



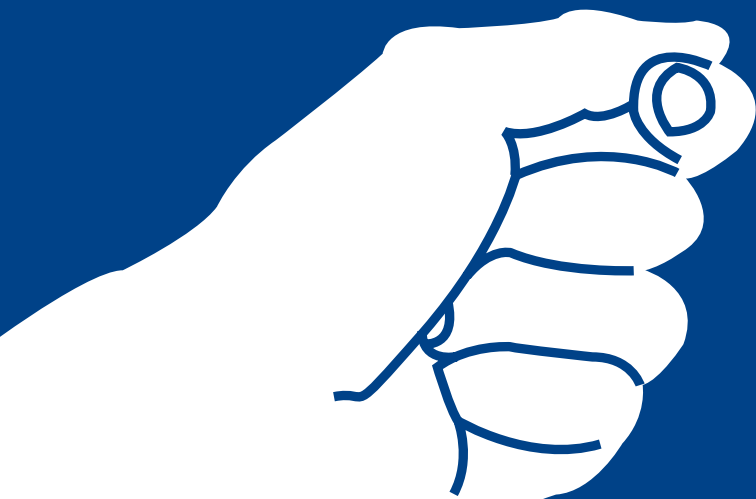
Royal College  
of Nursing

2020 | International Year  
of the Nurse and Midwife

# Survey exploring skin health issues among nursing staff in the UK: results of a national survey

A project commissioned by  
the Royal College of Nursing

CORPORATE



# Be skin aware

# Working group members

## Royal College of Nursing

Rose Gallagher, Professional Lead Infection Prevention and Control  
Rose Harrison, Corporate Relations Account Manager  
Kim Sunley, RCN National Officer

## Guy's and St Thomas' NHS Foundation Trust/ King's College London (Occupational Health Service/ School of Life Sciences and Medicine)

Dr Vaughan Parsons, Research Manager and Research Fellow

## Cardiff University (School of Healthcare Sciences)

Professor Dinah Gould, Professor in Nursing

## SC Johnson Professional

John Hines, Research and Development Director  
Georgia Oxley, Product Evaluation Technician  
Caroline Fellows, Product Evaluation Manager  
Martyn Hodgkinson, Marketing Manager  
Kevin Ormandy, Product Evaluation and Claims Director

This report was written by Dr Vaughan Parsons with data and figures produced by Georgia Oxley and Professor Dinah Gould. All members reviewed and commented on the final report.

For more information contact: Rose Gallagher, Professional Lead Infection Prevention and Control, Royal College of Nursing, Email: [Rose.Gallagher@rcn.org.uk](mailto:Rose.Gallagher@rcn.org.uk)

## In collaboration with:



SC Johnson Professional have supported the development, publication and distribution of this RCN survey and collaborated with the RCN to ensure wide promotion. The sponsors have not had any editorial input into the content, other than a review for factual inaccuracies.

---

### RCN Legal Disclaimer

This publication contains information, advice and guidance to help members of the RCN. It is intended for use within the UK but readers are advised that practices may vary in each country and outside the UK.

The information in this booklet has been compiled from professional sources, but its accuracy is not guaranteed. Whilst every effort has been made to ensure the RCN provides accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, the RCN shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in or left out of this website information and guidance.

Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

© 2020 Royal College of Nursing. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Publishers. This publication may not be lent, resold, hired out or otherwise disposed of by ways of trade in any form of binding or cover other than that in which it is published, without the prior consent of the Publishers.

# Contents

Executive summary	4
Background	6
Purpose	8
Methods	9
Presentation of results and discussion of key findings	10
Recommendations	19
References	23
List of abbreviations	25
Appendix	26

# Executive summary

National Health Service (NHS) staff are the NHS's greatest asset yet employers (NHS and non-NHS health care organisations) continue to face unprecedented challenges in terms of staff retention and high levels of nursing vacancies (43,000 nursing vacancies in England alone).

There is high prevalence of skin (hand/wrist) problems in nursing staff despite continued efforts by some employers and individual employees to improve hand care practices and minimise occupational risk factors (or exposures) in the workplace (Soltanipoor et al., 2019; Visser et al., 2014). When skin problems arise, the impact of staff health and work functioning can be serious in terms of increased sick absence and potential job loss.

In 2019, the Royal College of Nursing (RCN) convened a working group to develop and implement a national skin health survey to all members with the aim of enhancing our understanding of relevant issues relating to skin health at work. The results from this survey were also used to inform the development of future infection prevention and skin health resources and initiatives, including the RCN's annual Glove Awareness work.

The survey comprised three key objectives:

1. to assess the prevalence of skin problems on the hands/wrists of RCN members and to understand the impact of skin problems on the hands/wrists on work functioning
2. to determine the level of support offered to members by employers in the prevention and management of skin disease on the hands/wrists
3. to assess awareness of the RCN Glove Awareness work

A total of 1531 members ('respondents') took part in the online survey. The majority of respondents were female (81%, n=1254) and respondents ages ranged from 18-65 years and over. Respondents were represented from diverse job roles and workplace settings (hospital, community, primary care and mental health), with the largest proportion (74%, n=1143) employed in the National Health Service (NHS).

At the time of the survey, almost half (46%, n=709) of respondents rated the condition of their hands /wrist as either 'poor' or 'very poor' and 93% (n=1444) of respondents reporting at least one skin symptom in the previous 12 month period, with 'dryness' the most common symptom experienced. Over half of respondents also experienced 'redness' and 'itching', with the back of the hands and in-between the fingers the most common sites where symptoms developed. While 'dryness' was the most prevalent symptom across all age groups, younger nursing staff were also more prone to experience multiple skin problems (redness, itching, cracking) compared to older nursing staff. This is consistent with previous research which has shown that nursing staff are more prone to developing skin problems on their hands/wrist soon after entering the profession (Skudlik, Dulong, Wendeler, John, & Nienhaus, 2009; Smith et al., 2006).

Moreover, over half of respondents reported that symptoms were present at the time of the survey, and 23% (n=358) of respondents reported a previous diagnosis of hand dermatitis by a treating physician which is broadly similar with prevalence rates in health care workers identified in previous research. The most common self-reported causes of hand dermatitis were glove and soap usage, excessive hand hygiene actions, including alcohol hand gel use. Of those who had a previous history of hand dermatitis, over a quarter (27%, n=291) of respondents also reported a previous history of atopy which, coupled with female sex and occupational exposure, are known to increase a person's susceptibility for developing future hand dermatitis (Coenraads & Diepgen, 1998; Meding & Swanbeck, 1990). The majority of respondents reported using hand cream at work, with over half (68%, n=957) using products at least several times a day which is in keeping in infection prevention and hand hygiene recommendations (NHS Plus, 2011).

We found the vast majority (78%) of respondents did not disclose skin problems to anyone in the workplace when symptoms developed, with over half (53%, n=758) having to limit or stop using recommended hand hygiene practices, such as use of anti-bacterial gel or wearing surgical gloves, due to concerns that this may aggravate their skin condition. Despite the large proportion of respondents who experienced skin problems,

only 83 respondents reported that they required work adjustments to support them to remain at work, with fewer (n=33) requiring time off work due to the severity of their condition. In terms of routine skin health surveillance, only 16% (n=240) reported that 'skin checks' were carried out in the workplace and less than half (42%, n=645) of respondents had received specific training on how to engage in good hand hygiene and hand care, with fewer respondents (26%, n=398) receiving specific training and advice on how to spot early signs of dermatitis.

Only a quarter (26%) of respondents were aware of the RCN's previous Glove Awareness Week campaign highlighting the need for more targeted promotional activities to better engage members.

The survey results provided valuable insight into issues relating to skin health at work among RCN members although caution is warranted when drawing definitive conclusions since the results are not representative of all members.

In light of the findings from this survey and in terms of future efforts to improve skin care in nursing staff, the RCN recognises that more needs to be done to reinforce the importance of maintaining good skin care practices in the workplace among all members including, but not limited to, encouraging and supporting nursing staff to apply hand moisturising cream at regular intervals during their shifts. More broadly, greater effort is also required to promote an improved culture within the profession which encourages nursing staff to seek advice and support from others (occupational health and managers) early when skin problems arise. Finally, as a professional body and trade union the RCN recognises that we have an important role to play in supporting employers to develop and implement robust routine health surveillance (skin checks) systems to monitor skin health in staff and to intervene early when skin problems arise. This pursuit recognises that NHS staff are the NHS's greatest asset.

A broad range of recommendations are proposed and are categorised into employer-, employee-, RCN- (and partner organisations), regulator-responsibilities.

# Background

Hand dermatitis can present as a serious occupational skin disease among health care workers with an estimated prevalence ranging from 16% - 24% compared to less than 10% in the general population (Madan et al., 2019; Thyssen, Johansen, Linneberg, & Menné, 2010). Skin problems on the hands/wrists is often attributed to frequent wet work practices and repeated exposures to irritants (soaps, detergents, chemicals) when performing clinical duties. In addition, the burden of serious skin problems can have significant economic costs for individuals (in terms of lost wages and leaving the health professions early) and to employers (in terms of loss to productivity and staff retention). Once an individual develops serious skin problems such as hand dermatitis the prognosis is poor. In the UK, current evidence suggests that, although the incidence of allergic contact dermatitis continues to decrease due to improved working conditions and work practices, the incidence of irritant contact dermatitis remains unchanged (Stocks et al., 2015).

Good hand hygiene among health care workers is the cornerstone of infection prevention and a range of workplace practices have been implemented in health care settings to minimise risk (Health and Safety Executive, 2020b; NHS Plus, 2011; Nicholson, 2010). These include use hand sanitisers to decontaminate the hands of pathogens, encouragement for staff to wash with soap and water only when the hands are visible dirty or soiled, reinforcing appropriate glove use (wearing for the least amount of time possible) and, the encouraging the regular and frequent application of hand moisturising cream which contain emollients during the day. These practices are largely focused on minimising transient colonisation of pathogens and onward transmissions of infection whilst encouraging an organisation-wide approach to optimal hand care. This is underpinned the written leaflet on hand dermatitis prevention titled 'Dermatitis: Occupational Aspects of Management- Evidence based Guidelines for Employees' which is widely available for staff working across the National Health Service (NHS) environment (NHS Plus, 2009). The Royal College of Nursing also offers a range of dermatitis available resources and education and information to its members which are designed to safeguard skin health. These include, Tools of the Trade professional guidance, posters on appropriate glove use and posters on spotting the early warning signs of dermatitis.

Causative factors such as frequent 'wet-work' and glove use increase the likelihood that skin problems will develop and symptoms can be aggravated further when health care workers are exposed to a variety of substances or accelerants that may irritate skin when combined with recommended hand-hygiene indications. As a result, compliance with hand hygiene policies may be challenged as nursing staff may be reluctant to comply fully if further discomfort is experienced or if these are likely to contribute to further deterioration in skin health.

Occupational skin disease is often considered in terms of preventing the onset of disease (primary prevention), health surveillance (secondary prevention) and work adjustment/modifications (tertiary prevention). Research studies exploring the effectiveness of new interventions designed to encourage good hand care practices in nursing staff have been developed and tested with mixed results. These include the SCIN (skin care intervention in nursing staff) trial (Madan et al., 2019), Healthy Hands trial (Soltanipoor et al., 2019) and the Hands4U trial (van der Meer et al., 2015). Most of these aim to facilitate the increased use of hand moisturisers and anti-bacterial hand rubs (as an alternative to washing with soap and water), with some interventions drawing upon psychological theory to promote behaviour change associated with improved hand care. Whilst the evidence of the safety and effectiveness of these prevention measures (such as use of hand cream containing emollients and anti-bacterial rubs) has been established, the challenge remains on how best to challenge misconceptions held by some health care workers that anti-bacterial rubs damage the skin's integrity, are more irritating and drying compared to washing with soap and water, and therefore more likely to cause hand dermatitis (Consensus Measurement in Hand Hygiene Project Expert Advisory Panel, 2009; Madan et al., 2019; Stutz et al., 2009).

The high prevalence of occupational dermatoses also presents significant challenges for employers in terms of routine health surveillance and regulatory compliance. In the UK, the onus has been placed on employers to introduce more enhanced health surveillance measures (skin checks) to screen and identify occupational skin disease in workers. In addition they need to ensure that such programmes are able to

adequately fulfil the requirements outlined in key regulatory policy documents such as the Control of Substances Hazardous to Health (COSHH) Regulations 2002 framework, the dermal exposure to hazardous substance (prevention of dermatitis) guidance and medical aspects of occupational skin disease guidance (Health & Safety Executive, 2011, 2015; Health and Safety Executive, 2004). While the HSE guidance fall short of mandating that specific actions are taken by employers, following guidance is a way for employers to show that they are meeting the requirements under COSHH. In addition, they also offer a range of 'higher level' actions (e.g. regular visual skin inspections or employees questionnaires administered annually) and 'lower level' actions (providing information about symptoms to watch out for) based on the level of risk for each workplace setting to consider. Importantly, the regulator's role is to also carry out onsite inspections to ensure adequate systems are in place for the management (prevention and detection) of hand dermatitis and to take action against organisations who fail to comply.

The purpose of this report is to provide feedback on the results from the 2020 Royal College of Nursing Skin Health survey of members.

### **Project working group**

A multi-professional working group was convened comprising RCN representatives' academic and scientific researchers with a special interest in hand hygiene and dermatological research from SC Johnson Professional, Occupational Health Service at Guy's and St Thomas NHS Foundation Trust / King's College London and School of Healthcare Sciences at Cardiff University.

# Purpose

The purpose of the national survey of RCN members was to seek contemporary feedback on issues relating to skin (hand/wrist) health at work. In addition, feedback from members was used to inform development of the annual RCN Glove Awareness campaign for 2020 as well as updated and newly developed educational material and resources designed to promote optimal hand care among RCN members.

Objectives:

1. To assess the prevalence of skin problems on the hands/wrists of RCN members and to understand the impact of skin problems on the hands/wrists on work functioning
2. To determine the level of support offered to members by employers in the prevention and management of skin disease on the hands/wrists
3. To assess awareness of the RCN Glove Awareness campaign



# Methods

## Development of the survey

A short online survey was developed and piloted by the working group, and was based on topic areas that were of particular interest which included:

- Basic demographics (employment status and hours of work, employer type, clinical setting, job type, area of clinical practice, length of service, age, ethnicity, and disability status, country of work, educational attainment)
- General assessment of skin health (current and past history of skin problems), sickness absence and work adjustments attributed to skin problems
- Organisational support for the prevention of hand dermatitis
- Awareness of the RCN Glove Awareness campaign.

