



UNIVERSITY OF LEEDS

This is a repository copy of *Skin cleansing and emolliating for older people: A quasi-experimental pilot study..*

White Rose Research Online URL for this paper:  
<http://eprints.whiterose.ac.uk/111421/>

Version: Accepted Version

---

**Article:**

Brooks, J., Cowdell, F., Ersler, S.J. orcid.org/0000-0001-6995-6121 et al. (1 more author) (2017) Skin cleansing and emolliating for older people: A quasi-experimental pilot study. International Journal of Older People Nursing, 12 (3). e12145. ISSN 1748-3735

<https://doi.org/10.1111/opn.12145>

---

© 2017 John Wiley & Sons Ltd. This is the peer reviewed version of the following article: Brooks, J., Cowdell, F., Ersler, S.J. and Gardiner, S. E.D. (2017), Skin cleansing and emolliating for older people: A quasi-experimental pilot study. International Journal of Older People Nursing. 12 (3). e12145, which has been published in final form at <https://doi.org/10.1111/opn.12145>. This article may be used for non-commercial purposes in accordance with Wiley Terms and Conditions for Self-Archiving.

**Reuse**

Unless indicated otherwise, fulltext items are protected by copyright with all rights reserved. The copyright exception in section 29 of the Copyright, Designs and Patents Act 1988 allows the making of a single copy solely for the purpose of non-commercial research or private study within the limits of fair dealing. The publisher or other rights-holder may allow further reproduction and re-use of this version - refer to the White Rose Research Online record for this item. Where records identify the publisher as the copyright holder, users can verify any specific terms of use on the publisher's website.

**Takedown**

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing [eprints@whiterose.ac.uk](mailto:eprints@whiterose.ac.uk) including the URL of the record and the reason for the withdrawal request.

## **Skin cleansing and emolliating for older people: A quasi-experimental pilot study**

Jill Brooks PhD, M.Phil, BA(Hons), RGN1; Fiona Cowdell DProf, MA, BA(Hons)3; Steven J Ersser PhD, BSc, RGN, Cert HE2; Eric D Gardiner BSc, MSc, PhD1

1. University of Hull, Hull, UK
2. University of Leeds, Leeds, UK
3. Birmingham City University.

Correspondence: Fiona Cowdell, Professor of Nursing and Health Research, Faculty of Health and Life Sciences, Birmingham City University, Westbourne Road, Birmingham, B15 3TN.  
Email: [fiona.cowdell@bcu.ac.uk](mailto:fiona.cowdell@bcu.ac.uk)

Funding information: Independent PhD studentship to Jill Brooks from Proctor and Gamble.

**Aims:** The aims of this study were to (i) assess the effect of low-cost hygiene and emollient regimens on the skin barrier function (SBF) of people aged >65 year with xerosis (dry skin) on their lower legs; (ii) to assess the utility of portable measures of skin barrier function in terms of stratum corneum hydration (SCH) and transepidermal water loss (TEWL) in community settings; and iii) to provide evidence for a randomised controlled trial on the treatment of adults in a resource-poor country with dry skin on their lower legs which causes and exacerbates the skin disease podoconiosis (non-filarial elephantiasis).

**Background:** Age increases the risk of impaired skin barrier function which can precipitate skin breakdown. Older skin is frequently characterised by troublesome xerosis and pruritus (itching). Hygiene and emollient practices are central to maintaining skin integrity but are currently under-researched.

**Method:** A quasi-experimental pilot study of five combinations of cleansing and emollient interventions was applied to the xerotic lower legs of ten participants with no skin disease for five consecutive days. Stratum corneum hydration and transepidermal water loss were measured at baseline and day six. Products were chosen because of effectiveness, low cost and availability in a poor-resource country.

**Results:** The greatest difference in transepidermal water loss pre-intervention–post-intervention was indicated by the regimen of soapy water, 2% glycerine soak and *Vaseline*<sup>TM</sup> (mean 1.14, SD 1.27). This regimen also indicated the greatest difference in stratum corneum hydration (mean 7.92, SD 3.93). The improvement in stratum corneum hydration was significantly greater than for the control ( $p = .011$ ), soap ( $p = .050$ ) or water soak ( $p = .011$ ).

