Ashford and St. Peter's Hospitals
NHS Foundation Trust

Nappy Rash Guideline

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Guideline History		
Date	**Comments**	**Approved By**
2020	New Guideline	Neonatal Guidelines Group

Contents

1. Nappy Rash

a) What is nappy rash?

Nappy rash (also referred to as napkin dermatitis) is defined as an irritant contact dermatitis attributed to the interaction of several factors (Onselen, 2018). In particular, it is associated with the prolonged contact of the skin with urine and faeces, which makes the skin prone to breakdown through friction with the nappy. Urine alters the skin pH from acid to alkaline, which increases the likelihood of localised micro-organism colonisation. This change in skin pH may also activate enzymes in the stool that denature proteins in the stratum corneum, leading to skin breakdown (Irving 2002).

Nappy rash is characterised by localised or more generalised red patches or erythema around the genitalia, perineum and anus. The skin may look sore and feel hot to touch, and there may be spots, pimples or blisters.

Most babies with mild nappy rash do not require analgesia, however if the rash is severe the baby may experience discomfort and distress and so the Neonatal Pain Assessment Tool should be used to guide management.

b) Common causes of nappy rash

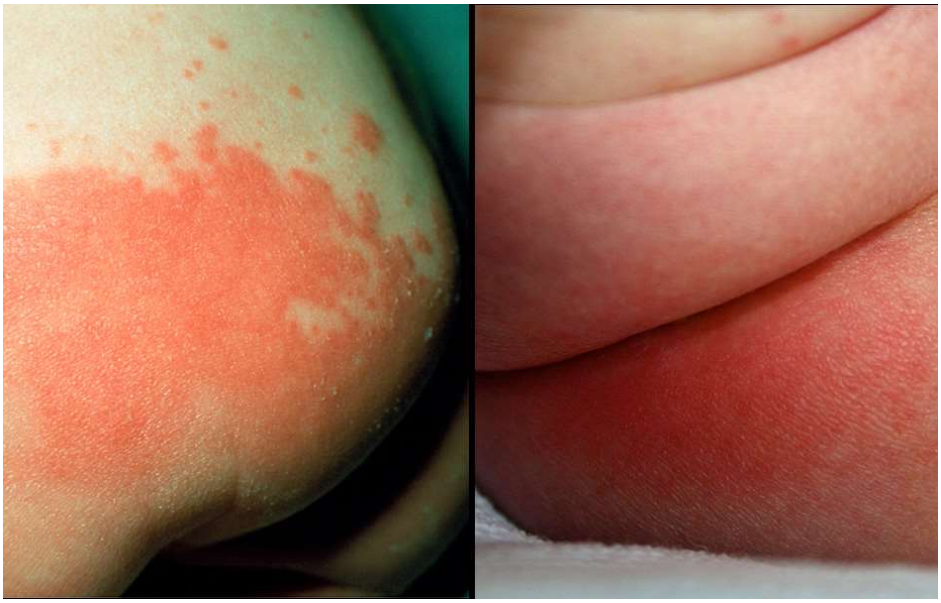
- Prolonged contact between the skin and urine and/or faeces. Babies with diarrhoea or chronic stooling are at increased risk of developing nappy rash.
- Nappy rubbing against babies' skin creating friction.
- Inadequate cleaning of the nappy area or not changing the nappy often enough.
- Soap, detergent, bubble bath or alcohol-based baby wipes - that may be an irritant to the baby's skin.
- Antibiotics – Babies on antibiotics are at an increased risk of developing nappy rash. Use of broad-spectrum antibiotics may predispose infants to developing nappy rash by increasing the risk of developing diarrhoea and secondary yeast infections (Herii, 2019).
- Babies with NAS
- Dietary factors - Breast-fed infants have a lower incidence of nappy rash than formula-fed infants, possibly because breast-fed infants have a lower stool pH (Herii, 2019)