This study did not explore respondents hand hygiene or glove use but focused on obtaining data on access to and frequency of moisturising cream usage as a highly effective preventive (and treatment) measure which protects and safeguards skin health, and so we were interested in understanding the extent to which this protective behaviour was being adopted by members.

For access to the online survey RCN members were required to follow a unique electronic link. Individuals were not required to complete any log-in registration before completing the survey.

## Administering and promotion of the survey

The online survey was open for the period 16 December 2019 - 12 January 2020 and the following methods were used to promote the survey to all RCN members.

- The online survey was accessible on the RCN website homepage ([www.rcn.org.uk](http://www.rcn.org.uk)) and a news story featured on social media accompanied by a formal press release which was sent to trade organisations. The survey was also advertised on Nursing Standards.
- The Glove Awareness campaign webpage on the RCN website was updated to include a prominent pop up icon directing members to the survey portal

- Nursing Times website published an article about the survey
- An email targeting RCN Forum members and the Infection Prevention Control network was circulated.
- Within the RCN organisation blogs were sent to all staff and RCN working group members engaged directly with professional leads and regional and country communications leads as well as informal networks to encourage wide promotion of the survey through all member channels.

The online survey took approximately 10 minutes to complete and paper surveys were not available.

## Data storage, data management and analysis

Data generated from each survey was retained in an online survey database administered by the Information Technology department at the RCN. Access to the online dataset was password protected and restricted to working group employed by the RCN.

Data collected from members was anonymised and pooled with other respondents. No personal identifiable information was collected from members nor was feedback provided on the results to individual employer organisations.

At the end of the survey period data was exported into excel spreadsheets, cleaned (excluded those ineligible) and graphs produced and initially analysed. We excluded n=63 respondents who identified as 'retired' and 'unemployed' from the analysis on the basis that these respondents were not in the workplace at the time this survey was undertaken which meant there was no impact of skin health due to current work practices and we also excluded partially completed survey (n=466).

For the purpose of the report, basis descriptive analysis was conducted on the data and the results are presented herein. We did not perform any inferential statistical analysis on the data due to the non-random sample used in the study.

# Presentation of results and discussion of key findings

Please refer to the appendices for a full set of graphs detailing a full breakdown of all responses.

## Demographics

The Royal College of Nursing had a total of 435,000 members at the time of the survey. All members were invited to contribute to the survey, of which 2074 completed the survey. 1608 members completed the survey in full and 466 members partially completed the survey.

## Survey population

The majority (91%, n=1390) of respondents were female followed by males (8%, n=127) and most were aged 25–64 years (90%, n=1390). The majority of respondents identified their ethnicity as White (89%, n=1367) followed by Black (4%, n=59) followed by Asian (3%, n=46). Over half (60%, n=920) of respondents work in hospital-based ‘acute’ areas of practice, with the remaining working in community, children, mental health or other sectors.

## Employment region and status

The majority of respondents who employed in England (81%, n=1254) followed by Scotland (10%, n=154), Wales and Northern Ireland (5%, n=76 and 4%, n=61 respectively).

The majority of respondents were employed at the time of the survey (92%, n=1428), with student nursing staff representing a small proportion (4%, n=62) of all responses. Seventy four percent (74%, n=1143) of respondents were employed in the National Health Service (NHS) followed by independent health care organisations and primary care (GP practices) (14%, n=220 and 7%, n=98 respectively), with the majority (74%, n=1135) of respondents having worked for their current employer for 3 years or longer. Over half of respondents (66%, n=1012) reported that they worked full-time and a third (31%, n=477) were in part-time employment. Less than half (45%, n=445) reported working shift lengths on 12 hour or more with the remaining reported that they either worked 8 hours or less or mixed shift patterns (33%, n=325 and 22%, n=215 respectively).

## Skin health and hand dermatitis, and its impact on work

A past history of atopy (as well as being female and exposure to irritants in the workplace) is known to increase an individual’s susceptibility for developing hand dermatitis in the future (Coenraads & Diepgen, 1998). In this survey we found that 71% (n=1088) of respondents reported a past history of either hay-fever, asthma or eczema anywhere on the body which is considered predictive risk factors for developing skin problems in the future and if problems arise, can then impact of the future prognosis (Lerbaek, Kyvik, Ravn, Menné, & Agner, 2008).

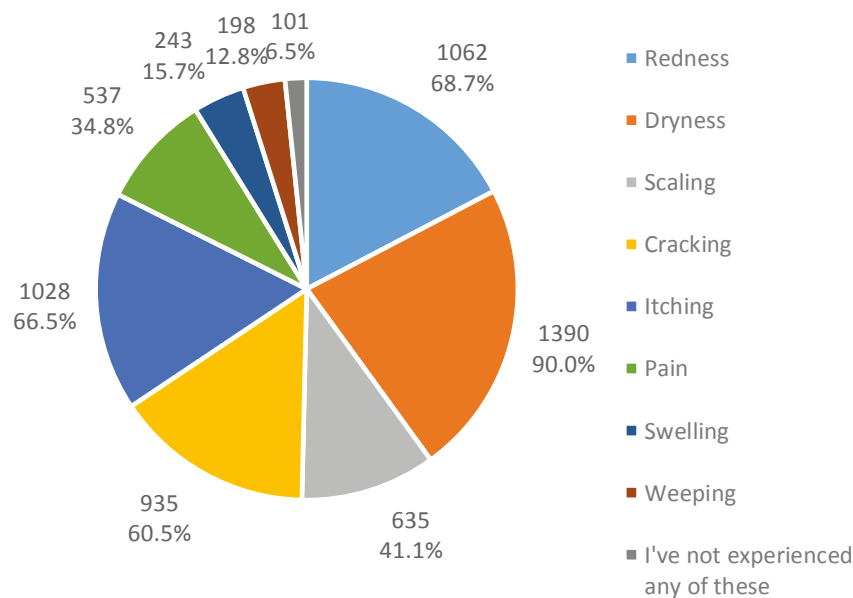
At the time of this survey approximately half (46%, n=709) of respondents rated the current condition of their hands as ‘poor’ or ‘very poor’ with less than a third (27%, n=413) rating their skin as ‘good’ or ‘very good’. Approximately a quarter (27%, n=421) of respondents were neutral in their self-rating of their skin condition.

Moreover, we found 23% (n=358) of respondents reported a previous diagnosis of hand dermatitis by a treating physician and this is broadly consistent with prevalence rates in health care workers observed in previous research (Madan et al., 2019; Skudlik et al., 2009; Smit, Burdorf, & Coenraads, 1993; Thyssen et al., 2010). The causes of work-related dermatitis were mostly attributed to glove and soap usage as well as excessive hand hygiene actions (39/131, n=30%; 36/131, n=27%; 36/131, n=27% respectively). Of those who reported a past history of hand dermatitis, over a quarter (27%, n=291) also reported a history of atopy (history of hay fever, asthma, eczema). Of the respondents who reported a previous diagnosis of hand dermatitis, the time point of when diagnosis were made remained fairly consistent over time and did not vary (i.e. increase or decrease) with length of service. Moreover, while over 71% (n=139) of respondents reported the cause had been identified, the survey did not enquire about the possible predictive risk factors (work and non-work related) which may have triggered the onset skin problems. Accordingly, it is possible respondents may have engaged in activities (e.g. housework, carer duties) outside the workplace

which may have increased their susceptibility for developing skin problems.

Nevertheless, as illustrated in figure 1, an important finding from this survey was that vast majority (93%, n=1444) of respondents self-reported that in the previous 12 months they had experienced a range of potentially debilitating symptoms on their hands/wrists which had the capacity to impact on work functioning and quality of life, with redness and dryness the most common complaint. This was in contrast to far fewer (7%, n=101) respondents who reported experiencing no symptoms during the same period.

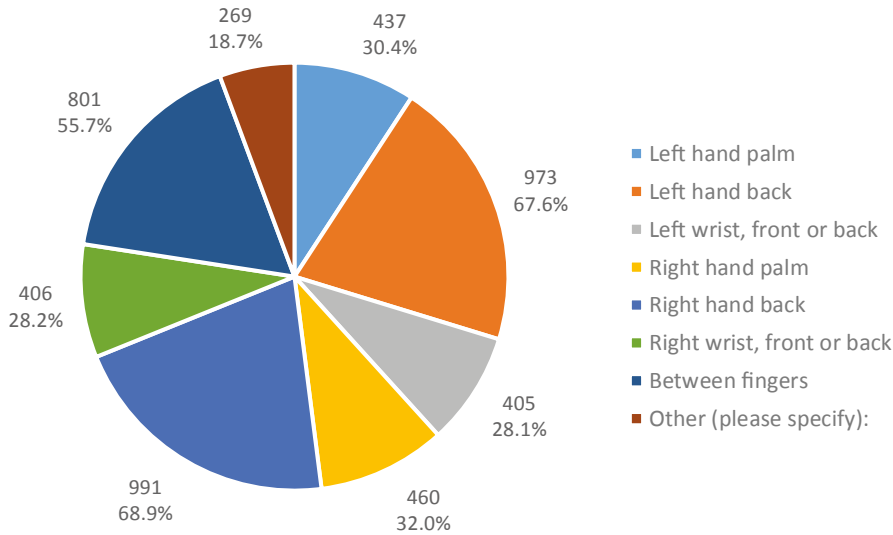
**Figure 1: Self-report assessment of skin symptoms in previous 12 months**



The results shown in figure 3 should not be regarded as evidence of hand dermatitis but rather a revealing insight into the general condition of respondents' skin health which were based on self-assessments and reflections in the absence of objective clinical assessments by a physician.

In this survey we also found that the most common region for experiencing skin problems was at the 'back of the hands' or 'in-between fingers' which is consistent with previous research examining the extent of skin problems in health care workers (Thyssen et al., 2010) (figure 2). These regions are more prone to skin problems mainly due to the thinner layer of skin coupled with poor drying techniques after handwashing.

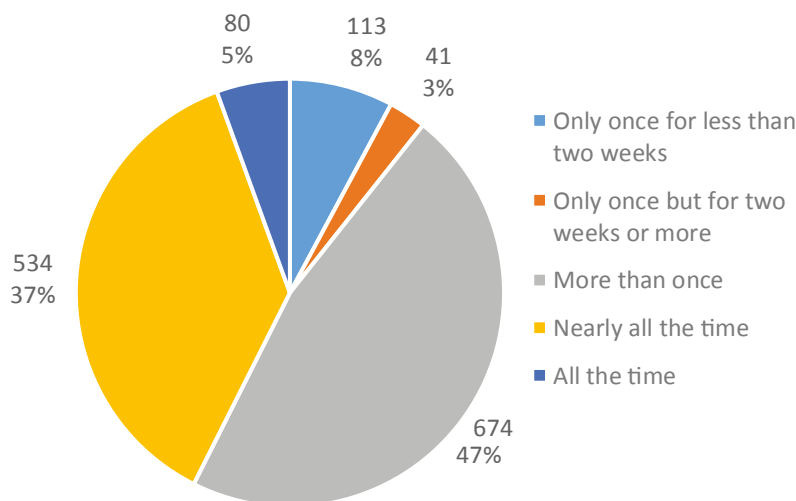
**Figure 2: Location of skin problems**



At the time this survey was conducted over half (51%, n=728) of respondents were currently experiencing skin problems on the hands/wrists, of which nearly half (42%, n=614) reported that symptoms were present ‘all’ or ‘nearly all’ of the time. Moreover, almost all respondents reported experiencing skin problems at some point in the previous 12 month period (figure 3).

One hundred and thirty one respondents suggested one or more reasons for their symptoms: wearing gloves (n= 39), soap (n= 36), excessive use of alcohol hand gel (n= 24) and having an allergy (n= 15). Miscellaneous reasons each suggested by five or fewer respondents included: exposure to chemicals

**Figure 3: Frequency of skin problems in the previous 12 months**



A particularly worrying finding was that the majority (78%, n=1124) of respondents chose not to report skin problems to anyone in the workplace when symptoms developed despite organisational policies (particularly in the NHS sector) which generally require staff to do so. Over half of respondents only decided to disclose skin problems to their manager or seek further advice and support from their local occupational health department, with 43% (n= 138) preferring instead to disclose and seek advice from outside the workplace (GP or pharmacist), suggesting that some nursing staff may have genuine concerns about the possible consequences of disclosing skin problems to their employers. This has important implications from an occupational health and infection prevention policy perspective, and highlights the need to better understand the barriers and drivers which influence the reporting of skin problems in the workplace.

Moreover coupled with the decision by nursing staff to disclose skin problems, it is important to consider how this also influences their decisions to engage in proactive help-seeking when symptoms are impacting on work, for example when to abstain from work or request work adjustments where necessary to do so. Furthermore, we found a large proportion of respondents expressed concerns that taking time off work due to skin problems would be viewed negatively by peers/managers and that any leave taken would have a detrimental impact on their colleagues in terms of reduced staffing levels (figure 4). This seems to suggest that it is important for nursing staff to demonstrate commitment to their job role by remaining at work despite experiencing skin problems. This was further evidence by the very small proportion (2%, n=33) of respondents who reported taking time off work in the previous 12 months due to skin problems. The decision to take time off work was also more likely to occur as the number of skin problems (symptoms) increased e.g. of the 33 respondents who took time of work due to skin problems, all had experienced three or more symptoms during the previous 12 months. Furthermore, when sick leave was taken due to skin problems the duration varied considerably i.e. 43% (n=20) were for seven days or less compared to 30% (n=10) for 14 days or more. It is important to consider this in the context of the broader issue of high presenteeism observed in the nursing workforce e.g. the RCN's biannual employment survey found the majority of all respondents (84%)

reported that they had gone to work at least once in the previous 12 months, despite feeling too ill to do so (RCN, 2019). This is also reflected on the overall NHS staff survey which found that 56% of respondents (across all NHS workforce) reported attending work in the last three months despite not feeling well enough to work (NHS England, 2020). Collectively these issues further highlight the important role that the workplace culture (including management support) can play in facilitating or inhibiting help-seeking behaviours by staff when skin problems arise.

In addition, for those who sought advice either from occupational health and managers because of skin problems, 83 respondents then required work adjustments (relocated to a different work setting) to support them to remain at work, of which nearly three-quarters (70%, n=57) required work adjustments in place for 14 days or longer. Approximately three quarters required work adjustments due to 'dryness', 'redness' and 'dryness' symptoms and over half in response to 'cracking' and 'scaling' symptoms.

