



Estimated educational  
content: 1 hour

## Emollients and older skin

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## Continuing Professional Development

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This module contains an estimated 1 hour of educational content, which can be included as part of your personal development and learning plan.

# Overview

Skin health is essential for all older people. The primary function of healthy skin is to act as a barrier against chemical, physical and mechanical hazards and invasion from microorganisms and allergens.<sup>1</sup> As everyone ages, skin integrity can be compromised, making it more vulnerable to external and internal injury.<sup>1</sup>

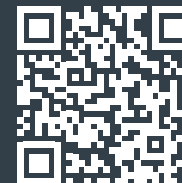
Dry skin (or xerosis) affects up to 75% of older people<sup>2</sup> and develops as a result of a skin barrier defect, characterised by changes in the levels of natural moisturising factors (NMFs), intracellular lipid levels in the stratum corneum (SC), and skin surface pH.<sup>3</sup> Emollients are the most important treatment in dry skin and dry skin diseases, including atopic eczema, asteatotic eczema and irritant/contact dermatitis.<sup>4</sup>

# Learning objectives

This module is aimed at district and community nurses, nurse practitioners, practice nurses and nurses who work in nursing and residential care homes, but may be suitable for anyone dealing with older patients.

The learning objectives for this module are to:

- Understand more about the changes to ageing skin including the impact on skin health and common dry skin conditions in older people
- Gain practical knowledge on Complete Emollient Therapy (CET) including application tips for older people
- Increase confidence in advising patients on emollient choice
- Understand when to refer a patient with a dry skin condition
- Understand the importance of maintaining and repairing the skin barrier in order to maintain healthy skin



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## Quick Facts

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Dry skin (or xerosis)  
affects up to 75% of  
older people.<sup>2</sup>

# Clinical learning

## The impact of ageing on skin health

As we age our skin changes and skin integrity can become compromised, making it more vulnerable to damage.<sup>1</sup> This can have a negative impact on a patient's self-esteem and can affect their daily life through sleep deprivation, discomfort and itching (pruritus).<sup>5</sup> Many older patients will present with multiple morbidities, and while skin conditions may not be the highest priority, skin conditions that are not recognised or treated can be severely detrimental to an older person's general health and affect quality of life.

Structural changes in the skin as a result of aging are due to intrinsic, extrinsic and medical factors.

### Intrinsic changes:

- Reduced lipid production, meaning the skin barrier function is not maintained to the same extent as in younger skin

- Reduced production of ceramides, which are responsible for maintaining the epidermal barrier
- Aquaporin gene expression is reduced, meaning that the flow of water and glycerol (essential for maintenance of skin hydration) is compromised, leading to poor skin hydration<sup>6</sup>
- Epidermal changes that alter function and reduce the skin's barrier function resulting in increased transepidermal water loss (TEWL). This causes dry, scaly, itchy skin with consequent damage from scratching (excoriation), increasing the risk of infection
- Irregular skin pigmentation and reduction of hair follicles
- Loss of collagen fibres, disintegrating elastin fibre and different fat and soft tissue re-modelling, resulting in fragile skin
- Decreasing number of skin immune cells

All individuals are prone to thinner and more fragile skin as a result of the intrinsic changes of the ageing process. This can result in skin that is susceptible to breakdown, ulceration and a reduction in the skin's defence against bacterial, fungal and chemical irritants.<sup>1</sup> Consequently, there is an increased likelihood of irritant and contact dermatitis developing in older skin.