- Gestational age — pre-term infants are at increased risk of developing nappy rash and secondary infection due to the reduced barrier function of immature skin (NICE,2018).
- Fungal infection

c) Types of nappy rash

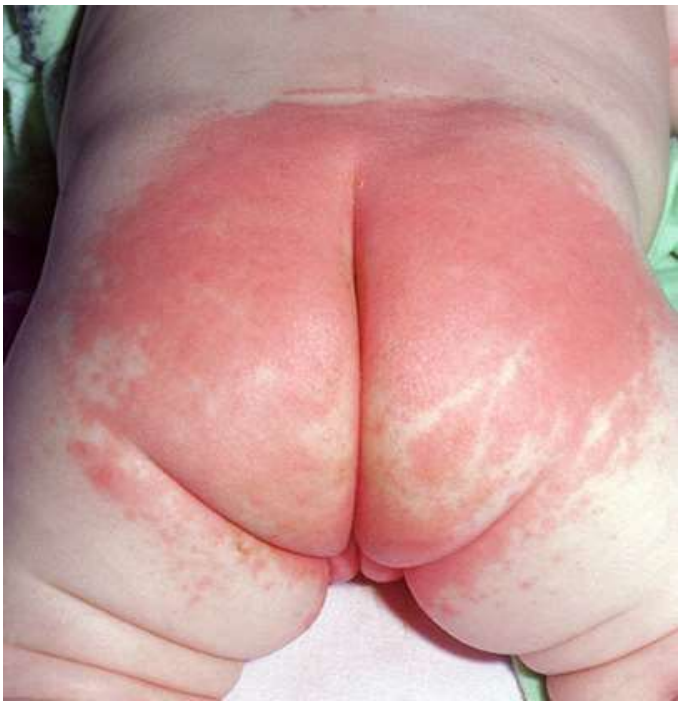
Nappy rash is a very common and can be defined as mild, moderate or severe.

Mild nappy rash is characterised by a pink outbreak, with scattered papules on the area covered by a nappy, scaling and/or dryness may be present.



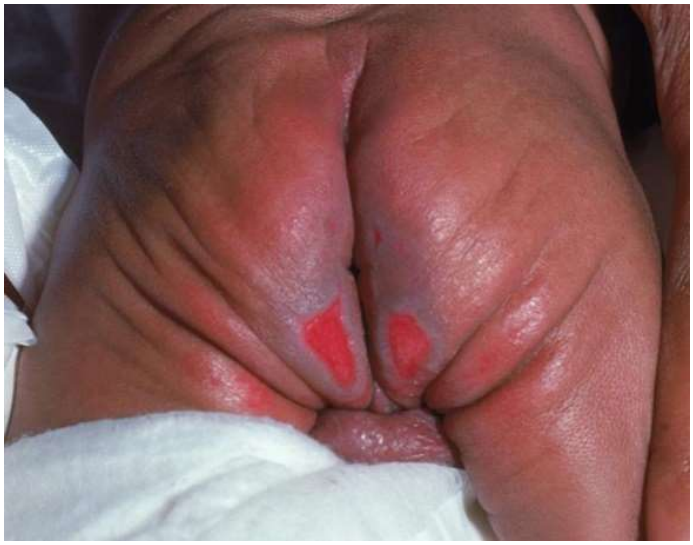
(Herii, 2019)

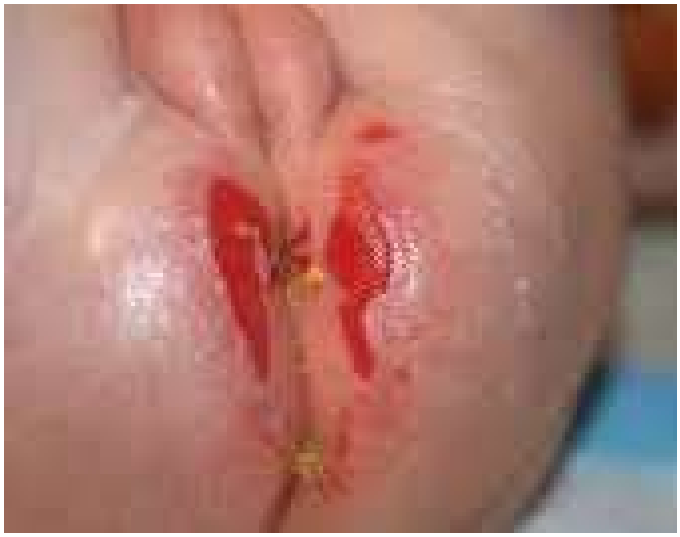
Moderate nappy rash is characterised by inflammation covering an area of greater than 10% of the nappy area, with or without papules, oedema or ulceration.



(Herii, 2019)

Severe nappy rash is characterised by extensive erythema with a glossy appearance, papules, and painful broken skin.