Figure 4: Reasons for continuing to work

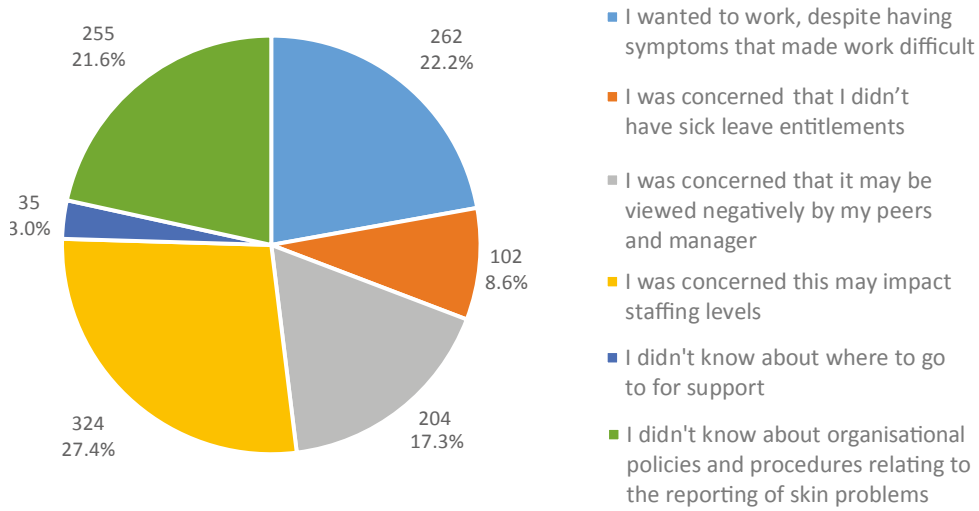
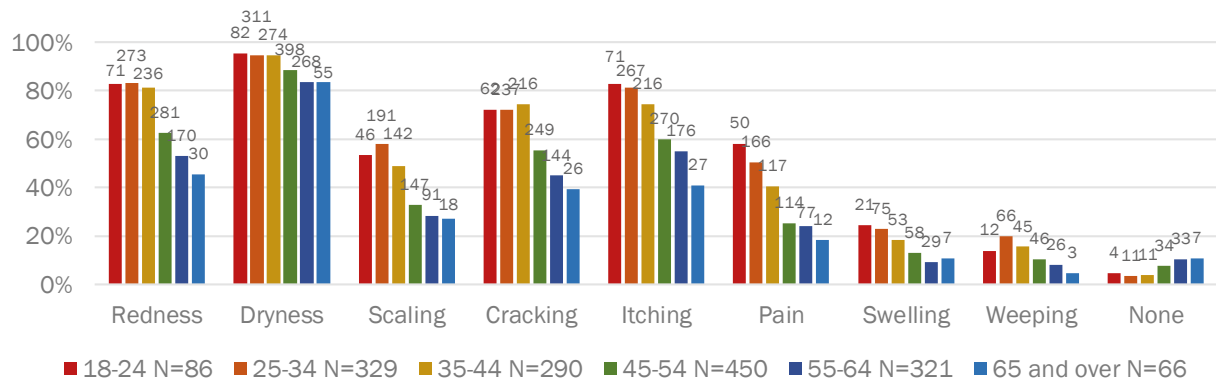


Figure 5: Symptoms and Age



As illustrated in figure 5, the most common skin problem (symptom) experienced by all nursing staff regardless of age was 'dryness'. However, we found that younger nursing staff (18-44 years) were more likely to experience multiple skin problems with 'redness', 'cracking' and 'itching' most common. The high prevalence of symptoms in younger health care workers is consistent with previous research which has shown that nursing staff are typically at increased risk of developing skin problems soon after starting their nursing training (Skudlik et al., 2009; Smith et al., 2006). Conversely, the survey found that symptoms were generally experienced less often as nursing staff progressed in their nursing career, however, this should not be taken as evidence that increasing workplace exposure and age are protective factors for the development of skin problems in nursing staff.

#### Symptoms, job role and shifts (hours/type)

As highlighted above, in this survey approximately 80% (n=1388) of respondents across all job roles (student, community nursing, management, hospital based, mental health, other) reported 'dryness' as the most commonly experienced skin problem (symptom). However we did not find any noteworthy variation in the number of hours worked (<8 hours or >12 hours or more) or shift type (full-time vs part-time) and the proportion of nursing staff who experienced specific symptoms, suggesting that an increase in time spent in the workplace did not lead to an increase the risk of respondents developing skin problems (symptoms).

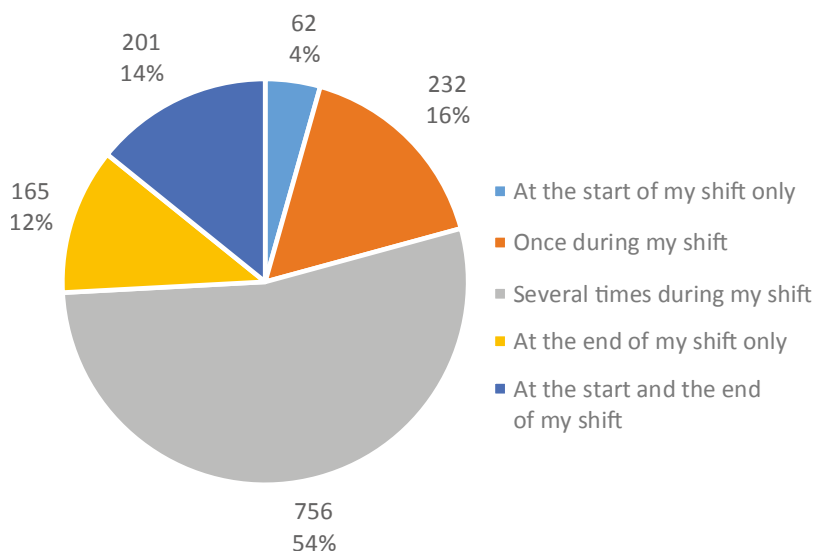
#### Impact of skin problems on hand hygiene measures and work

In this survey we found that skin problems can discourage nursing staff from engaging in ongoing protective behaviours to minimise the transmission of pathogens (such as using antibacterial gels for decontamination or the wearing of gloves when performing clinical tasks) particularly if pain or discomfort is experienced or where there are genuine concerns are held that these type of preventative action may irritate an existing condition. For example we found over half (53%, n=758) of respondents had to either limit or stop using sanitiser or washing their hands/wrists with soap and water and 18% (n=258) had to limit or stop wearing examination or surgical gloves when skin problems developed. In particular, we found that the presence of symptoms relating to 'dryness', 'redness', 'cracking' and 'itching' were more likely to discourage nursing staff from engaging in good hand care practices (use of anti-bacterial gels or wearing gloves).

#### Use of moisturising cream which contains emollients

The regular application of hand moisturising creams remains the cornerstone of effective hand dermatitis prevention and treatment (NHS Plus, 2009) and we were encouraged to see that the vast majority of respondents reported using hand creams at least once during the day, with over half using cream several times which is in keeping with current best practice guidelines (Figure 6).

**Figure 6: Frequency of hand cream use at work**

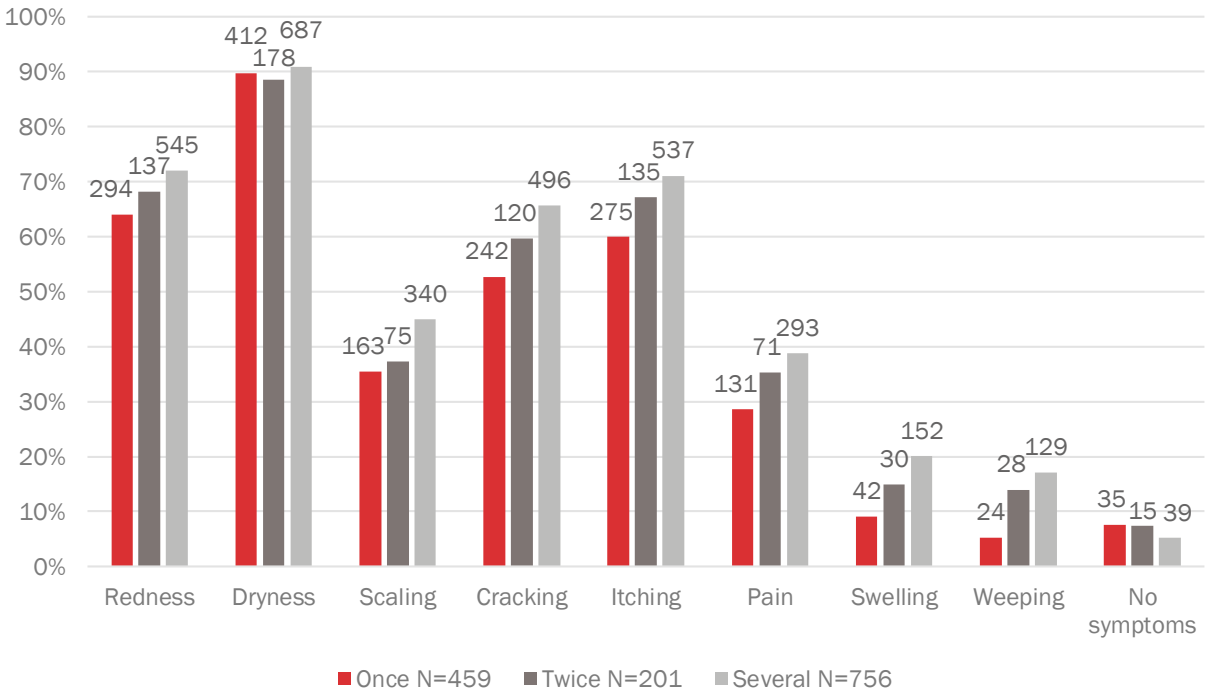


In this survey we found that over of half (51%, n=788) of respondents had a preference for using hand cream products brought into the workplace by themselves as opposed to those who had a preference for using supplies providers by their employer either in individual supplies or those available in ward-based communal dispensers (10%, n=155 and 32%, n=493 respectively). The preference for using personal supplies of hand cream was similar across all workplace settings (hospital based, primary/community care, care homes and other). Nevertheless it was concerning to note that a small proportion either did not have routine access to any moisturising cream in the workplace or had to rely on products supplied by patients/public (6%, n=99 and 1%, n=8 respectively). Moreover, the survey found that community/GP/care home based nursing staff were more likely than hospital based nursing staff to rely on personal supplies of moisturising creams as opposed to supplies issued by the workplace (see table 48 in the appendix). Nevertheless, there is still onus on employers to ensure staff have access to appropriate supplies of moisturising cream at all times in the workplace.

In addition, we compared the frequency of hand cream usage across different workplace settings (hospital, community/primary care, care home and other) and it was encouraging to find that approximately half (48%-56%) of all respondents for each workplace setting reported using hand cream at least several times a days, with less than a quarter (23%-33%) of respondents reporting usage only once per day.

Moreover, as illustrated in figure 7 we found that hand moisturising cream appeared to be used more often as a treatment when one or more symptoms ('dryness' and 'redness') had developed rather than being applied as a preventative measure. More specifically, of those that applied hand cream several times a day there were only 5% (n=39) who reported no symptoms despite the potential impact of exposures in the workplace (wet-work) and current guidelines which recommend regular usage during shifts as an important preventative measure.

Figure 7: Symptoms and Creams Usage





In addition, we also compared respondents self-rating of the condition of their hands with the frequency of hand cream usage and found wide variation in responses. In particular, there was a large proportion of respondents (46%, n=651) who self-rated the condition of their hands as poor/very poor despite in this group using hand cream either once or several times a day compared to a small proportion of respondents (27%, n=376) those who rated their hands as good/very good when using hand cream.

(When interpreting the above information it is important to note that for the question 'What hand cream/emollients do you have access to in the workplace', respondents were not able to select 'all options which apply' to their own experience therefore the responses are most likely 'which cream they are most likely to use' rather than 'which cream they have access to').

### **Education and training relating to skin care at work**

Another important finding from this survey related to the provision of education and training to equip nursing staff with the knowledge and skills required to engage in good hand care practices at work. In this survey, we found less than half (42%, n=643) of respondents across the various workplace settings (NHS, primary care, independent health care organisations or other) reported that they had received skin care health information or training, with even fewer (26%, n=397) having received any specific guidance on how to spot the early warning signs of work-related dermatitis. This finding was of particular concern given the requirement for NHS organisations in particular, to provide hand hygiene training across their workforces either at induction or as part of mandatory updates.

### **Routine health surveillance and skin checks at work**

In this survey we found only 16% (n=239) of respondents reported that hand/wrist skin checks were carried out in their workplace in the past 12 months and this raises concerns about the lack of routine skin health surveillance across health care sector. Where skin checks were provided we found wide variation in who was responsible for conducting these (manager,

colleague, occupational health team, infection control team) and also in the frequency of when they occurred (i.e. 8%, n=19 'monthly' compared to 55%, n=132 'annually').

From an occupational health and infection prevention policy perspective, embedding an effective workplace skin health surveillance approach for monitoring and detecting skin issues remains a challenge for many health care organisations, and this issue continues to gain prominence in light of recent changes to regulatory compliance requirements set out by the Health and Safety Executive (HSE) (Health and Safety Executive, 2020a). Nevertheless, it is important to recognise that implementing an effective mass workplace health surveillance response which complies with HSE guidance will have significant resource and financial implications for organisations. In response to this, health care organisations under the direction of occupational health and infection prevention teams, are exploring new and novel surveillance systems which are pragmatic in their approach and effective in identifying occupational skin disease among workers whilst mitigating against the risk of future enforcement and financial penalties for non-compliance. Such approaches could include embedding skin surveillance part of routine work practices e.g. during one-to-one meetings between staff and managers, team meetings, annual flu jab clinics or health and safety training days. One such approach would be to implement a reliable screening tool nursing staff could use to self-assess and report the presence or absence of skin problems namely, hand dermatitis. Researchers who led on the SCIN trial (Madan et al., 2020) developed and tested the reliability of such a tool which included one question i.e. 'In your opinion, do you currently have hand/wrist dermatitis?' with the response options Yes/No/Unsure. The researchers found that nursing staff (including student nursing staff) were overwhelmingly able to reliably self-assess themselves as 'not' having hand dermatitis and so have recommended that this tool be used as part of future mass skin health surveillance. The benefits of using such a tool is that is clinically- and very cost-effective to deliver and that only positive cases would need to be follow-up for formal assessment and management (Further details are outlined under Recommendations).

