETS, NSAIDS OR INTRAMUSCULAR INJECTIONS.



PLEASE CONTACT THE BELFAST CITY HOSPITAL HAEMOPHILIA CENTRE TO INFORM IF A PATIENT HAS ATTENDED E.D. OR MINOR INJURIES DEPARTMENT SO THAT TREATMENT ADVICE OUTCOMES CAN BE MONITORED SAFELY.
CONTACT 028 950 40444 Mon-Fri 9am to 5pm
EXCLUDING BANK HOLIDAYS. A VOICEMAIL SERVICE IS AVAILABLE.

CLOTTING FACTOR TREATMENT OUT OF HOURS CAN BE OBTAINED **FURTHER TO ADVICE** FROM BLOOD BANK AT BELFAST CITY HOSPITAL, ROYAL VICTORIA HOSPITAL AND ALTNAGELVIN AREA HOSPITAL

IF A PATIENT REQUIRES DDAVP (DESMOPRESSIN/OCTIM) THIS CAN BE OBTAINED FROM THE PHARMACY DEPARTMENT.

TRIAGE

ADVICE

TREAT

Prompt triage and assessment of the patient as soon as they arrive in your department.

Contact the doctor on call for Haemophilia to get advice about treatment as soon as possible.
Mon-Fri 9am-5pm
Haemophilia Consultant
Dr Gary Benson
Belfast City Hospital
Tel: 028 950 40444
Out of hours: Haematology
Specialty Registrar
Via BCH Switch Board
Tel: 028 90 329241

Treat the patient according to Haemophilia advice.
Administer appropriate clotting factor without delay.

Don't ignore unusual symptoms. Seek advice from the doctor on call for Haemophilia.

Injuries or bleeds that seem minor may be more serious in a patient with Haemophilia.

Every patient should carry a bleeding card like this. Ask to see theirs.

BLEEDING DISORDER INFORMATION CARD

Name: _____ NIS No: _____

Date of Birth: _____

Diagnosis: _____

Level: _____

Usual Treatment Product: _____ Current Inhibitor: _____

Contact: Northern Ireland Haemophilia and Thrombosis Unit
Tel: 028 950 40444 Out of hours: 028 950 40666

Adapted with permission and thanks from East Kent Hospitals University NHS Foundation Trust H Manson 2016

Emergency Treatment for people with Haemophilia and related bleeding disorders poster taken from the policy: "Out of hours care for patients with congenital bleeding disorders under the care of the Northern Ireland Haemophilia Comprehensive Care Centre at Belfast City Hospital"