**Conclusion:** A regimen of washing skin with soapy water, soaking in 2% glycerine for 30 min and applying *Vaseline*<sup>TM</sup> has a beneficial effect on the skin barrier function in older people. The study supports previous findings on the positive effects of glycerine on skin barrier function.

**Implications for practice and research:** Skin barrier function in older people can be improved using a regimen of washing, soaking in 2% glycerine and applying *Vaseline*<sup>TM</sup>.

**Keywords:** emollient, glycerine, hygiene, older people, skin barrier function, xerosis

### **What does this research add to existing knowledge in gerontology?**

- Results suggest that a simple, low-cost hygiene and emollient regimen using soap, water, 2% glycerine and *Vaseline*TM may be effective in maintaining SBF for older people.

### **What are the implications of this new knowledge for the nursing care of older people?**

- Skin health is essential for well-being, particularly for older people who are more prone to skin breakdown. Current skincare is predominantly based on custom and practice. Further research is needed into optimum and acceptable skincare regimens. This preliminary study suggests that until evidence-based guidance is available on the most effective emollient to apply to dry skin, the combination of washing with soap, a 2% glycerine soak and the application of *Vaseline*TM may be considered for the treatment of xerosis.

### **How could the findings be used to influence policy or practice or research or education?**

- Literature review indicates a lack of knowledge about optimum skin hygiene and emollient regimens for older people.
- Probes for measuring SBF are feasible and useful for research based in community settings.
- The study suggests a simple, low-cost intervention that improves SBF. Further research including RCTs is required to provide robust evidence to inform best practice.™

### **Introduction**

Skin is affected by age and inevitably becomes more vulnerable to damage (Fore 2006). This is due to numerous intrinsic and extrinsic changes which can impair SBF. Intrinsic changes include: reduction in cell turnover, sensory receptors (Finch 2003), natural moisturisation (Harding 2000), blood supply (Fore 2006), elasticity (Finch 2003), sweat production (Ersser 2012) and subcutaneous fat (Burr 2005). Extrinsic skin changes are caused by environmental factors, for example sun damage (Lawton 2007). Skin is also affected by ambient temperature and relative humidity, tending to become xerotic in cold weather and conditions of low humidity (Nash 2009). Other factors that impact on skin health include excessive washing (particularly using harsh products), lack of hygiene (causing build-up of potential pathogens resulting in increased risk of infection), trauma,

reduced mobility, incontinence, depression and dementia, poly-pharmacy, diabetes and vascular changes and poor nutrition (Cowdell et al 2014). The net effect of skin ageing is a diminished SBF which makes the skin significantly more vulnerable to damage (Baranowski & Ayello 2004) and potentially the consequent problems of breakdown. More recent meta-analytic evidence suggests that SBF changes in older people are not clear (Kottner, Licherfeld & Blume-Peytave, 2013).

---

It is estimated that xerosis affects 59-85% of older people (Beauregard & Gilchrest 1987). This is because as skin ages sweat glands atrophy and sebum production decreases. Stratum corneum lipids also reduce decreasing the ability of the skin to retain water. This results in dry, thickened, flaky, reddened skin (xerosis) which initiates an inflammatory response. The lower leg is one of the places most likely to be effected (Balaskas *et al.*, 2011). Xerosis increases the risk for other problems such as pruritus, infection, skin tears and pressure ulcers (Hunter 2003; Cole & Nesbitt 2004). The inflammatory response worsens without intervention. To break the cycle of progression there is a need to treat the symptoms, repair the stratum corneum (SC) and enhance the SBF (Rawlings & Matts 2004).

Skin cleansing and emollient regimens are one of several factors that contribute to maintaining skin integrity, defined as skin being a sound and complete structure in unimpaired condition (North American Nursing Diagnosis Association 2013); it is an important, but often overlooked, subject. Fundamental skin care, namely washing and emollient use, is central to maintaining skin integrity. Recent reviews have concluded that there is a dearth of empirical evidence on the relative benefits of different cleansing and moisturising regimens for older people including the effects of emollients after bathing (Cowdell & Steventon 2015, Cowdell *et al.*, 2014, Kottner *et al.*, 2013). Furthermore, there is a lack of clarity about clinical practice norms in skin care regimens for older people in all settings. However, whilst maintaining hygiene is essential, over-washing, particularly with harsh products, can result in impaired skin integrity (Gardiner 2008). There is therefore a need to balance maintaining health and wellbeing through meeting personal hygiene needs and not over cleansing and thus potentially compromising SBF (Voegeli 2008). Any intervention should have minimal adverse effects and products should be acceptable to the person to ensure treatment concordance (Cowdell 2010).