## **Awareness of RCN Glove Awareness Week and suggested strategies to improve skin health**

In this survey we are interested in better understanding members' general awareness and knowledge the RCNs Glove Awareness campaign, and importantly to identify areas where further promotional work is required. Of the total number who completed the survey, only 26% (n=398) of members reported that they were aware of the Glove Awareness Week. Of this, over half (64%, n=251) received information about the campaign directly from the Royal College of Nursing with lesser (28%, n=109) gaining awareness via social media platforms. The workplace environment and professional publications (including the Nursing press) were less effective in raising the profile of the campaign to the nursing workforce. Nevertheless this survey captured valuable feedback from members on how skin health might be improved. This question was answered by 477, most providing more than one suggestion. These included: greater publicity to raise awareness of skin problems, for example campaigns, promotional materials and via social media (n=122), better access to hand cream or more effective hand cream (n=98), better hand hygiene products (n=75), improved education for health workers such as how to care for hands and occupational health entitlements (n=69), increasing managers' awareness of skin problems (n=45), better gloves (n=17), regular skin checks (n=15) and better access to occupational health services (n=14). A number of suggestions were made by individuals that are not easily achievable such as better staffing or shorter shifts. There were also a few suggestions not compatible with standard infection prevention protocols: cooler tap water (it is maintained at 60°C or higher in hospitals to prevent Legionella infection) and replacing paper towels with cotton roller towels (potential for cross-infection). Of the 477 supplying detailed answers, 122 could not identify any action that could be taken. In a few cases individuals had solved the problem for themselves by avoiding exposure to particular chemicals (a different one in each case).

# Recommendations

In light of the findings from this survey the following recommendations are made. These are categorised into employer, employee, RCN (other partner organisation) and regulatory responsibilities with recommended actions that can be taken.

1. Employer responsibilities	Recommended actions
<p><b>Strategies for promoting and supporting good hand care at work (Practice and Education)</b></p>	<ul style="list-style-type: none"> <li>• Employers to ensure that they are meeting the requirements of the COSHH regulations and identifying who is at-risk of hand dermatitis and how they may be exposed, and putting in measures to prevent and manage risk including health surveillance programmes</li> <li>• Employers to ensure robust health surveillance programmes are in place and to consider using existing interactions with staff such as one-to-ones; team meetings, annual flu jab or staff appraisals to check skin. (see next recommendation for more details)</li> <li>• Employers to actively and regularly promote the importance of good hand care at induction and mandatory education updates as well as staff forums (team meetings, during hand over) and to remind staff of skin health information and resources which are available to them</li> <li>• Employers to review and where necessary enhance the availability of moisturising cream as well as the signage used to highlight the location of hand cream dispensers in workplace settings</li> <li>• Employers to consider offering staff free individual supplies of emollient hand cream for use in the workplace</li> <li>• Employers to reinforce the important role that occupational health teams play in providing care and support to staff when skin health issues arise (which may include practical work adjustments to support staff to remain at work as well as fast tracking referral pathway to local dermatology). Employers should also ensure timely management and self-referrals to OH are available.</li> <li>• Employers (individual work location e.g. wards, clinics) to create innovative opportunities for nursing staff to apply hand cream during shifts. For instance, embedding usage of hand cream behaviour as a team activity during shift hand over.</li> <li>• Review and where necessary update hand hygiene training modules to ensure content includes, in addition to advice on when and how to wash hands, practical advice on good hand care practices (i.e. regularly application of hand moisturising cream)</li> </ul>

2. Employee responsibilities	Recommended actions
Strategies for promoting and supporting good hand care at work (Practice)	<ul style="list-style-type: none"> <li>All nursing staff to model good hand care actions and behaviours in the workplace and encourage peers to do so in a supportive manner.</li> <li>Senior organisational leaders and managers to lead by example and to use their professional networks and influence to promote a workplace culture which actively supports good hand care practices.</li> </ul>
Reinforcing the requirement to follow existing hand care policy and procedure (Policy and Practice)	<ul style="list-style-type: none"> <li>All nursing staff to follow recommended hand care advice as outlined in relevant policies and guidelines.</li> <li>All members are reminded of their responsibility to adhere to organisational policies with regard to the disclosure and reporting of skin problems at work.</li> </ul>
3. ROYAL COLLEGE OF NURSING (or partner organisations) responsibilities. (A decision on which organisations should be responsible for leading on each of these will need to be agreed)	Recommended actions
Strategies for promoting and supporting good hand care at work (Education)	<ul style="list-style-type: none"> <li>To coincide with activity supporting the 2020 Glove Awareness Week campaign develop targeted messaging and promotional material which emphasises the benefits of regularly (after, during and after shifts) applying hand moisturising cream at work as a highly effective preventative strategy. In addition, use messaging to demystify the use of anti-bacterial gels as a safe alternative to soap and water. This should include messaging that many anti-bacterial gels contain moisturising ingredients designed to minimise skin irritation when applied as directed.</li> <li>Educational institutions to incorporate evidenced-based hand care information and training as part of pre-registration nursing and midwifery training. This should include the provision of personal supplies of hand moisturising creams containing emollients for students to use during their clinical placements. This would also help to embed the importance of good hand care practices early on in nursing staff' professional training and careers.</li> </ul>
RCN Glove Awareness campaign (Education)	Enhance marketing and promotional activities to raise the profile of the Glove Awareness Week among all members and periods of associated activity.
Dissemination of survey results and future research (Education)	<ul style="list-style-type: none"> <li>Presentation of survey results across professional forums                             <ul style="list-style-type: none"> <li>Glove Awareness Week (2020) activity</li> <li>Faculty/Society of Occupational Medicine conference in Edinburgh</li> <li>Publication of a manuscript in a relevant scientific journal</li> <li>Relevant infection prevention and control, occupational health and employment events</li> </ul> </li> <li>Conduct a qualitative study (focus-group interviews) with members to explore in more detail issues relating to the promotion and prevention of skin health in the workplace as one element of evidence generation to inform clinical practice. In particular this would help to better understand the factors which impact on the uptake hand hygiene measures (including use of hand moisturising cream) and of the reporting of skin problems when issues arise.</li> </ul>

4. Regulator (Health and Safety Executive) (Policy)	Recommended actions
<p><b>Raise the importance of reporting skin problems across all local regulators and health care organisations</b> (Policy and Practice)</p>	<p>Local regulators to promote the importance of reporting of data relating to skin problems to THOR (The Health and Occupation Research Network group based at the University of Manchester) across all health care organisations.</p> <p>This should be aligned with reporting requirements outlined in the 'RIDDOR- Reporting of Injuries, Diseases, and Dangerous Occurrences Regulation which stipulates a reporting procedure to be followed when diagnoses are made for certain diseases, including occupational dermatitis (Health &amp; Safety Executive, 2013).</p>
<p><b>A novel workplace health surveillance approach (Use of an effective screening tool)</b> (Policy and Practice)</p>	<p>The HSE to explore in partnership with the RCN and working group members the viability of adopting the proposed standardised workplace health surveillance screening tool for use in the health care sector.</p> <p>If support for the above proposal is given then employers should explore the practicalities of incorporating this skin surveillance as part of other existing routine workplace interactions e.g. hand hygiene training, one-to-one meetings between staff and managers, team meetings, annual flu jabs sessions/ health and safety training).</p> <p>Where appropriate, skin surveillance should include use the brief 'skin health check' self-assessment questionnaire (such as the tool developed for use in the SCIN trial). This tool only requires nursing staff to answer one question i.e. 'In your opinion, do you currently have hand/wrist dermatitis?' with the response options Yes/No/Unsure. This tried and tested method could be embedded as part of annual hand hygiene training and where positive (yes) or unsure cases are reported then nursing staff are required to take selfie hand photos which are then emailed to local OH teams for formal assessment and follow-up consultation where necessary.</p> <ul style="list-style-type: none"> <li>• To carry out regular proactive inspections of health care establishments to ensure they are meeting the requirements outline in COSHH.</li> </ul>

### Strengths of the survey

- First national survey of RCN members relating to skin health at work
- Respondents represented a diverse range of job roles and workplace settings
- Valuable feedback was obtained to inform future skin health resources and initiatives

### Limitations of the survey

- The results are not fully representative of all RCN members.
- Respondents may have been more motivated to take part in the survey because of strong personal reasons e.g. those with a current or past history skin problems (selection bias).
- Respondents may have had a desire to be seen to be complying with organisational skin health policies by performing the required hand care practices (use of hand cream) in the workplace, and so their responses may not be an accurate reflection of their true skin care practices in the workplace.
- Respondents provided self-report responses (e.g. assessing current skin health and causes of skin problems/hand dermatitis) and so we were unable to verify the validity of these responses in the absences of objective clinical assessments by physicians.
- Respondents may have had difficulty accurately reflecting on their past information and experiences relating to skin health at work (recall bias).

### Conclusion

In this survey we sought feedback from members in relation to their own skin health and its impact on work and quality of life. We also enquired about the range of workplace strategies in place to promote and safeguard good hand care practices such as the training, the availability of hand cream and routine health surveillance. We also used this survey as an opportunity to explore the relationship between the different factors which are known to be associated with hand dermatitis, including its prevention.

A range of recommendations have been proposed in light of the findings from this survey and these will inform future skin health and hand hygiene initiatives.

### Acknowledgements

The working group would like to convey our thanks and appreciation to all RCN members who took part in this survey. Your feedback will make an important contribution to future hand hygiene initiatives developed by the RCN and its partner organisations.

# References

- Coenraads, P. J., & Diepgen, T. L. (1998). Risk for hand eczema in employees with past or present atopic dermatitis. *Int Arch Occup Environ Health*, 71(1), 7-13.
- Consensus Measurement in Hand Hygiene Project Expert Advisory Panel. (2009). *Measuring Hand Hygiene Adherence: Overcoming the Challenges*. Retrieved from Oakbrook Terrace, Illinois:
- Health & Safety Executive. (2011). Dermatitis inspection report 2008/09: Prevention and management of work related contact dermatitis in the NHS acute sector.
- Health & Safety Executive. (2013). RIDDOR-Reporting of Injuries, Diseases, and Dangerous Occurrences Regulation 2013. London: HSE.
- Health & Safety Executive. (2015). Dermal exposure to hazardous substances. Prevention of dermatitis. . London: HSE.
- Health and Safety Executive. (2004). *Medical aspects of occupational skin disease* (Guidance Note MS 24 ). London: HSE Books.
- Health and Safety Executive. (2020a). Health surveillance. Retrieved from [hse.gov.uk/skin/professional/health-surveillance.htm](https://www.hse.gov.uk/skin/professional/health-surveillance.htm)
- Health and Safety Executive. (2020b). Work-related contact dermatitis in the health services. Retrieved from [hse.gov.uk/skin/employ/highrisk/healthcare.htm](https://www.hse.gov.uk/skin/employ/highrisk/healthcare.htm)
- Lerbaek, A., Kyvik, K. O., Ravn, H., Menné, T., & Agner, T. (2008). Clinical characteristics and consequences of hand eczema – an 8-year follow-up study of a population-based twin cohort. *Contact Dermatitis*, 58(4), 210-216. doi:10.1111/j.1600-0536.2007.01305.x
- Madan, I., Parsons, V., Ntani, G., Coggon, D., Wright, A., English, J., . . . Williams, H. C. (2020). A behaviour change package to prevent hand dermatitis in nurse working in the National Health Service: results of a cluster randomised controlled trial. *Br J Dermatol*. doi:10.1111/bjd.18862
- Madan, I., Parsons, V., Ntani, G., Wright, A., English, J., Coggon, D., . . . Williams, H. (2019). A behaviour change package to prevent hand dermatitis in nurses working in health care: the SCIN cluster RCT. *Health Technol Assess*, 23(58), 1-92. doi:10.3310/hta23580
- Meding, B., & Swanbeck, G. (1990). Predictive factors for hand eczema. *Contact Dermatitis*, 23(3), 154-161.
- NHS England. (2020). National Briefing: Summary of the 2019 NHS Staff Survey London UK.
- NHS Plus. (2009). Dermatitis: Occupational Aspects of Management: A National Guideline: Royal College of Physicians.
- NHS Plus. (2011). Diagnosis, management and prevention of occupational contact dermatitis. Concise Guidance to Good Practice series, no 13. London (UK): Royal College of Physicians, Faculty of Occupational Medicine.
- Nicholson, P. J. (2010). Evidence-based guidelines: Occupational contact dermatitis and urticaria. *Occupational Medicine*, 60(7), 502-504.
- RCN. (2019). Biannual Employment Survey. . London UK: Royal College of Nursing.
- Skudlik, C., Dulon, M., Wendeler, D., John, S. M., & Nienhaus, A. (2009). Hand eczema in geriatric nurses in Germany - Prevalence and risk factors. *Contact Dermatitis*, 60(3), 136-143.
- Smit, H. A., Burdorf, A., & Coenraads, P. J. (1993). Prevalence of hand dermatitis in different occupations. *International Journal of Epidemiology*, 22(2), 288-293.
- Smith, D. R., Choe, M. A., Jeong, J. S., An, G. J., Chae, Y. R., & Jeon, M. Y. (2006). Hand dermatitis among korean nursing students. *International Journal of Nursing Practice*, 12(3), 160-165.
- Soltanipoor, M., Rustemeyer, T., Sluiter, J. K., Hines, J., Frison, F., & Kezic, S. (2019). Evaluating the effect of electronic monitoring and feedback on hand cream use in healthcare workers: Healthy Hands Project. *Contact Dermatitis*, 80(1), 26-34. doi:10.1111/cod.13148
- Stocks, S., McNamee, R., van der Molen, H., Paris, C., Urban, P., Campo, G., . . . Agius, R. (2015). Trends in incidence of occupational asthma, contact dermatitis, noise-induced hearing loss, carpal tunnel syndrome and upper limb musculoskeletal disorders in European countries from 2000 to 2012. *Occupational and environmental medicine*, 72(4), 294-303.