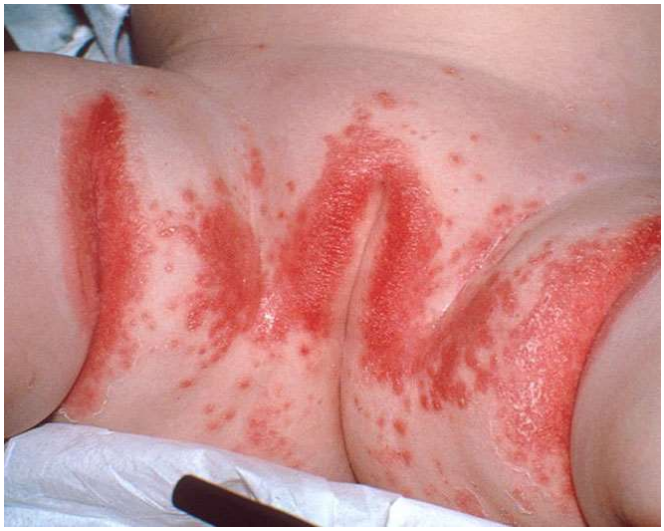
(Herri, 2019)

d) Fungal infection nappy rash

Fungal infection of the nappy area is usually caused by secondary infection of nappy rash with of with Candida albicans (Onselen, 2018).

Common symptoms of fungal nappy rash:

- A rash that is bright red
- Raised with well-defined edges
- Characterised by satellite spots or pustules
- Rash doesn't respond to standard cream and takes a while to treat
- Rash may extend into the leg folds
- The rash may be associated with thrush infection in the baby's mouth (Cohen, 2017)



(Herii, 2019)

e) Preventive Measures

- Regular nappy care – every 3-6 hours
- Effective skin cleansing with nappy changes – ensuring skin is gently but thoroughly dried with each nappy care
- Changing dirty nappies as soon as possible
- Implement parent craft/education

f) Treatment of nappy rash

Initial management:

- Expose area to air for as long as possible
- Apply a preventative barrier cream i.e. Medihoney/Bepanthen with every nappy change for at least 48 hrs
- No wet wipes or bathing products
- Document in the notes

If symptoms persist/worsen:

- Inform medical team
- Take pictures (get parental consent) and document in wound care plan
- If skin becomes broken commence treatment with Orabase for at least 48hrs

If symptoms persist and there is suspicion of fungal infection:

- Swab nappy area
- Start treatment for at least 48hrs with Clotrimazole cream and Oral Nystatin according to Neonatal Formulary

2. Supporting References

Cohen, B. 2017. Differential diagnosis of diaper dermatitis. doi: 10.1177/0009922817706982

Harii, k. 2019. Diaper dermatitis. Available at: <https://www-uptodate-com.libproxy.kcl.ac.uk/contents/diaper-dermatitis> [Accessed 30 April 2020].