There is a degree of consensus about optimum regimens amongst experts who advise that: people should bathe regularly in warm rather than hot water (Lawton 2007); they should not soak for too long or over-wash (British Association of Dermatologists 2006); should use gentle wash products and emollients which are acceptable to them (Lawton 2007) and gently rub or pat the skin dry (Ersser 2005). However, the extent to which these recommendations are followed in practice is unknown.

---

The ideal washing and emolliating intervention is one that removes dirt from skin without causing dryness or irritation and which maintains or promotes skin integrity and comfort. Soap is currently the most commonly used skin cleansing agent. It removes dirt and oils. Most soap has a pH of 7-10 (Ananthapadmanabhan *et al.*, 2013). All testing methods of soaps indicate that excessive exposure induces barrier damage and skin dryness followed by inflammation (Wolf & Parish 2012). Therefore if possible soaps with a low pH (<7) should be used and over-washing avoided. There is evidence that regular emollient use is beneficial to aging skin (Watkins 2011) and specifically that it has a positive effect on skin integrity (Moncrieff *et al.*, 2015) and can lead to a reduction in the incidence of skin tears (Carville *et al.*, 2014). Emollients are best applied when skin is moist as it is after bathing or washing when skin has a high water content (Holden *et al.*, 2002, Ersser *et al.*, 2012).

At present there is a significant gap in knowledge about optimum hygiene and emollient skin care for older people and a need to develop a robust evidence base to guide practice; the pilot study presented here is one element in a programme of work that will help address this knowledge gap.

---

## Aims

To:

- Assess the effect of simple, low cost hygiene and emollient regimens on SBF of people aged >65 years with normal aging skin including xerosis but without skin disease.
- Assess the utility of portable measures of SBF in home and care settings.
- Provide evidence for an RCT on the skin treatment of adults in a resource-poor country with the disease podoconiosis which is caused by dry skin on the lower legs.

## **Method**

### **Study design and sample**

We conducted a pilot quasi-experimental study. Ten females were recruited in the United Kingdom (UK); two were resident in a private care home and eight lived in their own homes. Inclusion and exclusion criteria are summarised in Table 1.

### **Data collection and measures**

Demographic data were collected (Table 2). Measures of TEWL and SCH were used to assess SBF. High values of SCH and low values of TEWL are typical of a healthy skin barrier (Fluhr *et al.*, 2006). SCH was measured with a *MoistureMeterSC<sup>TM</sup>* and TEWL with a *VapoMeter<sup>TM</sup>*, which are non-invasive probes with high reproducibility, short measuring times and provide a robust indicator of SBF. ([www.delfintech.com](http://www.delfintech.com) 2015a, b). Guidelines for using these measures were followed meticulously (Plessis *et al.*, 2013). As these instruments are sensitive to changes in ambient temperature, relative humidity, skin surface temperature and sweating, participants were seated with their lower legs exposed and uncrossed for 20 minutes prior to readings being taken. No hot drinks were given during this time. To avoid confounding results participants were asked to refrain from using emollients for 3 days before the trial and from taking an immersion bath or shower for the duration of the trial. The trial took place over six consecutive days in May 2013.

Measures of SCH and TEWL were taken from each specific site at baseline and on day 6. All interventions and recordings were carried out by the principal investigator to ensure intervention fidelity and consistent measurement.

### **Intervention**

The experimental groups consisted of a set of simple, low cost interventions, applied to the lower leg sites, that were selected based on evidence where available or on current custom and practice; these are detailed below. Five combinations of cleansing and emolliating were used on five sites. The control conditions were the untreated site, without cleansing agents or emollients.

*Soap:* The soap used had a pH of 10 (highly alkaline) which is consistent with that of many soaps available in the UK (Baranda *et al.*, 2002) and in resource-poor countries. All testing methods of soaps indicate that excessive exposure induces barrier damage and skin dryness followed by inflammation (Wolf & Parish 2012). This is because the emulsifying effect of soap removes sebum and therefore affects SBF; soap also disrupts the skins' acid mantle due to its alkalinity. Soaps with a higher pH (>7) are likely to cause more dryness than those with a pH (<7) which are closer to the skin's normal pH value to 4-6 (Ali& Yosipovitch 2013).