Stutz, N., Becker, D., Jappe, U., John, S. M., Ladwig, A., Spornraft-Ragaller, P., . . . Loffler, H. (2009). Nurses' perceptions of the benefits and adverse effects of hand disinfection: alcohol-based hand rubs vs. hygienic handwashing: a multicentre questionnaire study with additional patch testing by the German Contact Dermatitis Research Group. *Br J Dermatol*, 160(3), 565-572. doi:10.1111/j.1365-2133.2008.08951.x

Thyssen, J. P., Johansen, J. D., Linneberg, A., & Menné, T. (2010). The epidemiology of hand eczema in the general population - Prevalence and main findings. *Contact Dermatitis*, 62(2), 75-87.

van der Meer, E., Boot, C., van der Gulden, J., Knol, D., Jungbauer, F., Coenraads, P., & Anema, J. (2015). Hands4U: the effects of a multifaceted implementation strategy on hand eczema prevalence in a healthcare setting. Results of a randomized controlled trial. *Contact Dermatitis*, 72(5), 312-324. doi:10.1111/cod.12313

Visser, M. J., Verberk, M. M., van Dijk, F. J., Bakker, J. G., Bos, J. D., & Kezic, S. (2014). Wet work and hand eczema in apprentice nurses; part I of a prospective cohort study. *Contact Dermatitis*, 70(1), 44-55. doi:10.1111/cod.12131

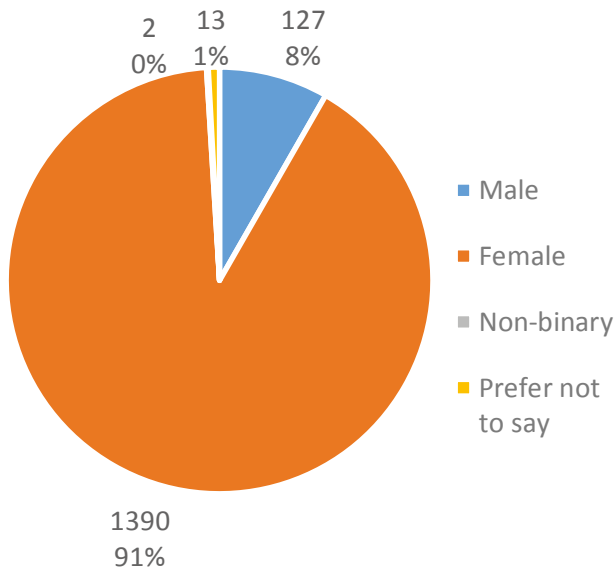


# List of abbreviations

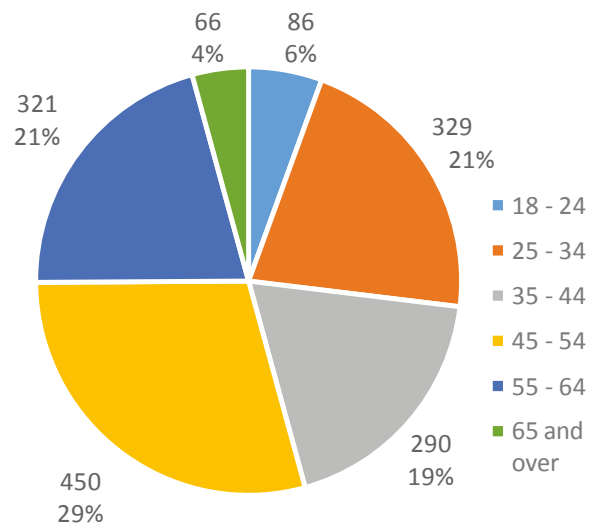
<b>COSHH</b>	Control of Substances Hazardous to Health
<b>GP</b>	General practice
<b>HSE</b>	Health and Safety Executive
<b>NHS</b>	National Health Service
<b>RCN</b>	Royal College of Nursing
<b>SCIN</b>	trial Skin care intervention in nurses trial
<b>THOR</b>	The Health and Occupation Research Network

# Appendix

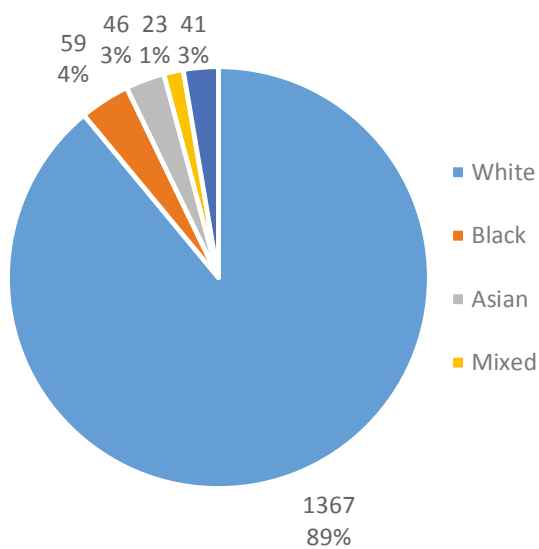
**Appendix 1: Gender**



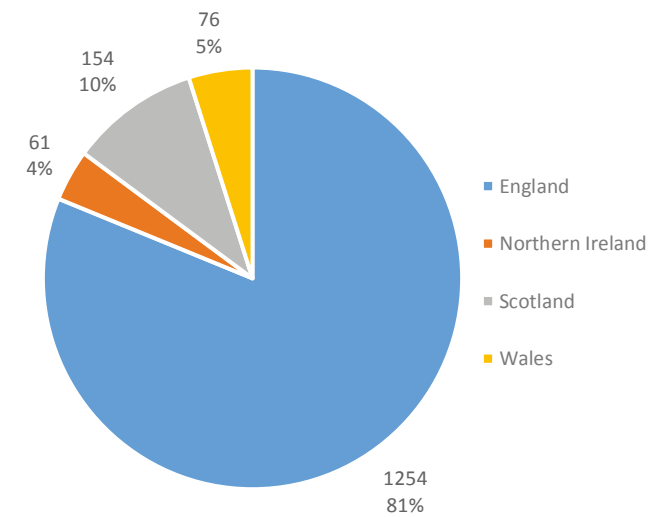
**Appendix 2: Age**



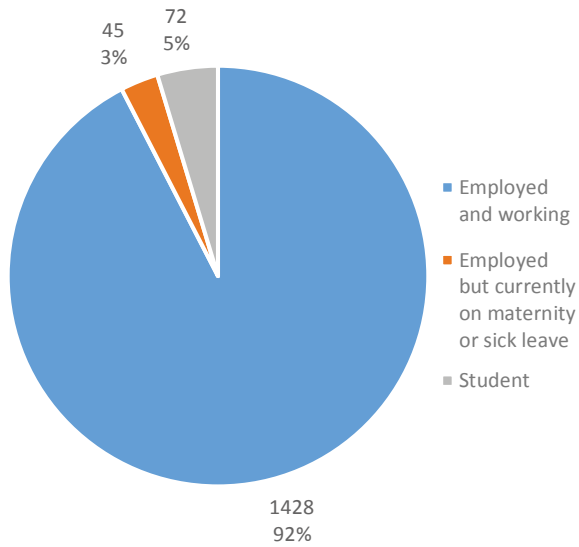
**Appendix 3: Ethnic Group**



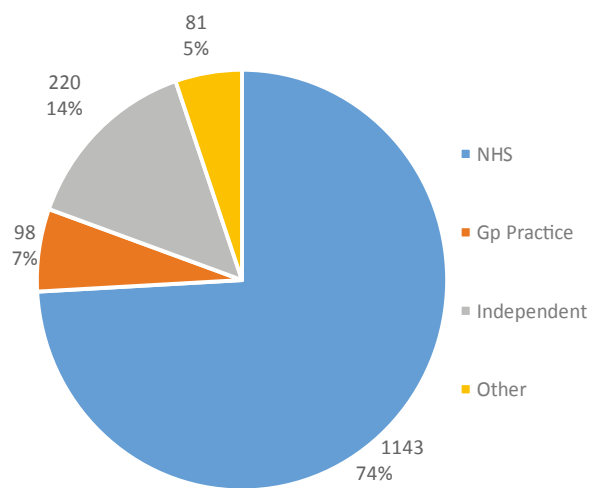
**Appendix 4: Region**



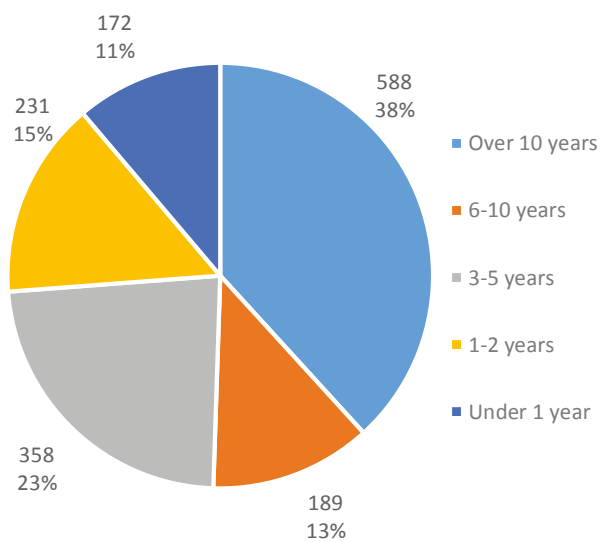
**Appendix 5: Employment Situation**



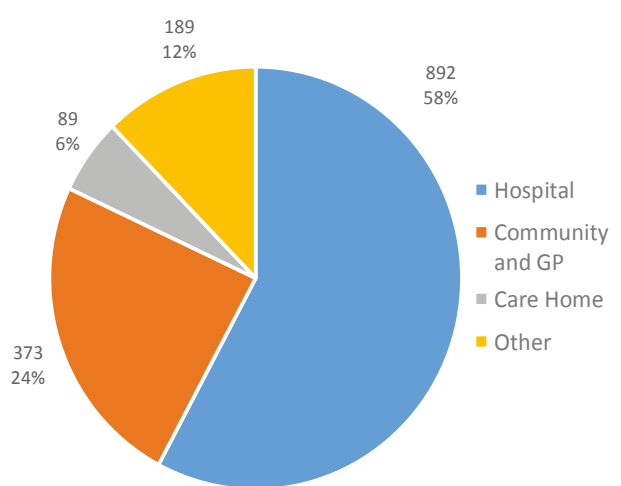
**Appendix 6: Main Employer**



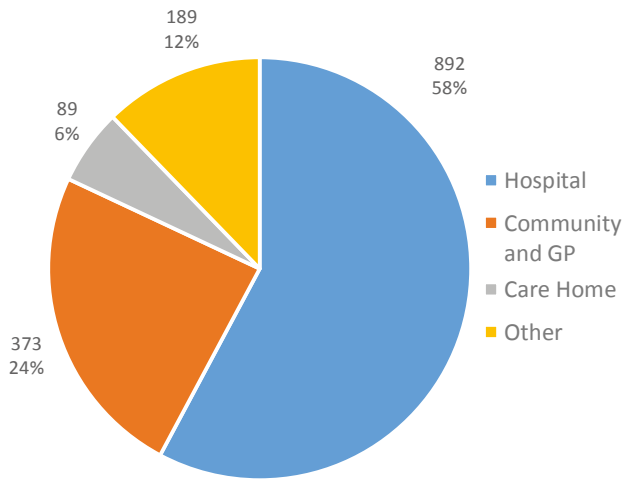
**Appendix 7: Time with Current Employer**