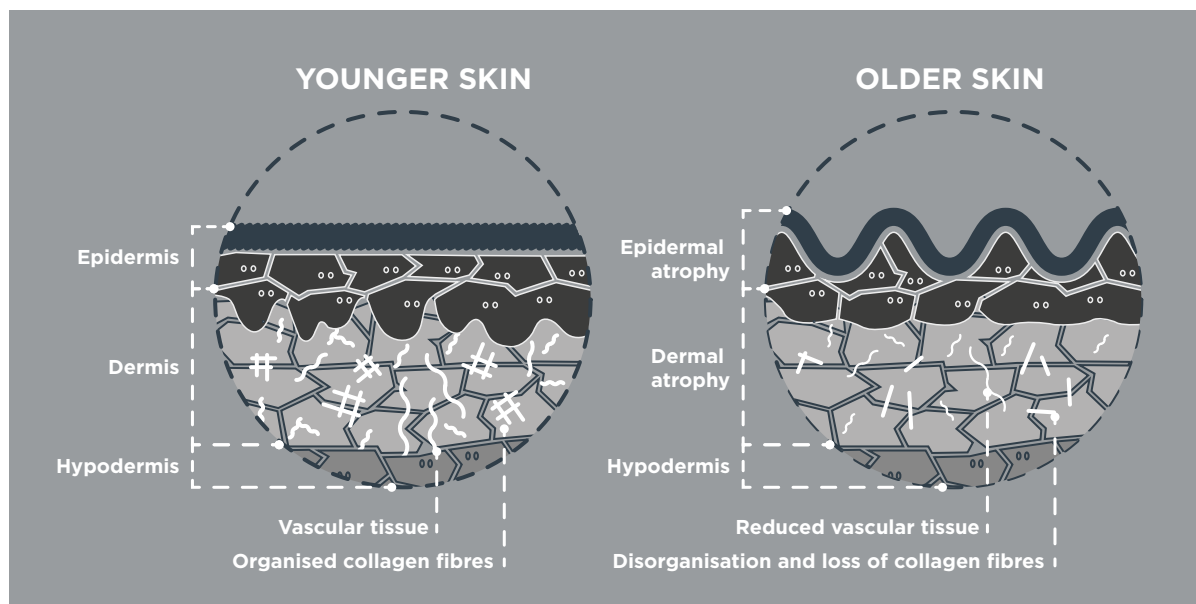


Diagram of intrinsic changes between younger and older skin

### Extrinsic changes

While one cause of dry skin in older people occurs because of the natural, intrinsic ageing process, there are other influences on the integrity of the skin in older people that can affect this. Extrinsic influences, such as environmental factors, contact with irritants, medications and medical conditions can also play a role in influencing the integrity and condition of the skin (Table 1).

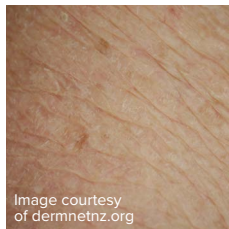
CATEGORY	CAUSE	DESCRIPTION
Extrinsic	Environmental	UV radiation damage (accounts for 90% of visible skin ageing), temperature, low humidity, weather, smoking, central heating <sup>17</sup>
	Irritants	Skin cleansing with soaps/detergents, maceration, incontinence <sup>1</sup>
	Drugs	Hypertension, cholesterol-lowering drugs, retinoids and chemotherapy <sup>17</sup>
Medical	Medical conditions	Hypothyroidism, diabetes, malnutrition (vitamin A deficiency) and chronic inflammatory skin conditions (atopic eczema) <sup>1</sup>
	Inflammation & mechanical injury	Skin lesions and pressure damage; the itch-scratch-itch cycle, shear and friction <sup>1</sup>
	Infection	Disruption of microbiome <sup>1</sup>

Table 1: Extrinsic and medical factors that can have an impact on skin health

## Common skin conditions seen in older people

There are a number of dry skin symptoms seen in older people that can be related to particular skin conditions. Common skin conditions in older people where the skin barrier is affected and itching occurs include:

### SKIN CONDITIONS



#### Dry skin / xerosis

Compromised skin barrier which can be exacerbated by external and medical conditions.



#### Atopic eczema

Lifelong condition with a complex interaction of genetic and environmental factors, including skin barrier defects - can often recur in older skin after absence in earlier years.



#### Irritant dermatitis

Occurs when chemicals or physical agents (such as soaps, detergents, incontinence, etc.) damage the skin.