*Emollient:* Glycerine is an emollient and humectant which has a positive effect on TEWL and SCH. It is a constituent of many commonly available emollient formulations. It is a humectant that attracts water from its surroundings by absorption and adsorption slowing or preventing excessive drying and evaporation. It is naturally present in skin and noted to be one of the best natural skin moisturizers (Chrit *et al.*, 2006). It is used in skin care products because of its moisturising and plasticising effects on the SC which prevent and treat dryness. A report from a global expert dermatology symposium notes that using glycerine to hydrate the SC corrects the effects of cleanser induced skin damage (Ananthapadmanabhan *et al.*, 2013). Studies have reported positive effects of a glycerine dilution below 2% (Iiyama & Kawahira 2008, Atrux-Tallau *et al.*, 2010). It is non-toxic and non-irritating when applied to the skin (Atrux-Tallau *et al.*, 2010, Roussel *et al.*, 2012). Although it occurs naturally in skin but may also be manufactured (Fluhr *et al.*, 2008). It is extensively used in cosmetics and dermatology products because of its moisturising effects. A review of the literature summarises the effect of glycerine as follows (Fluhr *et al.*, 2008):-

- improves SCH
- inhibits SC lipid phase transmission
- improves SBF
- increases desmosomal degradation
- increases skin mechanical properties
- accelerates wound healing
- guards against irritating stimuli
- has an antimicrobial effect

From previous research it can be deduced that low concentrations of glycerine between 2% - 5% have a positive effect on improving SBF (Gloor *et al.* 2001, Atrux-Tallau *et al.*, 2010). Glycerine was chosen for the pilot because of its positive effects on SBF and because it is low-cost and easily available in resource-poor countries.

*Emollient:* Petroleum jelly (*Vaseline*<sup>TM</sup>) is a readily available occlusive (ointment) emollient. It forms a thin film on the surface of the skin which fills the spaces between the desquamating corneocytes which are abundant in dry skin conditions, smoothing the rough stratum corneum surface and increasing the ability of the skin to hold water (Levi *et al.*, 2010). *Vaseline*<sup>TM</sup> applied to skin after the application of a humectant such as glycerine, significantly reduce TEWL (Draelos 2010).

Six 5cm x 5 cm areas of participant's lower legs were marked and assigned to interventions by a sequential organisation; 3 sites each on lateral aspects of left and right legs between knee and outer malleolus. The lower leg was chosen as it is an area likely to be effected by xerosis (Balaskas *et al.*, 2011) and measurements in this area did not unnecessarily compromise participant's dignity. Interventions were allocated sequentially to ensure that different sites of the lower leg were used for each intervention because different skin areas will have differences in, for example thickness, blood supply and skin dryness. Measured amounts of 1.5ml of water, soapy water and glycerine were added to 8 ply, 5cms x 5cms gauze swabs and applied to the skin. All interventions except *Vaseline*<sup>TM</sup> were covered in cling film to ensure controlled contact with the skin. During the study the relative humidity of the environment was between 34-54% and ambient temperature between 19-22°C. The interventions and their rationale are presented in Table 3 and Table 4 documents the sequence of interventions.

### **Data analysis**

Post-intervention minus pre-intervention value changes in SCH and TEWL were computed for all treatments and participants. Descriptive statistics (means and standard deviations) were calculated and profile plots constructed. Friedman's test was used to examine whether the changes differed significantly between the six treatments. If statistically significant, then Friedman's test was followed by a post-hoc Nemenyi test to establish which treatment pairs

differed significantly. R for Windows software Version 3.0.0 was used for the statistical analysis.

### Ethical considerations

A University Research Ethics Committee gave approval for this study. All participants received an information sheet and gave written consent. All data was handled in line with the agreed data management plan.

## Results

The ten participants were all female aged 65-95 years (mean 76.4). No males agreed to participate. During the study the relative humidity of the environment was 34-54% and the ambient temperature 19-22°C. All participants reported that they had not had a shower or immersion bath during the trial or used any other emollients for three days before or during the trial.