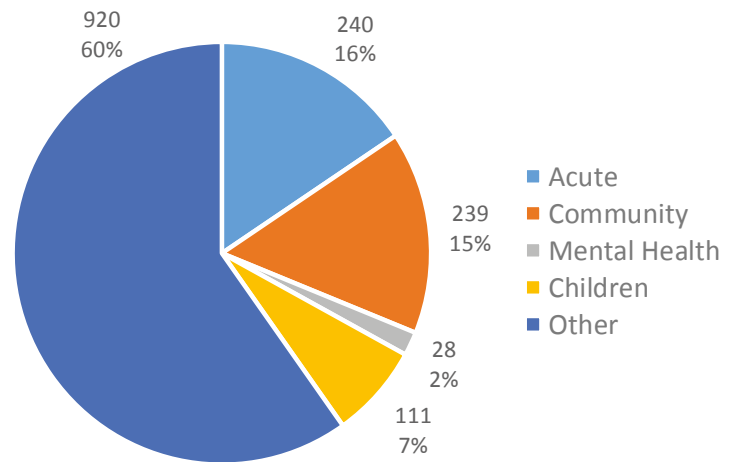
**Appendix 8: Job Role**



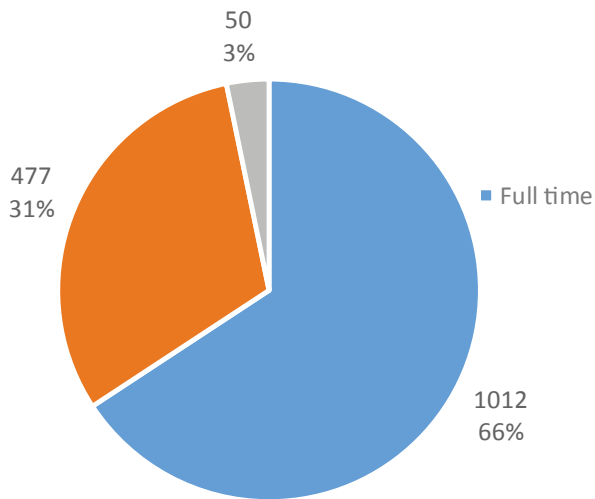
**Appendix 9: Job Setting**



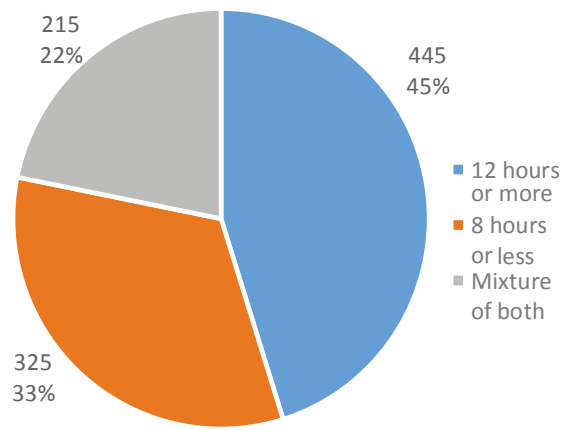
**Appendix 10: Area of Practice**



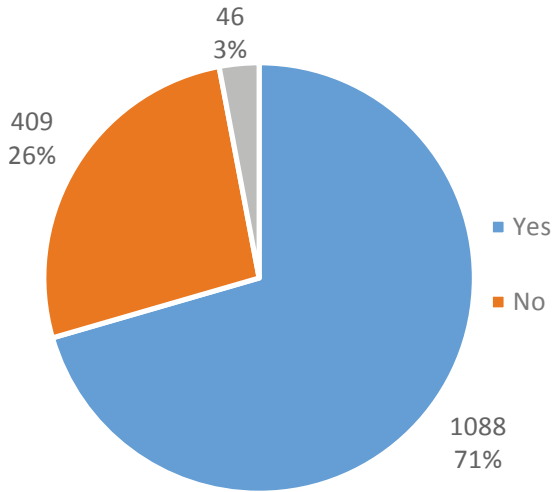
**Appendix 11: Hours Worked**



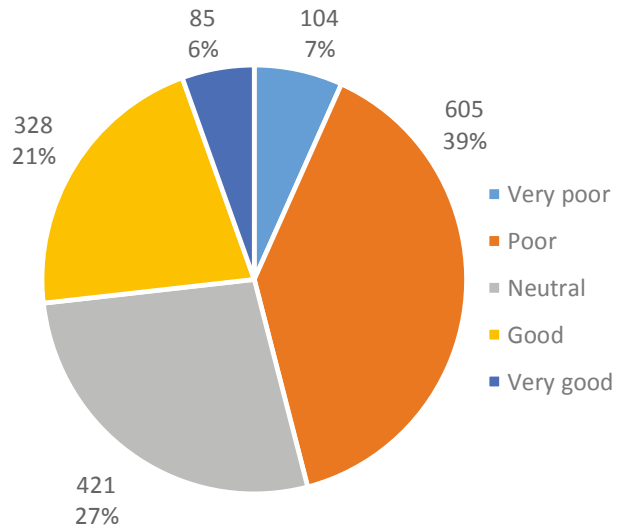
**Appendix 12: Shift Length**



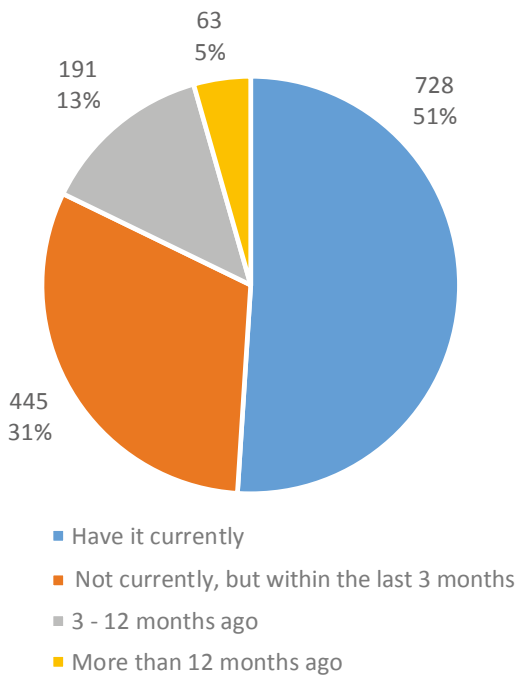
**Appendix 13:** Have you ever suffered from hay fever, asthma, eczema anywhere on the body?



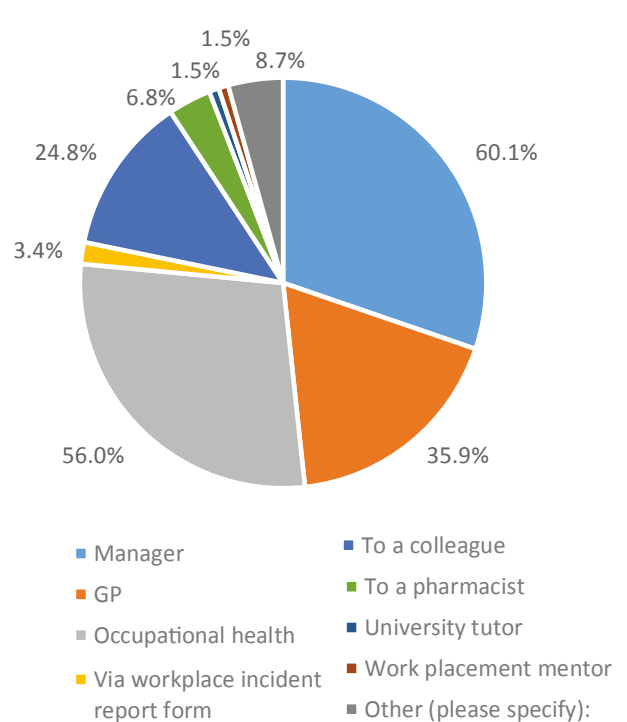
**Appendix 14:** In general, how would you rate the condition of the skin on your hands, including wrists?



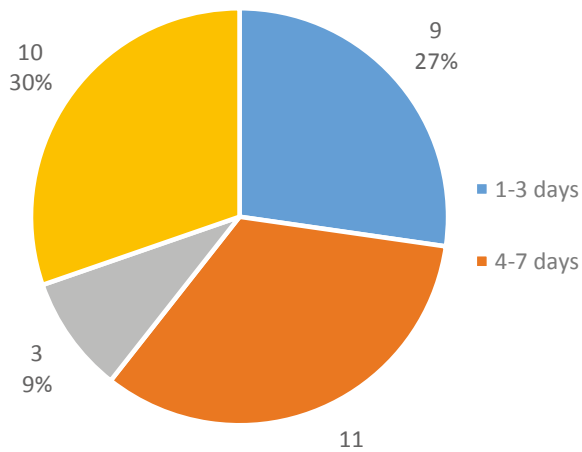
**Appendix 15:** When did you last have skin problems on your hands/wrists?



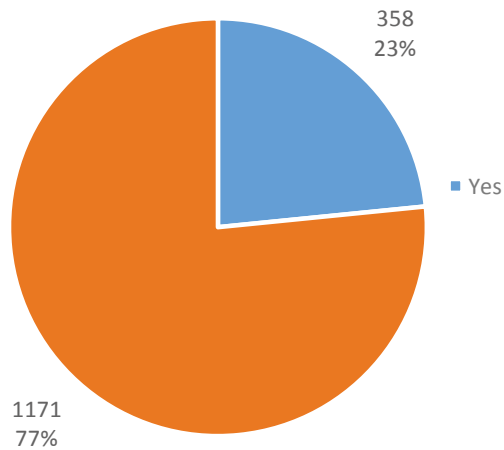
**Appendix 16:** Who did you report the problem to? Select all that apply.



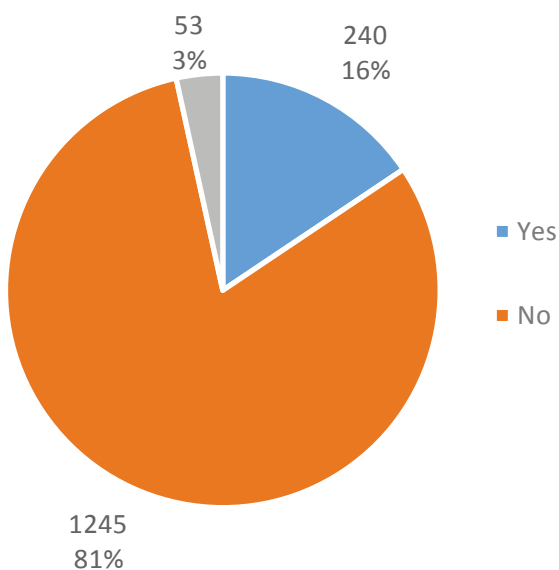
**Appendix 17:** Duration of time off due to problems with skin on hands.



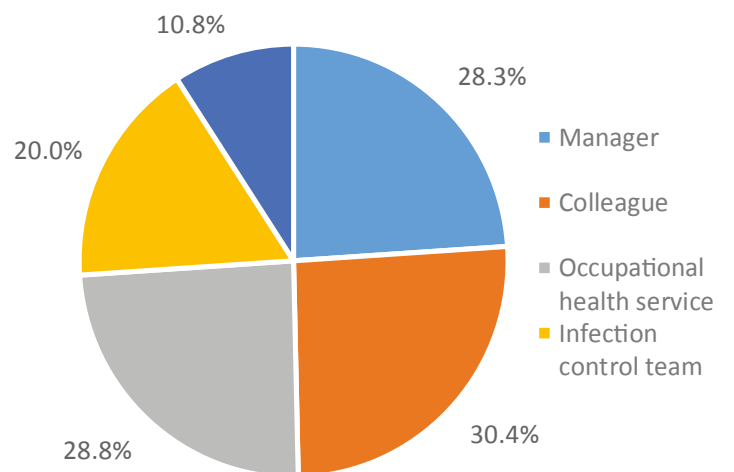
**Appendix 18:** Have you ever been diagnosed by a doctor (GP, dermatologist, occupational health physician or other doctor) as having work-related or occupational dermatitis?



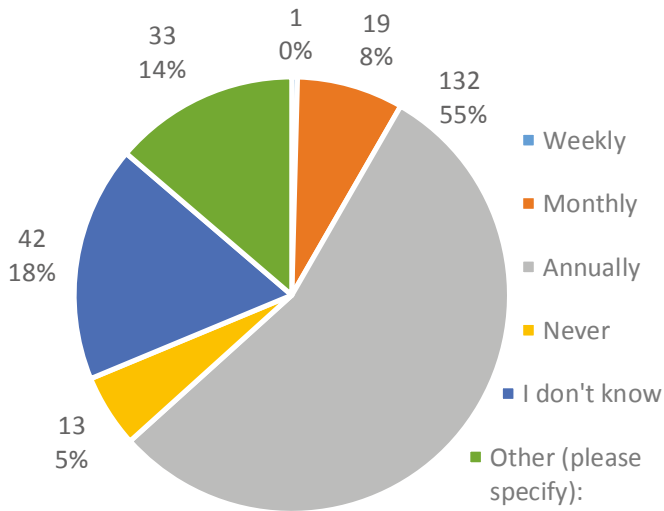
**Appendix 19:** In the last 12 months, have you had a hand/wrist skin check carried out in the workplace?



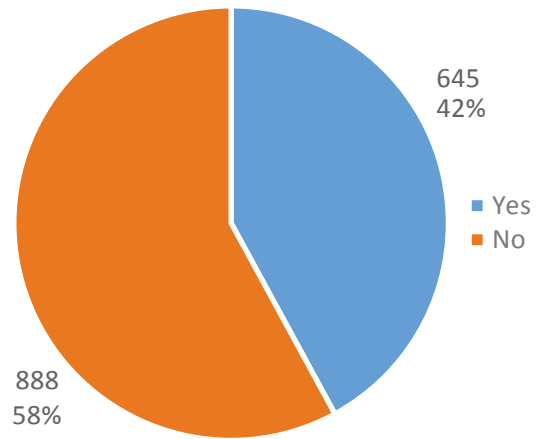
**Appendix 20:** Who carried out the skin check? Check all that apply.



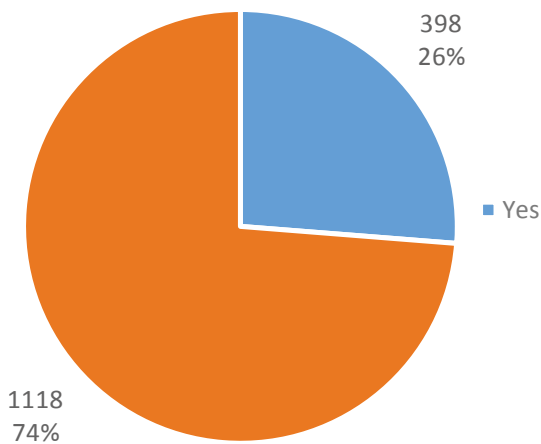
**Appendix 21:** How often are hand/wrist skin checks carried out in the workplace?



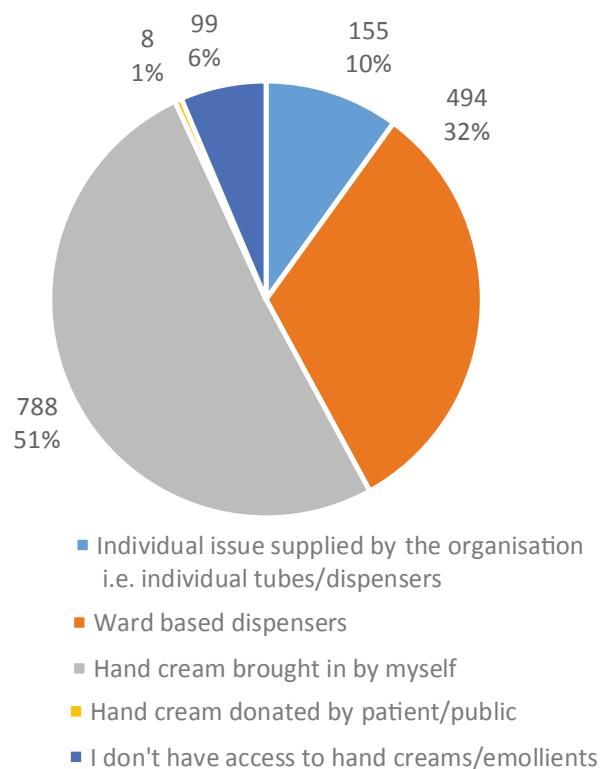
**Appendix 22:** Have you received information/training/education on how to protect the skin on your hands/wrists at work?



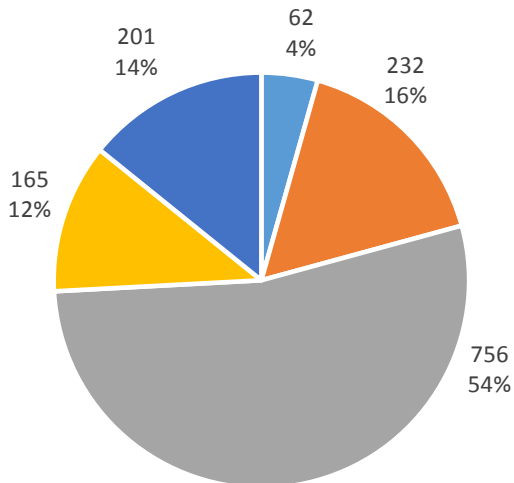
**Appendix 23:** Have you received information/training/education on how to spot the early warning signs of work-related dermatitis?