#### Allergic dermatitis

Caused by a reaction to an allergen that comes into contact with the skin e.g. fragrance.



Image courtesy of dermnetz.org

### Discoid eczema

Common pattern of eczema with round, intensely itchy patches.

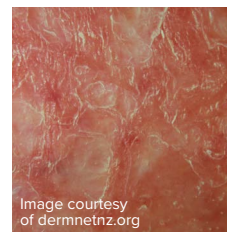


Image courtesy of dermnetz.org

### Varicose eczema

Eczema that occurs as a result of very dry skin, most commonly seen in older people. Also known as eczema craquelé.



Image courtesy of dermnetz.org

### Varicose eczema

Also known as gravitational and stasis eczema. Associated with venous hypertension due to varicose veins. If the eczema breaks down it can lead to leg ulceration. Additionally these patients are at risk of developing cellulitis when skin breaks are present.



Image courtesy of dermnetz.org

### Nodular prurigo

Itchy, firm lumps which are typically grouped. Around 80% of people with this condition have a history of atopic eczema.



### Allergic dermatitis

Chronic inflammatory condition with skin symptoms of red, defined plaques covered with a silvery scale.



### Ichthyosis vulgaris

Genetic lifelong condition with excessively dry skin.



### Bullous pemphigoid

Autoimmune blistering disease that starts with blisters appearing on a background of inflamed itchy skin. Most commonly occurs in older adults.



### Drug reaction

Acute or sub-acute adverse cutaneous reaction to a drug or medicine, can present in many forms and is common in older people due to polypharmacy.

Images to the left show urticaria from nonsteroidal anti-inflammatory drug use and morbilliform drug eruption (bumpy/raised red/erythematous lesions).





## Quick Fact

### SKIN ASSESSMENT

It is good practice to look at all areas of skin and appendages as part of a comprehensive skin assessment.

## Skin assessment

Older people should have their skin assessed as part of an holistic assessment. It is important to examine the skin, noting any observations or skin changes outlined by the patient, and document this in the patient record.

The skin assessment should also include questions to find out how the patient is managing their condition, whether there are any identifiable extrinsic factors and if there is any psychological impact to note:

- How long has the skin been dry?
- Is itch present?
- What is the normal skin care routine (including how the skin is washed)?
- Is there any pattern to the skin condition or any identified triggers?
- Are there any known allergies?
- Does the skin condition have any impact on mood?
- Does the skin condition affect their daily life/stop them doing anything?

### Tips for skin assessment:

- Ensure there is good natural light, where possible, to examine the skin as artificial light can change the colour and tone of skin.
- It is good practice to look at all areas of skin and appendages as part of a comprehensive skin assessment. Don't forget to check the scalp, nails and mucous membranes, especially if the patient mentions skin symptoms in areas other than the surrounding skin.
- When recording patient notes, try to describe what is seen using objective and standard terminology like, erythema (redness), scratch marks/excoriations (which may indicate pruritus [itching]), crust (dried exudate) and scale (dry flaking skin). The extent of coverage will also be important, e.g. generalised, localised, symmetrical or asymmetrical, as this can help to understand if the condition is likely to be intrinsic or extrinsic, e.g. fungal infection may be only on one limb, but psoriasis will be symmetrically distributed.

### Pruritus in absence of skin symptoms

Some older people will experience pruritus in the absence of any recognisable symptoms of common skin conditions. If skin changes are due to scratching, assess for scabies, as many new scabies cases occur in patients aged 65 years or older, especially those in their 80s and 90s.<sup>8</sup>

If no skin eruption or skin symptoms are present, it may be necessary to initiate a metabolic workup with a pruritus blood screen (thyroid, parathyroid, iron deficiency) and evaluate for malignancy or for neuropathy. The use of best practice, in terms of assessment of systemic disease (pruritus blood screen) and implementation of self-care and prescription therapies, is recommended. If, however, no resolution of symptoms is gained from maximum therapy input, emollients and maximum antihistamine doses, then referral is suggested.