Descriptive statistics for SCH levels and TEWL are reported in Tables 5 and 6 respectively. It is clear that the greatest mean increase in SCH level at day 6 is found for soap, glycerine and *Vaseline*™. The greatest improvement of skin barrier function, as reflected in a mean decrease in TEWL was indicated by the soap, glycerine and *Vaseline*™ regimen. Although overall the differences between the six treatments were not statistically significant for TEWL changes; this was a small improvement on that observed for the control treatment. This difference is also apparent from the profile plots (Figures 1 and 2). From Friedman's test it was found that there were statistically significant treatment differences for changes in SCH level but not for TEWL ( $p=0.002$  and  $0.185$  respectively). The post-hoc Nemenyi test for SCH level changes indicated that three treatment pairs differed significantly (Table 7).

The measurement tools were found to be practical and simple to use in residential and home settings. The *VapoMeter*™ was within its factory calibration period of up to 2 years. The *MoistureMeter* was calibrated by the PI according to the manufacturer's instructions. The interventions were well tolerated by the participants and all completed the study. Humidity of the environment was checked at each visit.

## **Discussion**

This is one of the few studies using these portable SBF measures outside a laboratory or hospital setting. The studies are listed on the Delfin web site (Delfin Technologies 2015a, b). Only one study was found which measured SCH and TEWL in those with podoconiosis and it used these probes (Ferguson *et al.* 2013). The study indicates the positive effects on SBF of soaking for 30 minutes a day for five days in the treatment combination containing 2% glycerine due to improvements in SCH, although not TEWL. The study confirms earlier research on the positive effects of glycerine and of *Vaseline*<sup>®</sup> increasing SCH (Fluhr *et al.*, 2008, Draelos 2010). Two percent (2%) glycerine and *Vaseline*<sup>TM</sup> are low cost interventions for use on dry skin and therefore this study may have a value in selecting interventions for use in resource poor settings. Whilst *Vaseline*<sup>®</sup> is an effective ointment emollient many patients find too greasy and prone to rub off on clothes; this may limit acceptability and therefore concordance (Dyble & Ashton 2011). It is unsurprising that the combination of an ointment (*Vaseline*) and humectant (glycerine) improved SBF, however, the addition of soap with its emulsification effect and so removal of the natural emollient sebum may have to a degree countered the therapeutic effect.

No other studies were found using the precise combination of washing the skin with soap and water, soaking in 2% glycerine and applying *Vaseline*<sup>TM</sup>. The effects on SCH may have been increased using a gentler cleansing product with a lower or neutral pH, rather than soap which typically has a high alkalinity.

Care environments for older people may be dry due to excessive central heating thus aggravating the drying of skin due to low humidity levels. In the study there were variations in humidity in the different settings in which the data was recorded but the humidity in the care home was not particularly low and indeed was higher than in some of the participants own homes. Dry skin results in erythematous or red, itchy, roughened skin and a breached SBF with increasing moisture loss (Lodén 2005). A deteriorating cycle of events may follow which does not improve without intervention (Rawlings & Matts 2004). Increasing SCH with the use of emollients improves SBF and helps to prevent dryness and so itching, skin tears (Carville *et al.*, 2014) and resilience against pressure damage (Benbow 2009). Using the two

emollients glycerine and *Vaseline*<sup>TM</sup> in combination may be a cost effective treatment for dry skin especially when used after a cleanser with a low pH.

## **Study limitations**

This pilot study has several limitations. First, it is quasi-experimental and therefore does not have the strength of evidence of a large randomised controlled study. Second the results may have been affected by the small sample (n=10) of all female Caucasian participants within a large age range. Third co-morbidities were not recorded which may have effected results. Forth the interventions were only applied for 5 days and included soap with an atypical alkalinity. Fifth not all of the interventions were tested separately because three sites on each leg were deemed to be the maximum number feasible and at each site the different interventions were only applied once or twice. A factorial design would be desirable for future studies. Sixth, although soaps used in clinical practice are often highly alkaline a gentler cleansing bar may have been of a more optimal (lower) pH, nearer that of the skin and potentially also could have had a lower emulsifying effect than soaps retaining more of the skin's sebum and natural emollient property. Future studies might consider reviewing the impact of soaking skin in water containing an emollient such as glycerine to examine its effects on SCH and TEWL using portable measures of SBF. Seventh, participants were given no choice of products so even if effective they may have been unacceptable for continuing use. Finally, the pilot was undertaken on older women so the results may not be generalizable to the adult population in the main study.