**Appendix 24:** What hand creams/emollients do you have access to in the workplace?

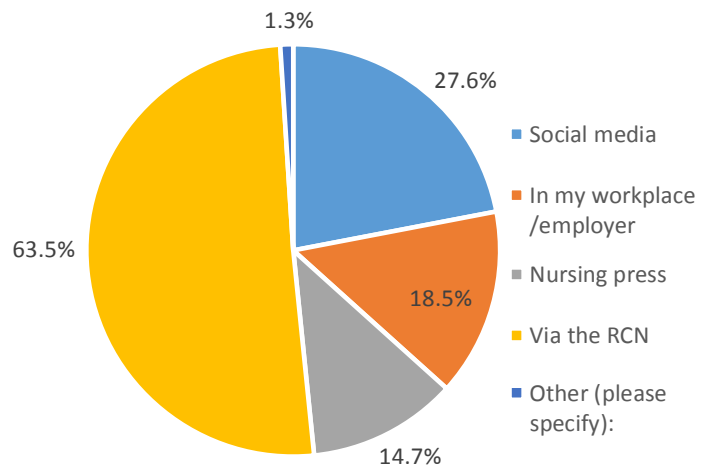


**Appendix 25:** How often do you apply hand cream/emollients while at work?



- At the start of my shift only
- Once during my shift
- Several times during my shift
- At the end of my shift only
- At the start and the end of my shift

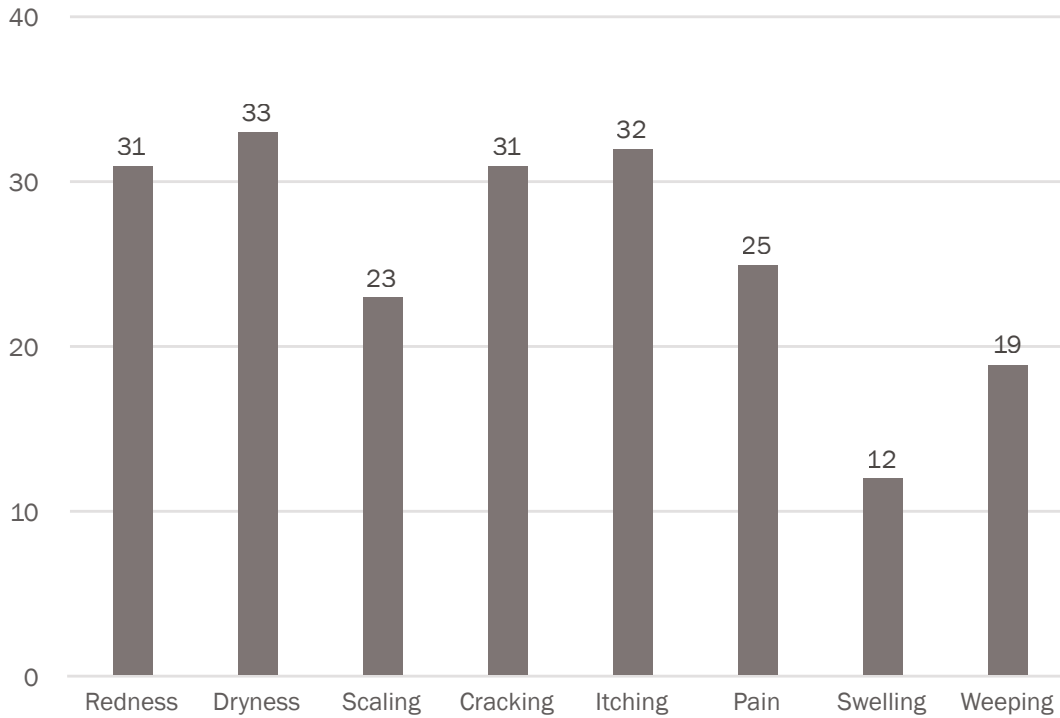
**Appendix 26:** Where did you hear about glove awareness week? Check all that apply.



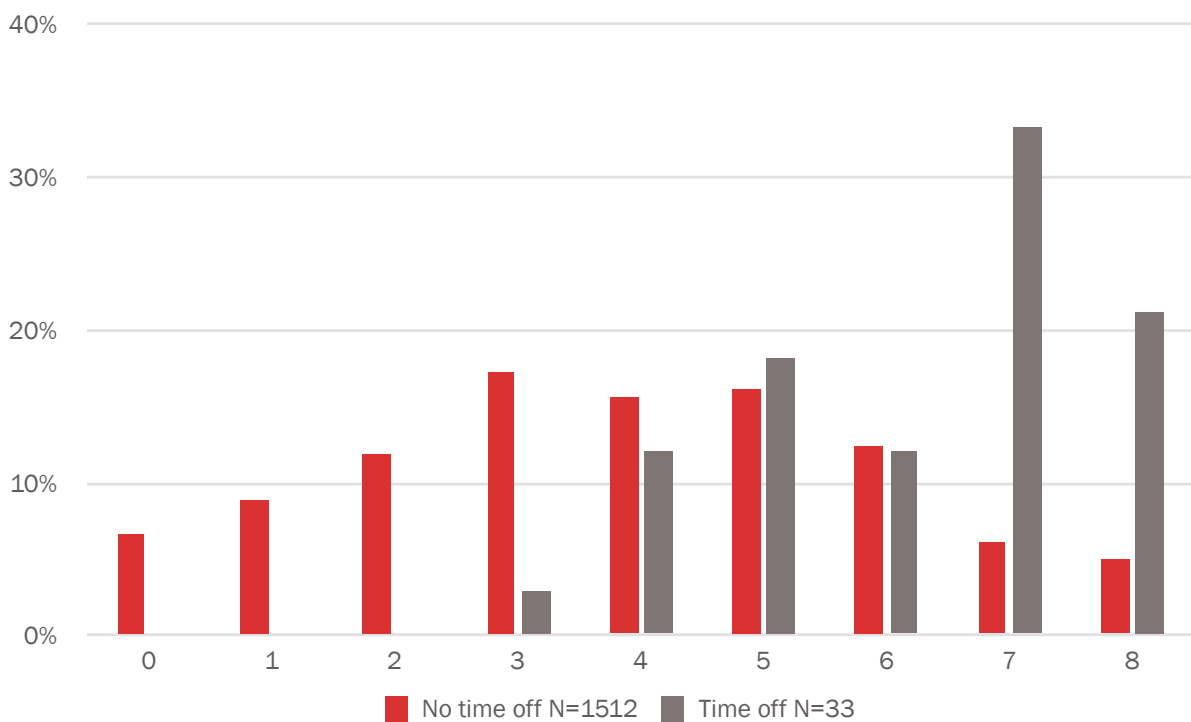
- Social media
- In my workplace /employer
- Nursing press
- Via the RCN
- Other (please specify):



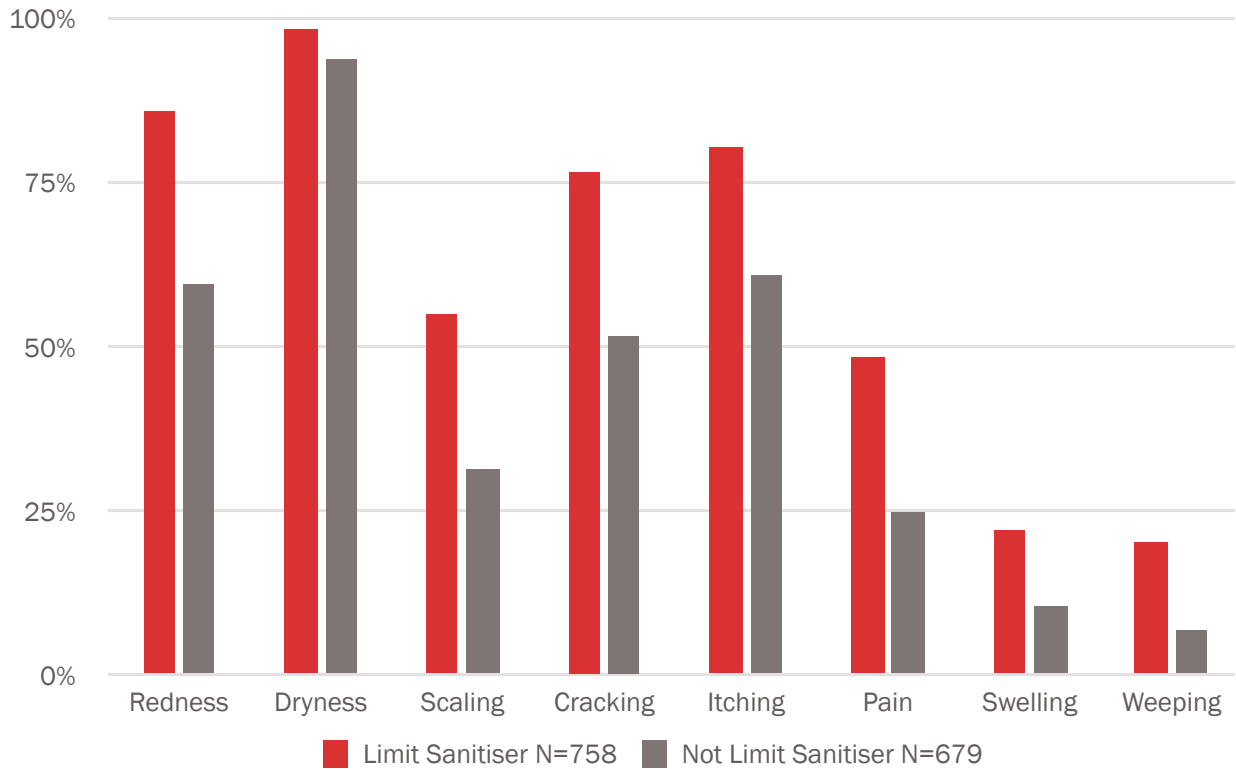
**Appendix 27: Symptoms experienced in those that had time off sick**



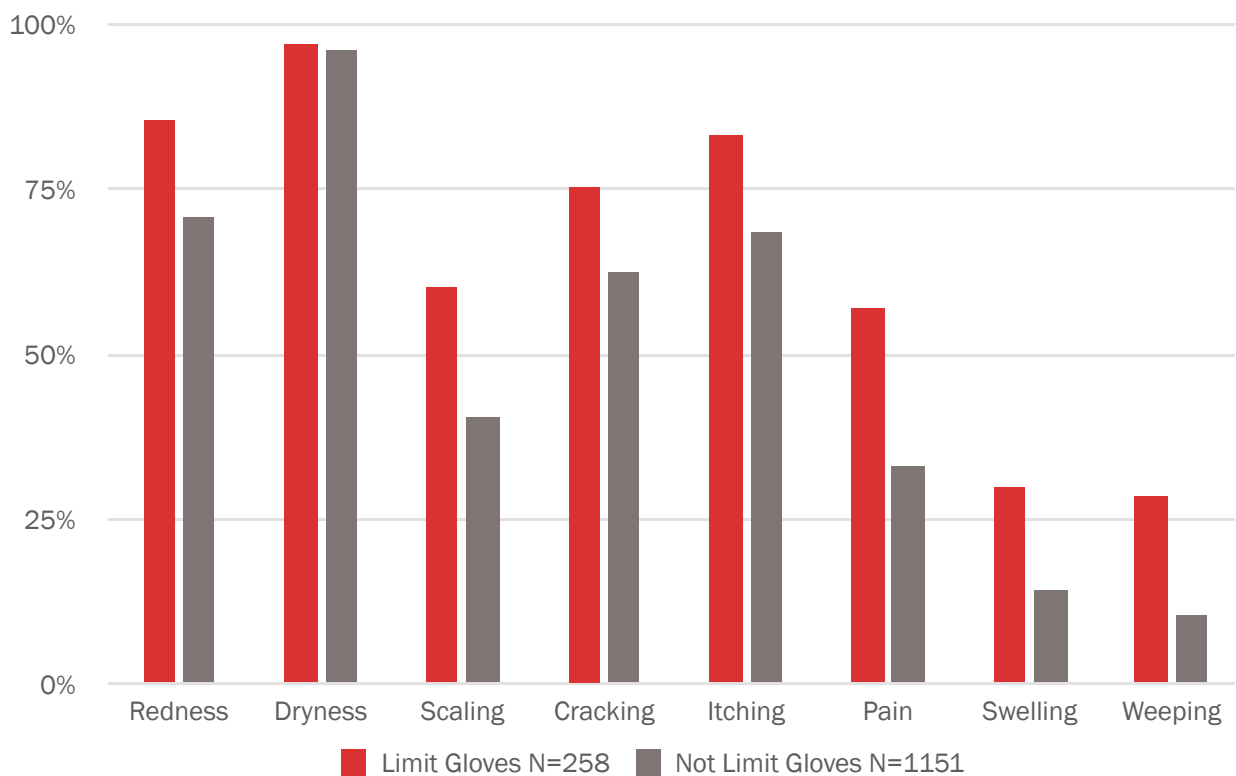
**Appendix 28: No. of symptoms in those that had time off sick due to skin problems and those that didn't have time off due to skin problems**



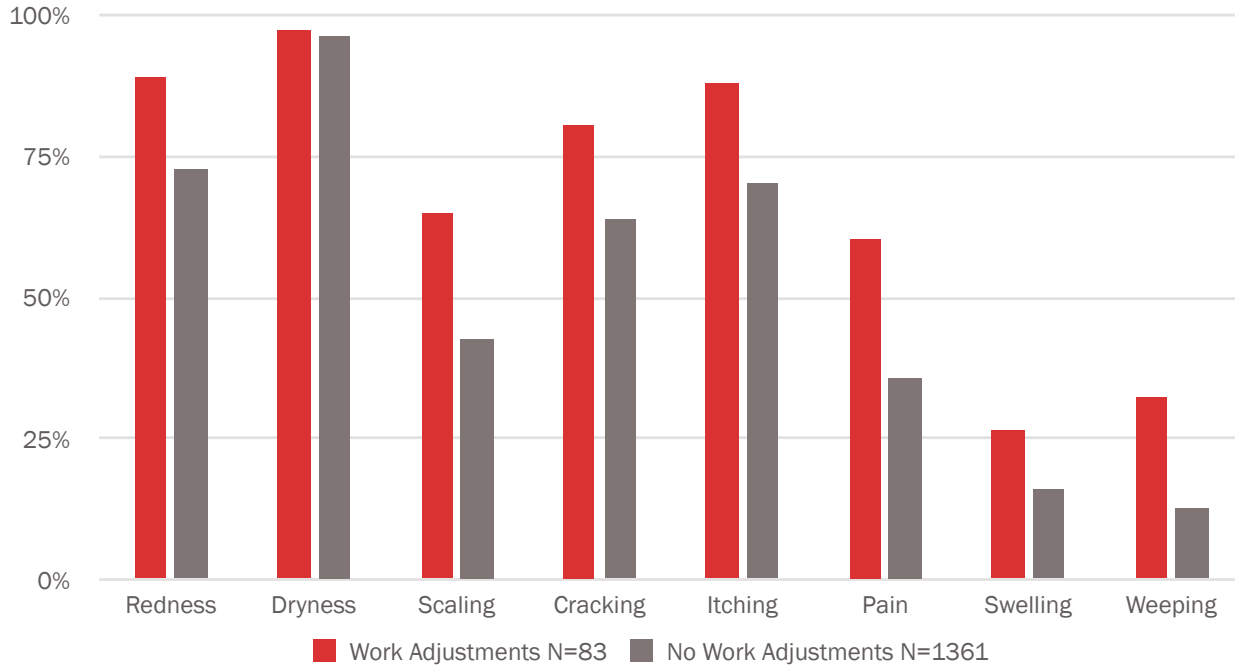
**Appendix 29: Symptoms experience and whether respondents have had to stop or limit use of sanitiser or soap and water**