## The role of Complete Emollient Therapy (CET) in older skin care

Emollients are essential for promoting skin health and preventing dry, problematic skin. Used regularly and consistently, they repair the compromised skin barrier when skin is ageing and/or inflammatory skin conditions are present.<sup>1</sup>

Complete Emollient Therapy (CET) is defined as:

“*Everything that goes on the skin should be emollient-based and all soaps replaced with emollient wash products*”<sup>4</sup>

- A Best Practice statement on managing dry and vulnerable skin in older people states:<sup>1</sup>
- All individuals should avoid skin irritants, including soap-based products
- A moisturiser should be applied at least twice daily as therapeutic treatment

- A moisturiser should be applied following the lie of the body hair and smoothed into the skin
- Soap substitutes should be used for washing
- Skin should be dried gently by patting, not rubbing, before application of leave-on moisturisers

NICE guidance recommends that, for the whole body, up to 500g/week (one tub or pump of emollient) should be prescribed.<sup>9</sup> A UK consensus statement also suggests that smaller quantity packs should be prescribed for use when away from the home.<sup>10</sup>



## Quick Fact

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The ultimate aim of emollient use is to moisturise the skin and help prevent transepidermal water loss (TEWL).

### EMOLLIENT CHOICE

## Emollient choice, application and safety

There is a range of medical emollients available, which can be used for washing and as leave-on moisturisers. Emollients will only be effective if used appropriately and are cosmetically acceptable to the patient.

Helping patients achieve concordance is very important and choice of emollient should be a joint decision between the patient and the healthcare professional. The ultimate aim of emollient use is to moisturise the skin and help prevent transepidermal water loss (TEWL), so emollient options considered should reflect the severity of the condition. However, patient preference plays a key role in adherence, so lifestyle should also be considered, as well as preferences regarding emollient consistency and fragrance. Samples could be offered for trial, where possible, to identify the most suitable emollient. Additionally, the batch numbers and expiry dates of those given should be recorded in patient notes.

### Range of available medical emollients:

**Lotions** contain more water than oil and are lighter than creams. They can be useful for regular daily applications, and some people prefer them for use on the face.

**Creams** are oil-in-water emollients, and are cosmetically acceptable and prevent TEWL better than lotions.

**Ointments** are oil only emollients and are better than creams at preventing TEWL, but can be quite greasy in texture.

**Humectant emollients** are cream formulations that contain additional Natural Moisturising Factors (NMFs), such as glycerine and urea, providing longer-lasting prevention of TEWL. Formats also include gels and sprays too.

## EMOLLIENT CHOICE

An important consideration is that preservatives are added to creams and lotions, as the presence of water in creams and lotions can provide a potential environment for bacteria to colonise. For some people with particularly dry/sensitive skin, these preservatives can act as a source of irritation, in which case ointments, which do not contain water or preservatives, are the preferred choice.

Generally, the lighter preparations are used for less dry skin and application on the face, and the greasier gels/ ointments are used for drier areas of skin, hands and feet. This means that patients may require different emollients for different parts of the body. There is no right or wrong emollient to use – the key is working with the patient to find what suits them and is suitable to treat their skin according to the severity of dryness.

It is also important to note that emollients containing Sodium Lauryl Sulfate (SLS), a surfactant, (e.g. Aqueous cream) can damage the skin barrier by increasing TEWL, particularly in patients known to have eczema, and should not be used for either washing or moisturising.<sup>11</sup> Fragranced products may also irritate dry skin and should be avoided by older people with eczema/dermatitis, especially if they are known to have a fragrance allergy.

## Application

Emollients should be used every day as ongoing treatment for dry skin, as well as a preventative measure when the condition of the skin is good. Several applications a day may be required if the skin is particularly dry.

The use of emollients to treat the whole body is also beneficial for minimising dry skin problems elsewhere.

Patients should be shown how to apply emollients by a healthcare professional to ensure optimal therapeutic use. Applying emollients with long, smooth strokes with the lie of the hair can help prevent the occurrence of folliculitis (inflammation of the hair follicles with associated pustules). It is also important to leave a thin film of emollient to soak in and avoid rubbing the product into the skin, which can trigger the itch-scratch-itch cycle.