## **Conclusion**

Despite the aging population and the increasing awareness of the importance of maintaining skin integrity for older people the evidence base for hygiene and emollient practices remains weak in terms of clinical and cost effectiveness and patient acceptability. This pilot study took place over a short time period but showed the positive influence on the SBF of older peoples' skin of using a combination of soap, a 2% glycerine soak and application of a thin layer of *Vaseline*<sup>TM</sup>. The study supports previous findings on the positive effects of the emollients glycerine and of *Vaseline*<sup>TM</sup> increasing SCH levels and reducing TEWL in those with dry skin. Even when used following the application of soap,

that typically has a high pH, these emollients were still effective. It also highlights the feasibility of using SBF measures outside the laboratory, within care and home settings. Further research is required to ascertain optimal hygiene and emollient regimens for older people in a suitably powered randomised controlled trial. The products and probes used in this pilot study will be used in the main RCT to promote and measure SBF in those in a resource-poor country with the skin disease podoconiosis.

### **Implication of Practice**

- Soap used for washing older skin should have a low pH to avoid drying the skin further.
- A regimen of washing, soaking the skin in 2% glycerine, careful drying and the application of a thin layer of Vaseline™ may be beneficial for those with xerosis.
- Over-washing with soap should be avoided.

### **Conflict of interest**

None declared.

### **Contributions**

Study Design: JB, FC, SE, and EG. Data management and analysis: EG, JB. Drafting and preparing the manuscript for publication: JB, FC, SE, EG. All authors approved the final manuscript.

### **References**

- Ali SM & Yosipovitch G. (2013) Skin pH: From Basic Science to Basic Skin Care. *Acta Dermato-Venereologica*, 93 (3), pp 261-267.
- Ananthapadmanabhan KP., Subramanyan, K. & Nole, G. (2013) A global perspective on caring for healthy stratum corneum by mitigating the effects of daily cleansing: report from an expert dermatology symposium. *British Journal of Dermatology*, 168, 1-9.
- Atrux-Tallau N., Romagny C., Padois K., Denis A., Haftek M., Falson F., Pirot F. & Maibach H. (2010) Effects of glycerol on human skin damaged by acute sodium lauryl sulphate treatment. *Archives of Dermatological Research* 302, 435-441.
- Balaskas E., Szepietowski JC., Bessis D., Ioannides D., Ponticelli C., Ghienne C., Taberly A. & Dupuy P.(2011) Randomized, Double-blind Study with Glycerol and Paraffin in Uremic Xerosis. *Clinical Journal of the American Society of Nephrology* 6(4) 748-752.
- Baranda L., Gonzalez-Amaro R., Torres-Alvarez B., Alvarez C. & Ramirez V. (2002) Correlation between pH and irritant effect of cleansers marketed for dry skin. *International Journal of Dermatology* 41 (8), 494-9.

Baranoski S. & Ayello E. (2004) Wound Care Essentials: Practice Principles. Springhouse, PA: Williams & Wilkins, 2004.

Beauregard S. & Gilchrest BA. (1987) A survey of skin problems and skin care regimens in the elderly. *Archives of Dermatology* 123(12), 1638–43.

Benbow M. (2009) Maintaining skin integrity and preventing pressure damage *Nursing and Residential Care* 11(9), 443-447.

British Association of Dermatologists (2006) Looking after elderly skin - a simple guide. [www.bad.org.uk/Portals/\\_Bad/images/default/elderly\\_skin\\_care.pdf](http://www.bad.org.uk/Portals/_Bad/images/default/elderly_skin_care.pdf) (accessed 25.2.14).

Burr S. (2005) Eczema and dry skin in the older person. London, National Eczema Society.

Carville K., Leslie G., Osseiran-Moissen R., Newall N. & Lewing G. (2014) The effectiveness of a twice-daily skin-moisturising regimen for reducing the incidence of skin tears. *International Wound Journal* 11(4), 446-453.

