



Estimated educational  
content: 1 hour

## Tissue viability & emollients

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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 care is central to tissue viability and when a patient has a wound the focus should not be purely on the wound environment but should include the peri-wound skin and overall skin health. Skin changes (for example on the lower leg when associated with venous disease) can make the skin more vulnerable and can lead to further complications if not adequately managed. Therefore, skin care for the peri-wound and surrounding skin needs to be considered as part of a woundcare management plan.

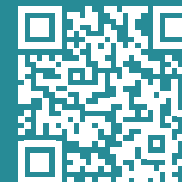
Complete Emollient Therapy (CET) is essential to prevent dry skin complications and potential skin breakdown. Healthcare professionals involved in wound care and tissue viability services require knowledge and understanding of the importance of maintaining the skin health of anyone compromised by a wound, especially in older people.

# Learning objectives

This module is aimed at tissue viability nurses, community nurses, nurse practitioners, practice nurses and nurses who work in care home settings, but will be useful for anyone involved in wound care.

The learning objectives for this module are to:

- Understand more about the skin barrier and the importance of skin health in wound care
- Gain practical knowledge on types of emollients and Complete Emollient Therapy (CET) for patients with wounds and dry skin
- Increase clinical confidence in advising patients on emollient choices as part of a skin management care plan



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## Quick Facts

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In patients aged 65 years and over, **56% have a degree of dry skin (xerosis).**<sup>2</sup>

# Clinical learning

## The risk of skin complications

Anybody with a wound is at risk of skin complications. The skin of older people (over 60 years) can be compromised by physiological changes that occur as a result of skin ageing. This is especially present in the epidermal barrier which can become defective, compromising skin barrier function through increased pH levels and decreased lipid function. Environmental factors can further add to the risk of skin complications in individuals with compromised skin barrier function.<sup>1</sup> The altered barrier function, which includes dry skin (xerosis), accounts for the increased incidence of dermatitis (irritant and contact) and pruritus in older people. In patients aged 65 years and over, 56% have a degree of xerosis and 9% experience moderate to severe xerosis.<sup>2</sup>

Xerosis is more common in older people who have a history of atopic eczema or have subclinical inflammation due to eczema.<sup>2</sup> Varicose eczema has a high prevalence in middle-aged to older people, affecting between 3-11%.<sup>3</sup> There is also an association between varicose eczema and leg ulceration as they both result from venous hypertension.



RISK OF SKIN COMPLICATIONS

## Environmental factors

There are many factors that can exacerbate dry skin conditions, some of which include:

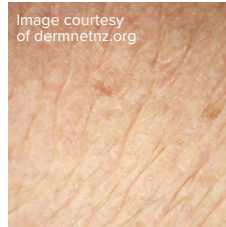
- Temperature
- UV radiation
- Soaps and detergents
- Stress
- Smoking
- Sleep patterns



## Skin symptoms and conditions seen in wound care

The skin of the limb or body area where a wound is present can be vulnerable, and is often referred to as 'surrounding skin'. Skin directly around the wound edge is known as the 'peri-wound' area. In leg ulceration, for example, the surrounding skin and the peri-wound skin can be compromised from both the effects of underlying disease (venous disease) and the effects of the wound itself (exudate, bacteria, matrix metalloproteases etc.).

Complications seen in the surrounding skin may compromise healing, and include:



### **Dry (xerosis), cracked and fissured skin**

Compromised skin barrier, exacerbated by environmental factors.



### **Atopic dermatitis (eczema) and irritant dermatitis**

Atopic or discoid on the trunk and limbs; varicose eczema (combination of venous eczema and stasis) on lower limbs – may be infected (weeping/yellow crusting). Irritant dermatitis aggravated by soap/detergents, and incontinence, resulting in moisture lesions. Irritant dermatitis can also be associated with chronic venous leg ulcers secondary to repeated use of dressings and bandages.



## Quick Fact

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Complications seen in  
the surrounding skin **may  
compromise healing.**



### Hyperkeratosis

Abnormal thickening of the stratum corneum (outer layer of the skin) associated with an over- proliferation of keratin-producing cells and commonly associated with venous insufficiency and leg ulceration.



### Fragile skin

Resulting in additional wounds, such as skin tears, with or without tissue loss. Fragile peri-wound skin may prevent migration of epithelial cells from wound edges, compromising the healing process.



### Allergic contact dermatitis

Due to an allergy to a topical treatment or dressing.



Image courtesy of dermnetz.org

### **Maceration**

Caused by unmanaged wound exudate.



Image courtesy of dermnetz.org

### **Excoriation**

Caused by chronic exudate and presence of elevated levels of matrix metalloproteases.



### **Pruritus**

Rubbing/scratching, leading to an intractable scratch-itch-damage cycle.