## Quick Fact

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Patient preference plays a key role in adherence, so lifestyle should be considered as well as preferences regarding emollient consistency and fragrance.

### EMOLLIENT CHOICE

Special attention must be paid to flexures (areas of skin between skin folds, like axillae and toe web spaces) and fissures (cracks in the skin) when demonstrating how to apply an emollient:

- Flexures are vulnerable to developing irritant dermatitis and infection (both bacterial and fungal). These areas should be patted dry after washing and emollient applied carefully/less generously to avoid potential maceration due to excess emollient.
- Fissures can be painful and are a portal for bacterial and fungal penetration, which can cause a skin infection. The use of lots of emollient on superficial fissures (ointment is preferable) can help and, if the fissure deepens over time, the use of a thin hydrocolloid dressing can prevent skin breakdown.

Emollient application may be challenging for older people. Difficult-to-reach areas of the body may need different application techniques too, which should be assessed by the responsible healthcare professional. Solutions for application should be discussed, e.g. emollient roller applicators or using emollient sprays, if a family member or carer is not available to help with regular application.

It is also important to check that the emollient dispenser is suitable for the patient and that they have all the information they need. A pump dispenser can be helpful, as long as the patient has enough strength and dexterity to push the spout. Where possible, prescribe an emollient with a pump dispenser to minimise the risk of bacterial contamination, in accordance with NICE guidance.<sup>9</sup> If a tub is used, it is important to remind patients to decant some emollient with a clean teaspoon to avoid contamination from dirty fingers.

Any inflammatory (red) skin condition will always need to be treated using emollient therapy and may require topical corticosteroids use. Where required, emollients and topical steroids should be applied separately and never mixed together, as this can alter formulations and may make treatments ineffective or more potent. Guidelines therefore recommend a gap between applying emollients and topical steroid treatment.<sup>12</sup> The suggested time can range from 15 minutes to 2 hours, but the important thing is that it fits with the patient's lifestyle, e.g. some patients prefer to put their emollients on at night and use their topical steroids in the morning. This module will not discuss the use of steroids, however, more information can be accessed via the links in the further reading section.



## Important Information

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If emollient products come into contact with dressings, clothing and bedding the fabric can be easily ignited with a naked flame. Patients should be recommended not to smoke, use naked flames or go near anything that may cause a fire while emollients are in contact with their medical dressings, clothing or bedding.<sup>13</sup>

### Safety

Emollients containing paraffin are flammable and the MHRA has provided a patient information leaflet, which can be given to patients and carers with supporting safety information.

Emollients can cause some surfaces to become slippery, so it is important to advise on safety precautions, such as using a rubber bath mat in the bath or shower, and to apply emollients when standing on a towel or sitting down. This is particularly important with spray emollients.



# Consultation hints and tips

## 1 Discuss and provide your patient with a written, personalised daily treatment plan

Any plans should be easily incorporated into a patient's existing daily routine. Ensure that they understand the plan and that sufficient quantities of emollients are prescribed. If required, ensure that delivery or collection methods are arranged and confirmed. If the patient has help from a carer or partner, then discuss the plan together with them.

## 2 It is important to emphasise to patients that Complete Emollient Therapy (CET) includes always washing with an emollient

Replacing soaps and cosmetic wash products with emollients for washing is an essential component of CET if dry skin is to be improved. However, if the use of soap is an important part of a person's routine and they do not want to use a soap substitute, then the drying effect of the soap can be counteracted with a good leave-on emollient.

## 3 Simplify the number of products provided to older patients

Mention to patients that some emollient products can double up as a soap substitute and a leave-on emollient. This can be achieved by applying emollient over the skin and simply rinsing off in the bath, shower or leg bath. Bath oils can also be used for washing – but they can be slippery so extra care is needed.