Chrit L., Bastien P., Sockalingum GD., Batisse, D., Leroy F., Manfait M. & Hadjur C. (2006) An in vivo randomized study of human skin moisturization by a new confocal Raman fiber-optic microprobe: assessment of a glycerol-based hydration cream. *Skin Pharmacology and Physiology*, 19(4), 207-215.

Cole L. & Nesbitt C. (2004) A three year multiphase pressure ulcer prevalence/incidence study in a regional referral hospital. *Ostomy Wound Management* 50(11), 32–40.

Cowdell F. (2010) Promoting skin health in older people. *Nursing Older People* 22(10), 21–26.

Cowdell F., Jadotte YT., Ersser SJ., Danby S., Walton S., Lawton S., Roberts A., Gardiner E., Ware F. & Cork M. (2014) Hygiene and emollient interventions for maintaining skin integrity in older people in hospital and residential care settings (Protocol). *Cochrane Database of Systematic Reviews* 2014, Issue 12. Art. No.: CD011377. DOI: 10.1002/14651858.CD011377.

Cowdell F. (2015) Developing the Evidence Base for Hygiene and Emollient Practices. *Nursing Older People* 27(4), pp16-20.

Delfin Technologies (2015a) *MoisturemeterSC* [http://www.delfintech.com/en/product\\_information/moisturemetersc/](http://www.delfintech.com/en/product_information/moisturemetersc/) (accessed 18.12.15)

Delfin Technologies (2015b) *Vapometer* [http://www.delfintech.com/en/product\\_information/vapometer/](http://www.delfintech.com/en/product_information/vapometer/) (accessed 18.12.15)

Draelos ZD. (2010) Active agents in common skin care products. *Plastic and Reconstructive Surgery* 125, 719-724.

Dyble T. & Ashton J. (2011) Use of emollients in the treatment of dry skin conditions. *British Journal of Community Nursing* 16, 214-220.

Ersser SJ., Getliffe K., Voegeli D. & Regan S. (2005) A critical review of the inter-relationship between skin vulnerability and urinary incontinence and related nursing intervention. *International Journal of Nursing Studies* 42(7), 823–35.

Ersser SJ., Maguire S, Nicol N., Penzer R., Peters J. (2012) Best Practice Statement for Emollient Therapy (British Dermatological Nursing Group). *Dermatological Nursing* (supplement) 11 (4):S2–S19

Ferguson JS., Yeshanehe W., Matts, P., Davey G., Mortimer P., Fuller C. (2013) Assessment of skin barrier function in podoconiosis: measurement of stratum corneum hydration and transepidermal water loss. *Br J Dermatol*, Mar; 168 (3): 550 -4.

Finch M. (2003) Assessment of skin in older people. *Nursing Older People* 15(2):29–30.

Fluhr JW., Feingold KR. & Elias PM. (2006) Transepidermal water loss reflects permeability barrier status: validation in human and rodent *in vivo* and *ex vivo* models. *Experimental Dermatology* 15, 483-492.

Fluhr JW., Darlenski R. & Surber C. (2008) Glycerol and the skin: Holistic approach to its origin and functions. *British Journal of Dermatology* 159, 23-34.

Fore J. (2006) A review of skin and the effects of aging on skin structure and function. *Ostomy Wound Management* 52(9), pp. 24-37.

Gardiner L.; Lampshire S.; Biggins A.; McMurray A.; Noake N.; van Zyl M.; Vickery J.; Woodage T.; Lodge J. & Edgar M. (2008) Evidence-based best practice in maintaining skin integrity. *Wound Practice & Research* 16(2), 5–15.

Gloor, M., Gabard, B., Fluhr, J., Lehemacher, W. (2001). Action of Aluminium Chlorhydrate and Glycerol Containing Experimental Skin Irritation Produced by Sodium Laurylsulfate and Solvents. *Dermatol Beruf Umwelt/Occupational Environmental Dermatology*, 49, pp 67–70.

Harding CR., Bartolone J. & Rawlings AV. (2000) Effects of Natural Moisturizing Factor and Lactic Acid Isomers on Skin Function. In: Loden M, Maibach HI (eds). *Dry skin and Moisturizers: Chemistry and Function*. Boca Raton, CRC Press. pp 29–41.

Holden C., English J., Hoare C., Jordan A., Kownacki S., Turnbull R. & Staughton RCD., (2002) Advised best practice for the use of emollients in eczema and other dry skin conditions. *Journal of Dermatological Treatment*, 13(3), pp. 103-106.