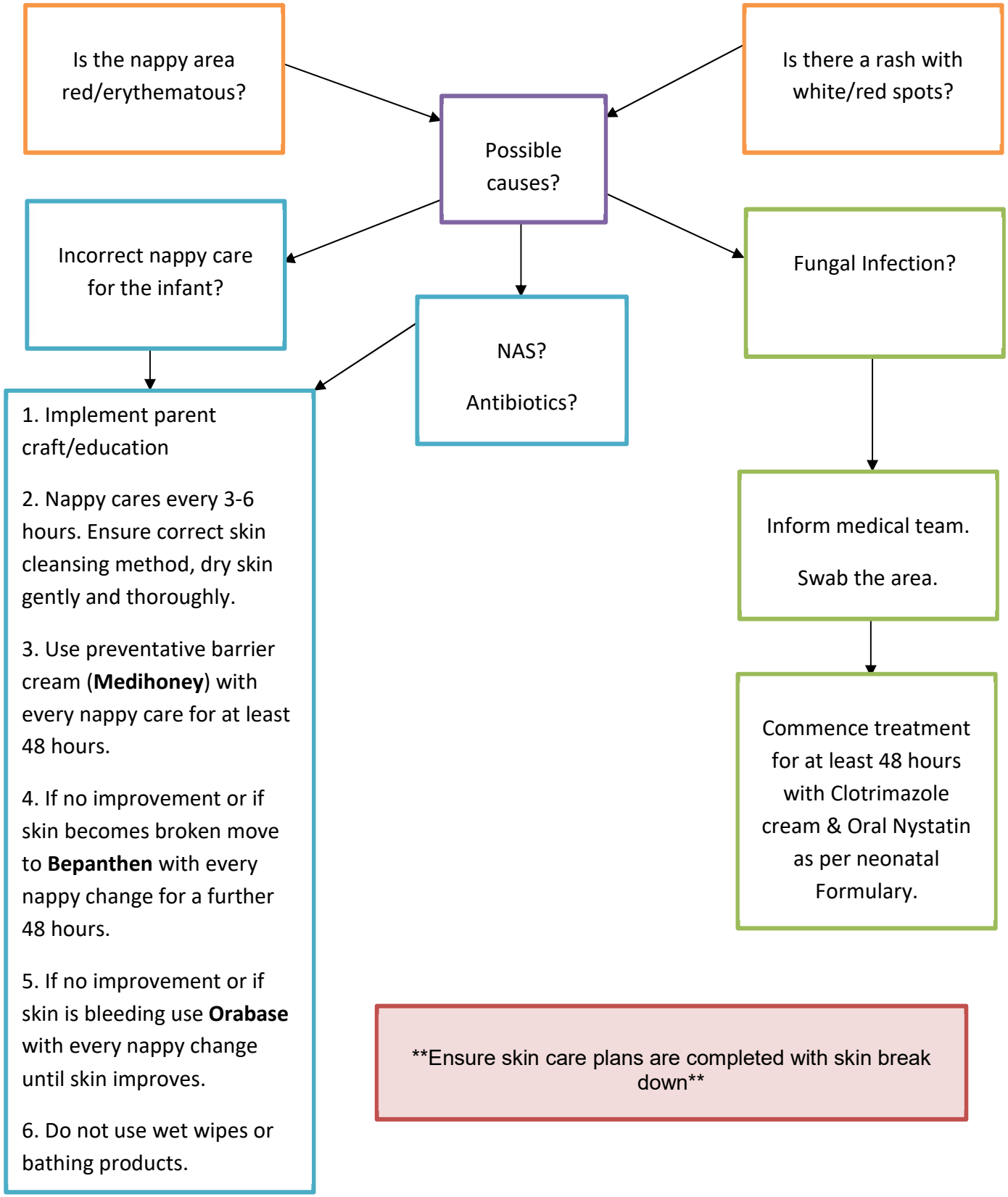
Irving, V. (2002). Meeting the Challenge: Maintaining the integrity of pre-term skin Nurse 2 Nurse July 2(9) 48-50

NHS (2018). Nappy rash. Available at https://www.nhs.uk/conditions/pregnancy-and-baby/nappy-rash/2 August 2018: [Accessed 25/4/20]

NICE (2018). Available at https://cks.nice.org.uk/nappy-rash#!backgroundSub:2

Onselen, J.V., (2018). British Journal of Family Medicine. Pavilion Publishing and Media Ltd. Available at: https://www.bjfm.co.uk/napkin-dermatitis-in-infants-overview-and-current-treatment-guidance [Accessed 25/04/20]

3. Appendix 1.0 - Summary of Nappy Rash Management



4.Guideline Governance

a. Scope

This guideline in relevant to all staff caring for babies across neonatal intensive care, transitional care and maternity.

b. Purpose

i. This guidelines aims to facilitate a common approach to the management of babies admitted under neonatal care. At times deviation from the guideline may be necessary, this should be documented and is the responsibility of the attending consultant.

ii. This guideline is subject to regular review to ensure ongoing evidence based practice.

c. Duties and Responsibilities

What is expected from the health care professionals using this guideline to look after infants.

d. Approval and Ratification

This guideline will be approved and ratified by the Neonatal Guidelines Group.

e. Dissemination and Implementation

i. This guideline will be uploaded to the trust intranet 'Neonatal Guidelines' page and thus available for common use.
ii. This guideline will be shared as part of ongoing education within the Neonatal Unit for both medical and nursing staff.
iii. All members of staff are invited to attend and give comments on the guideline as part of the ratification process.

f. Review and Revision Arrangements

a. This policy will be reviewed on a 5 yearly basis.
b. If new information comes to light prior to the review date, an earlier review will be prompted.
c. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Neonatal Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

g. Equality Impact Assessment

Background • Who was involved in the Equality Impact Assessment
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
Conclusion • Provide a summary of the overall conclusions
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment

h. Document Checklist

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document:

Policy (document) Author:

Executive Director:

		Yes/No/ Unsure/NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?		
	Is the purpose of the document clear?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?		
	Who was engaged in a review of the document (list committees/ individuals)?		
	Has the policy template been followed (i.e. is the format correct)?		
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		

		Yes/No/ Unsure/NA	Comments
	Are local/organisational supporting documents referenced?		
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?		
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?		
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?		
8.	**Review Date**		
	Is the review date identified and is this acceptable?		
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?		
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?		

Committee Approval (Neonatal Guidelines Committee)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair		**Date**	
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			