### **Oedema**

Commonly associated with lympho-venous disease and can result in cellulitis and poor wound healing.

## Skin assessment

As skin health is so important to wound healing, it is essential to include the skin as part of a holistic wound assessment. Assessment of wounds or areas at risk of a wound should determine the condition of the skin and findings should be documented in the patient record:

- 1 Record areas of the body with skin changes
- 2 Record general skin condition
- 3 Note any recent skin changes and report any suspicious lesions
- 4 Ask the patient how their skin feels and whether it bothers them? (e.g. is it itchy or sore?)

Dryness	Inflammation	Injury	Moisture	Pigmentation
Normal	No inflammation	Intact	Normal	Normal skin tone
Dry	Mildly inflamed	Excoriation/ fissures	Pink & damp	Discolouration
Dry/flaky	Mildly inflamed	Skin tears	Red & wet +/- yellow crusting	Hypopigmentation
Dry/scaly	Severely inflamed	Wound/ ulceration	Moisture lesion/ulcer	Hyperpigmentation

**Checklist for skin assessments:**

- Examine skin in natural light
- Inspect skin folds for signs of bacterial and/or fungal issues
- Describe what you see, including skin symptoms and patterns of distribution.
- Inspect the skin for changes around a wound such as dryness, inflammation, maceration or excoriation. Then generally inspect for moisture lesions, areas of pain, weeping areas or yellow crusting, etc.
- Where appropriate, inspect the lower leg skin for changes caused by venous insufficiency which could include ankle flare (presence of abnormal visible vessels around the ankle), dry skin, hyperkeratosis, hyperpigmentation / haemosiderin staining (brown/rusty pigment caused by breakdown of haemoglobin in the capillaries), lipodermatosclerosis, oedema, varicosities (dilated and tortuous veins), varicose eczema
- As a comprehensive skin assessment, it is good practice to look at all areas of skin and appendages, including the nails, scalp and mucus membranes (especially if patient mentions skin symptoms in areas other than the surrounding skin)



## Quick Fact

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It is recommended that an adult should use at least 500g emollient per week and a child at least 250g.<sup>4</sup>

### COMPLETE EMOLLIENT THERAPY

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

Emollients are essential for promoting skin health, preventing dry skin and constantly repairing the compromised skin barrier. This is even more important 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> ”*

In some cases this is easier said than done, so it is important to work closely with your patients to identify an appropriate treatment regimen. A best practice statement on managing dry and vulnerable skin in older people states:<sup>1</sup>

- All individuals should avoid skin irritants
- A moisturiser should be applied at least twice daily as therapeutic treatment
- A moisturiser should be applied following the line 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
- It is recommended that an adult should use at least 500g emollient per week and a child at least 250g<sup>4</sup>



## 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. It is recommended to **keep away from fire when using these products**.<sup>5</sup>

## Emollient choice

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 patient preference is a key factor in adherence, especially for topical medications.

An emollient needs to prevent transepidermal water loss (TEWL), which is the main cause of dry skin. Generally, oil-in-water emollients (creams) are more cosmetically acceptable for patients and are used most regularly. Lotions are lighter than creams with more water than oil and may be useful for regular daily applications. Oil-only emollients (ointments) are better at addressing TEWL but can be quite greasy in texture. A combination of emollient products can be used to establish an effective hydration regimen. For example, patients could use a lotion or cream for the body and an ointment for the surrounding skin of the wound area.

A further emollient type is humectant containing emollients, which are cream formulations containing added natural moisturising factors (NMFs), i.e. glycerin and urea, providing a longer-lasting prevention against TEWL.

## Emollients vs barrier preparations

### BARRIER PREPS



Barrier preparations (sprays and films) have a completely different mode of action from emollients. Barrier preparations are used to protect the skin from moisture (i.e. wound exudate or urine) and can be effective in the management of peri-wound skin damage and moisture lesions. They have added ingredients to form a barrier specifically to interfere with the absorption and penetration of skin irritants. They are usually applied to areas of the skin which are at risk of moisture damage or where moisture-related skin damage is already present.<sup>6</sup> Barrier preparations should be used in conjunction with skin and wound care and not as a replacement for good wound and skin care.

# Consultation hints and tips

## 1 Complete Emollient Therapy (CET) includes always washing with an emollient

Replacing soaps and cosmetic wash products with emollient-based wash products is an essential component of Complete Emollient Therapy (CET). Daily emollient washes should be used for skin cleansing, for example as a soap substitute when washing legs as part of leg ulcer care.

## 2 Using emollients with hosiery and healed wounds

An emollient cream will be preferable to prevent soiling of hosiery with greasy ointments. Hosiery should be removed, the skin washed and moisturised with subsequent reapplications on a daily basis.