Hunter S., Anderson J., Hanson D., Thompson P., Langemo D. & Klug MG. (2003) Clinical trial of a prevention and treatment protocol for skin breakdown in two nursing homes. *Journal of Wound, Ostomy & Continence Nursing* 30 (5), 250–8.

Kottner J., Licherfeld A. & Blume-Peytavi U. (2013) Maintaining skin integrity in the aged: A systematic review. *British Journal of Dermatology* 169 (3), 528-42.

Lawton S. (2007) Addressing the skin-care needs of the older person. *British Journal of Community Nursing* 12(5), 203–8.

Levi K., Weber RJ., Do JQ. & Dauskardt RH. (2010) Drying stress and damage processes in human stratum corneum. *International Journal of Cosmetic Science* 32, 276-293.

Lodén M. (2005) The clinical benefit of moisturizers. *Journal of the European Academy of Dermatology and Venereology* 19, 672-688.

Iiyama J. & Kawahira K. (2008) Effects of bathing in warm water with added glycerin on skin conditions and prevention of skin disorders in patients with severe motor and intellectual disabilities. *Journal of the Japanese Society of Balneology, Climatology & Physical Medicine*, 71(3), 173-179.

Moncrieff G., Cork M., Lawton S., Kokiet S., Daly C. & Clark C. (2013) Use of emollients in dry-skin conditions: consensus statement. *Clinical & Experimental Dermatology* 38(3), 231-238.

Nash K. (2009) Managing dry skin: cold weather, low humidity among causes of xerosis in elderly. *Dermatology Times* 30, 47.

North American Nursing Diagnosis Association (2013) Nursing diagnosis for impaired skin integrity. <http://nursing-diagnosis-intervention.blogspot.co.uk/2012/07/nursing-diagnosis-impaired-skin.html> (accessed 18.12.15)

Overgaard-Olsen L. & Jemec GB., (1993) The influence of water, glycerine, paraffin oil and ethanol on skin mechanics. *Acta Dermato-Venereologica (Stockholm)*, 73, pp. 404-406.

Plessis J., Stefaniak A., Elof F., Swen J., Agner T., Chou T-Z., Nixon R., Steiner M., Franken A., Kudla I. & Holness L. (2013) International guidelines for the in vivo assessment of skin properties in non-clinical settings: Part 2. Transepidermal water loss and skin hydration. *Skin Research & Technology*. 19, 265-278.

Ramsing DW. (1997) Effect of water on experimentally irritated human skin. *British Journal of Dermatology*, 136, 364.

Rawlings AV. & Matts PJ. (2004) Stratum corneum moisturization at molecular level: An update in relation to the dry skin cycle. *Dermatology Foundation* 38, 1-12.

Roussel L., Atrux-Tallau N. & Pirot F. (2012) Glycerol as a Skin Barrier Influencing Humectant. In: Loden M. & Mailbach H I (eds) *Treatment of Dry Skin Syndrome*. Berlin Heidelberg: Springer-Verlag, pp. 473-480.

Voegeli D. (2008) LBF 'no-sting' barrier wipes: skin care using advanced silicone technology. *British Journal of Nursing* 17 (7), 472, 474-6.

Warner RR., Stone KJ. & Boissey YL. (2003) Hydration Disrupts Human Stratum Corneum Ultrastructure. *Journal of Investigative Dermatology*, 120(2), 275-284.

Warner RR., Boissey YL., Lilly N.A., Spears MJ., Mckillop K., Marshall JL. & Stone KJ., (1999) Water disrupts stratum corneum lipid lamellae: damage is similar to surfactants. *Journal of Investigative Dermatology*, 113, 960-966.

Watkins P. (2011) The use of emollient therapy for ageing skin. *Nursing Older People* 23(5), 31-38.

Wolf R. & Parish L.C. (2012) Effect of soaps and detergents on epidermal barrier function. *Clinics in Dermatology* 30, 297-300.

**How to cite this article:** Brooks, J., Cowdell, F., Ersser, S.J. and Gardiner, S. E.D. (2016), Skin cleansing and emolliating for older people: A quasi-experimental pilot study. *International Journal of Older People Nursing*, 00: 1–9. doi: 10.1111/opn.12145