## 4 Provide tips on applying emollients to difficult-to-reach body areas

Some older patients may struggle with dexterity, so it is important to provide an emollient in suitable containers. Others may also find it difficult to apply emollients to certain areas of their body. The back can be reached by applying emollient to the back of the hand or using an emollient roller applicator, but this should be thoroughly washed after each application. For patients with dry skin on lower legs and feet, an emollient spray can be useful, but do advise that it will make the floor slippery so apply when sitting or standing on an old towel.

### CONSULTATION HINTS AND TIPS

**5 Stress the importance of particularly vulnerable areas of skin**

Older patients should pay special attention to flexures and fissures when applying emollients as they can be vulnerable to developing infection due to bacterial or fungal penetration, which means their care is of the utmost importance.

**6 Ensure accurate diagnosis with a comprehensive skin assessment**

Pruritus (itching) may occur in the absence of a skin condition, so it is important to carry out a thorough skin assessment for patients. This should take place in good natural light, where possible, and assess all areas of skin and appendages (nails, hair and mucous membranes). A description of key points should be recorded in the patient notes, including coverage and distribution for comparison at future consultations.

**CONSULTATION HINTS AND TIPS**

## Criteria for referral

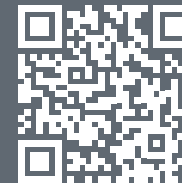
Sometimes the use of a good emollient regimen and appropriate strength topical steroids are not enough to settle an inflammatory skin condition such as eczema or psoriasis. Whatever the age of the patient, particularly if it is worsening or causing psychological distress, the following criteria should be used to guide referral for a specialist opinion:

- The diagnosis is uncertain
- The condition is not controlled with current treatment
- There is recurrent secondary infection
- Treatment advice is needed (such as bandaging techniques)

For patients with pruritus, without any skin symptoms, the NICE Clinical Knowledge Summaries (CKS) state that there is no evidence or guideline as to when to refer for specialist input, so see earlier guidance for management.



### CRITERIA FOR REFERRAL



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# Summary of learning

- **Maintaining skin health and integrity is essential for older people to promote comfort and reduce the risk of infection**
- **Intrinsic, extrinsic and medical factors in ageing skin compromise skin health and its barrier function**
- **Complete Emollient Therapy (CET) is essential to prevent dry skin, the complications that can arise from it (infection) and further breakdown of the skin**
- **Healthcare professionals should be able to conduct an holistic skin assessment and advise older people on skin care, including practical, daily treatment regimes**
- **Patient lifestyles, dexterity and strength should be considered when developing treatment plans and prescribing products, to ensure suitability**

## SUMMARY OF LEARNING

### Continuing Professional Development

This clinical learning booklet has been endorsed by the CPD Certification Scheme and can be used as a CPD resource.

If you are a GP, you can use it towards your CPD accreditation scheme and as part of your Personal Development Plan (PDP).

If you are a nurse, you can use it towards NMC revalidation for both individual and participatory learning.<sup>14</sup>

Individual learning may involve you reflecting on your learning, and identifying points to improve practice in caring for patients with older skin – see questions below to help with this reflection.

### Individual learning – enquiry-based reflection

Recall an older person you have treated who had a dry, itchy skin condition:

1. What were the causes of dry and itchy skin?
2. How did you conduct an holistic skin assessment?
3. What treatment for dry and itchy skin did you advise?
4. What can you do in the future to prevent complications due to dry and itchy skin?

# Further reading

National Eczema Society (NES)

*eczema.org*

## Dermatology professional groups

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British Association of Dermatologists (BAD)

*bad.org.uk*

British Dermatological Nursing Group (BDNG)

*bdng.org.uk*

Primary Care Dermatology Society (PCDS)

*pcds.org.uk*

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Images for dry skin/xerosis, irritant dermatitis, allergic dermatitis, discoid eczema, varicose eczema, asteatotic eczema, nodular prurigo, bullous pemphigoid and drug reactions provided by DermNet New Zealand. Image for ichthyosis vulgaris provided by Waikato District Health Board.



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