NHS Ipswich and East Suffolk Clinical Commissioning Group
NHS West Suffolk Clinical Commissioning Group

Care Home Skin Care Pathway

Is this a SHORT-TERM or MINOR skin condition that will resolve with self-care?

For example
- Minor dry skin
- Fungal skin infection
- Skin irritation e.g. sensitivity
- Skin rash e.g. heat / viral

YES

Suitable for self care
Prescription **NOT** required

Think pharmacist!
Purchase over the counter (OTC)

Useful self-care links

- **Think pharmacist leaflet** https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2015/11/ThinKPharmacistLeaflet.pdf
- **Common skin conditions**: https://www.nhs.uk/live-well/healthy-body/common-skin-conditions/

NO

Prescription **MAY BE** required

Has resident been reviewed by a nurse or GP for treatment of this?

Request review if necessary, then follow **chronic pathway** (below)

CHRONIC PATHWAY: for chronic or vulnerable skin condition that may alter skin integrity

For example
- At risk of pressure / moisture damage
- Incontinence / immobility
- Venous / arterial disease impacting lower limb
- Respiratory disease
- Eczema / psoriasis
- Diabetes malnutrition
- Steroid-induced skin changes

Is this a **NEW** prescription request?

NO

Is the product on **REPEAT** prescription?

(Not all preparations are appropriate to go on repeat - see overleaf for further guidance)

YES

Please order via the usual process for repeat prescriptions

Skin Care order form NOT REQUIRED

NO

Check CCG skin care formulary list **overleaf** and choose appropriate product*

YES

Complete skin care order form and send to GP

*If a non-formulary product is required, please complete CCG exception reporting form via IESCCG and WSCCG website wound care section

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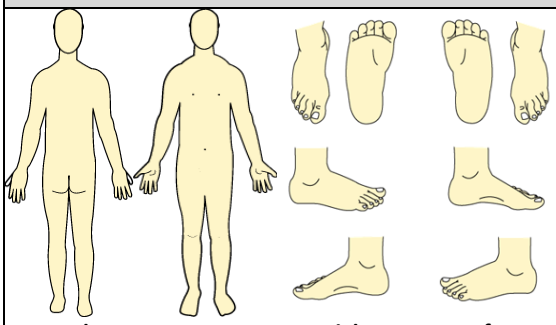
Care Home Skin Care Product Request Form

All **new**, **changing** OR **non-repeat** skin care products must be requested via this form - please complete and return to your GP Practice
GPs may refuse to prescribe unless **ALL** the relevant sections have been completed

 # Products that may be placed on repeat prescription for long-term protection of skin integrity

Patient name:	Date of Birth:	GP:
Date of request:	NHS number (optional):	
Care Home:	Name of staff member:	

Mark wound locations with 'X'	**Skin condition**	**Frequency of application**	**Has the resident been referred to**
 **Back** **Front** **Right** **Left**	☐ Eczema / psoriasis ☐ Pressure damage ☐ Moisture damage ☐ Infected / fungal ☐ Minor dry skin (**OTC**) ☐ Other, specify:	☐ More than once a day ☐ Once daily ☐ Alternate days ☐ Three times weekly ☐ Twice weekly ☐ Once Weekly ☐ Occasionally (**OTC**)	☐ District Nurse ☐ Tissue Viability ☐ Dermatology ☐ Vascular ☐ Dietician ☐ Other, specify: **Date referred**
	Duration of skin condition		**Total number of skin ailments**

EMOLLIENTS - PLEASE SELECT ONE CHOICE OF EMOLLIENT ONLY					
Type of emollient	**Formulary List** (Tick box for relevant product & size)		**Frequency and area of application**	**Indication**	**Quantity for a month supply**
	Product	**Size**			
Emollient Cream Soap Substitute	☐ EPIMAX® **Original Cream #** *(can be used as soap substitute)*	☐ 500g		Chronic skin conditions e.g. psoriasis or eczema	Expected quantity **1 x 500g per month** This may increase if required as soap substitute or for more frequent application
Emollient Gel	☐ EPIMAX® **Isomol Gel #**	☐ 500g			
Emollient Ointment	☐ Zeroderm® ointment **#** *(can be used as soap substitute)*	☐ 500g			
	☐ 50/50 ointment **#**	☐ 500g			

BARRIER PREPARATIONS - PLEASE SELECT ONE CHOICE OF BARRIER ONLY					
Please refer to the CCG Skin Care Algorithm **step-up step-down** approach when choosing a barrier preparation. Please tick below to indicate current stage of skin damage.					
☐ **PREVENT**	☐ **PROTECT**		☐ **REPAIR**	☐ **RESTORE**	
Type of cream	**Formulary List** (Tick box for relevant product & size)		**Frequency and area of application**	**Indication**	**Maximum quantity for a month supply**
	Product	**Size**			
Barrier cream	☐ Medi Derma-S barrier cream **#** *(1st line barrier cream for care homes)*	☐ 90g tube		For INTACT or damaged skin	**1 tube per month** (Additional for increased skin surface area)
Barrier film	☐ Medi Derma-S barrier applicators	☐ 1ml swab		Mild to moderate skin damage as per algorithm	Reapply every 24-72hrs **Not routinely on repeat**
	☐ Medi Derma-S barrier pump spray	☐ 30ml spray			
Barrier products with restricted use – Severe moisture damaged skin					
Barrier Ointment	☐ Medi Derma Pro skin protectant	☐ 115g tube		For severe moisture excoriated skin only	Short term use until resolved **Review after 2 weeks** **Not on repeat**
Skin cleanser	☐ Medi Derma Pro foam & spray incontinence cleanser	☐ 250ml			