## 3 Moisturise all the skin twice a day

All older people (over 60) with wounds will have dry skin. In younger people the surrounding skin will be susceptible to damage and tears, but may also be dry. It is important to maintain skin health for the whole body, so moisturising several times a day, or at least daily, is essential to repair the skin barrier and prevent dry and itchy skin generally.

If a dressing/bandage is being applied an ointment is a good choice. If the skin is prone to general, all-over dryness, a cream may be preferred. Alternatively, the patient may also benefit from using both an ointment and a cream. This could be because some areas of the skin are minimally affected, while others are worse (e.g. skin folds), or because they may simply find it more cosmetically acceptable to wear lighter preparations throughout the day, and the heavier preparations during the night. An ointment is particularly useful for treating very dry surrounding skin or areas with hyperkeratosis.

# Consultation hints and tips

## 4 Support your patients with a daily skin care routine

Working with patients on a daily skin care plan is essential. This plan should be discussed with the patient and fit around their lifestyle and normal hygiene routine. Some essential points to communicate with patients and their carers are:

- A daily routine with emollients for washing (rather than soaps) is essential
- Emollients should be used for the whole body to prevent dry skin
- Apply a leave-on emollient with smooth downward strokes (do not rub), and leave a thin film to soak in
- Prescribe the emollient the patient likes, to help fit with their lifestyle
- More than one emollient may be required for different areas of the body, or it may be preferable to use different emollients during the day and night

## 5 Emollients and topical treatments – mind the gap

If a patient with a wound has a complication, for example a diagnosed skin condition or an infection, other topical treatments (e.g. topical corticosteroids, antibiotics and antifungal preparations) should be applied separately from emollients. All guidelines recommend a ‘gap’ between an emollient and topical treatment, in any order, but it is preferable to use an emollient first with very dry skin. Emollients and topical treatments should never be mixed together as this alters formulations and may make treatments either ineffective or more potent. If there is constant skin irritation, consider investigation for allergies.



## Quick Fact

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A referral should be made if a venous ulcer is failing to progress at three months according to the PCDS.

# Criteria for referral

Patients with wounds and leg ulcers are generally managed in primary care, with support from tissue viability teams for more complicated wounds.

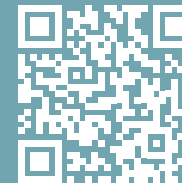
If skin complications become difficult to manage, dermatology advice and referral should be considered.

The four main areas where referral to dermatology may be necessary are<sup>7</sup>:

- Infection
- Over granulation
- Malignant changes / suspicious lesions
- Eczema and cellulitis

The Primary Care Dermatology Society (PCDS)<sup>7</sup> gives additional specific guidance for referral of patients with leg ulcers (including skin complications), which include:

- Venous ulcers failing to progress at three months or which have not healed by twelve months
- All ulcers of an arterial or mixed aetiology – assessment needed for reconstructive surgical / radiological procedures
- All diabetic and rheumatoid ulcers
- Failure to adequately control underlying pathologies
- Suspected malignant change (refer urgently as a 2-week rule to dermatology)
- Suspected cases of contact allergic dermatitis
- Post-healing – consideration should be given to the referral for further investigations of venous leg ulcers to see if surgical intervention would reduce the risk of re-ulceration. Such a referral would depend on local resources, and is particularly relevant for patients developing ulcers from a young age



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## Summary of learning

- **Both the wound and the surrounding skin should have equal focus for care**
- **A thorough skin assessment should be carried out when treating wounds to ensure diagnosis and prompt treatment to prevent deterioration of the surrounding skin**
- **Complete Emollient Therapy (CET) is essential to prevent dry skin complications and prevent potential further breakdown of the skin**
- **There are a variety of emollient types available, and it may be necessary to prescribe a combination of products for patients to effectively manage their skin**
- **Where additional topical treatments are required, such as steroids, these should be applied at a separate time from emollients**

### 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.

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

### Individual learning – enquiry-based reflection

Recall a patient case where skin symptoms or conditions were present alongside a wound:

1. What was the skin symptom or condition?
2. Identify the skin symptoms that led to diagnosis?
3. How were you able to restore skin integrity?
4. What can you do in the future to prevent skin complications?

# Further reading

## Wound care societies

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Leg Ulcer Forum  
[legulcerforum.org](http://legulcerforum.org)

Lindsey Leg Club  
[legclub.org](http://legclub.org)

The Society of Tissue Viability  
[societyoftissueviability.org](http://societyoftissueviability.org)

Wound Care Alliance UK  
[wcauk.org/home](http://wcauk.org/home)

## Dermatology professional groups

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British Association of Dermatologists (BAD)  
[bad.org.uk](http://bad.org.uk)

British Dermatological Nursing Group (BDNG)  
[bdng.org.uk](http://bdng.org.uk)

Primary Care Dermatology Society (PCDS)  
[pcds.org.uk](http://pcds.org.uk)

## References

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