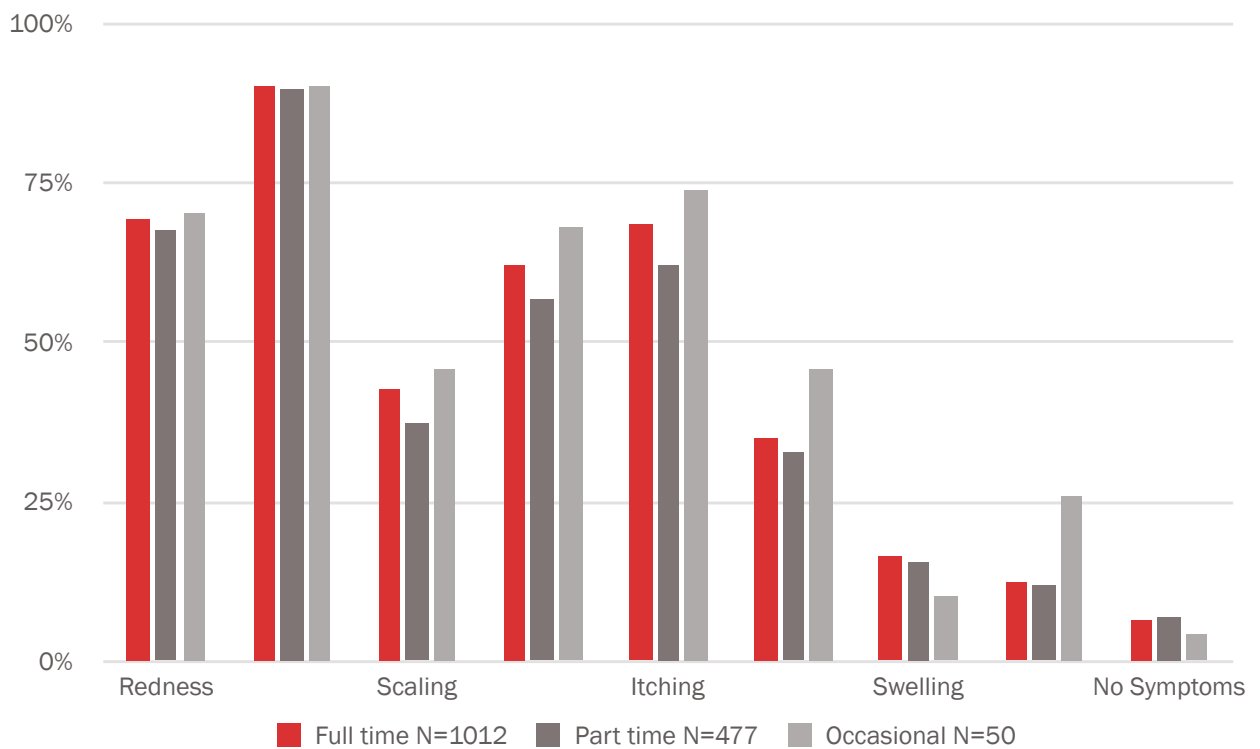
**Appendix 30: Symptoms experienced and whether respondents have had to stop or limit use of gloves**



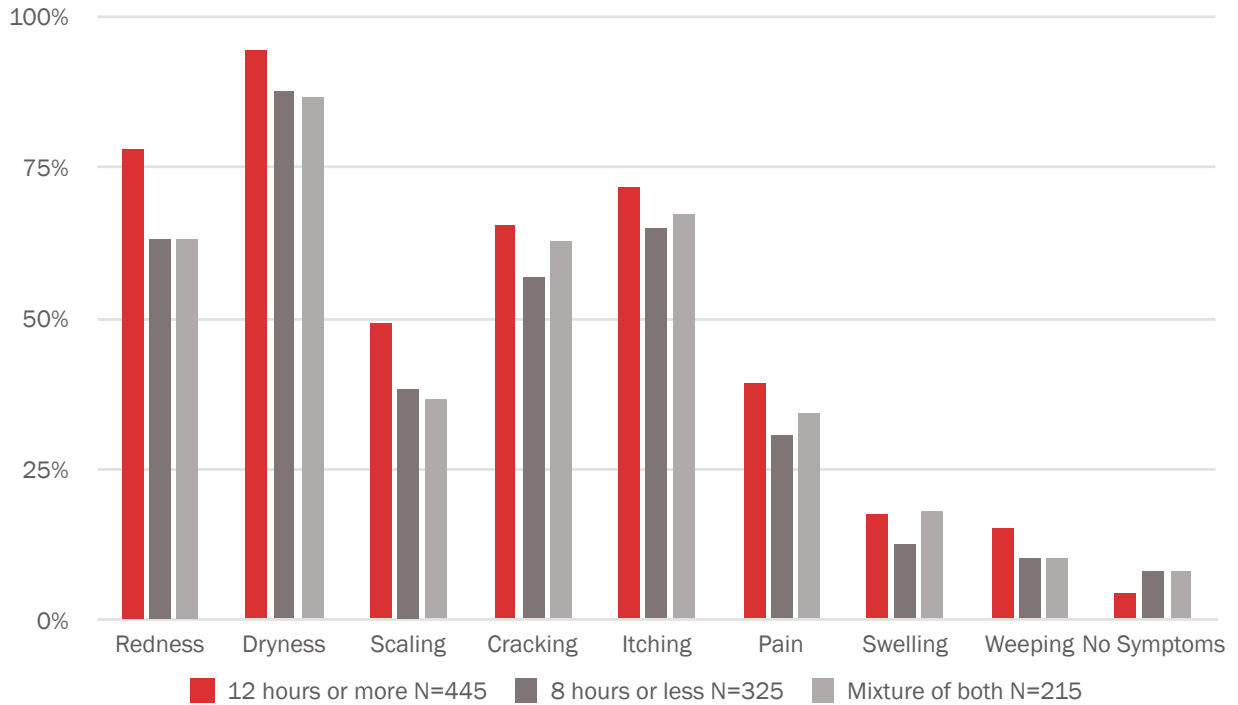
**Appendix 31: Symptoms experienced and whether work adjustments were put in place**



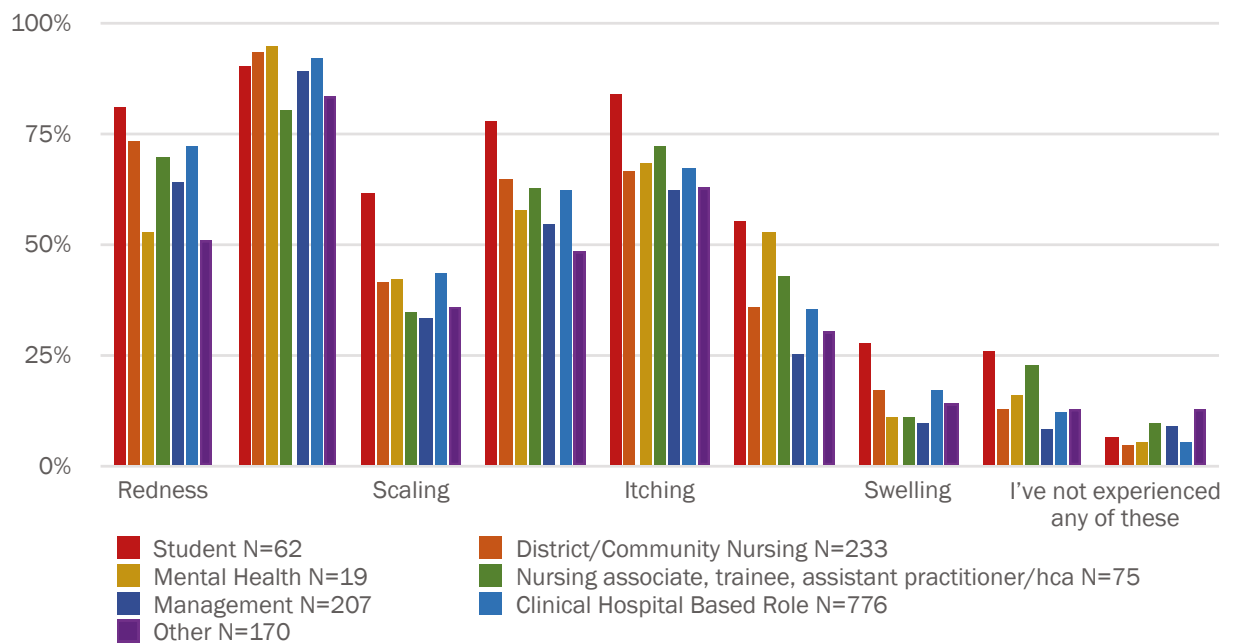
**Appendix 32: Symptoms and hours worked**



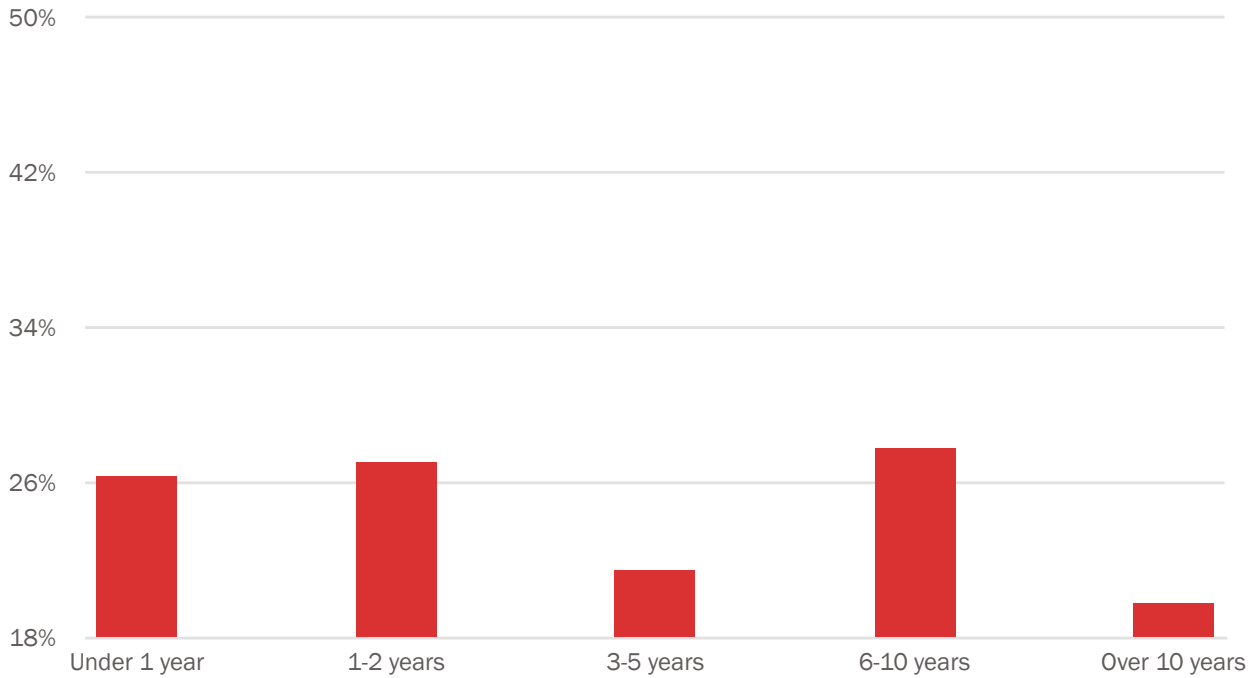
### Appendix 33: Symptoms and shift length



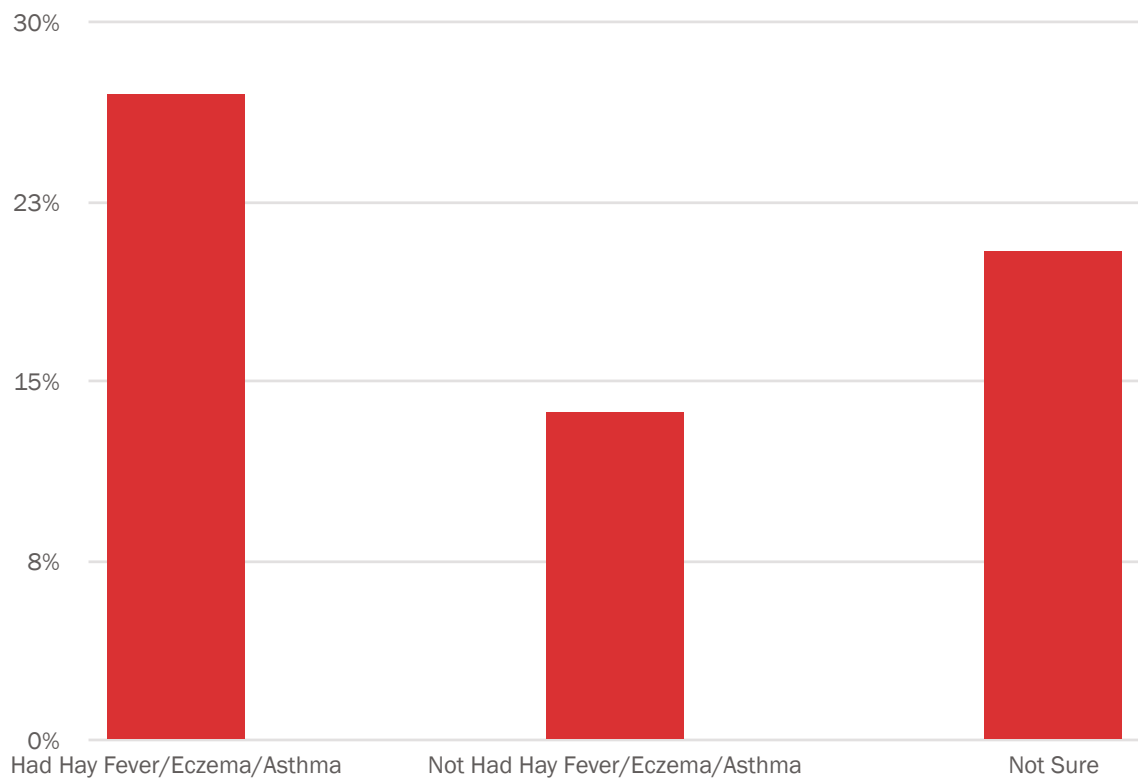
### Appendix 34: Symptoms and job role



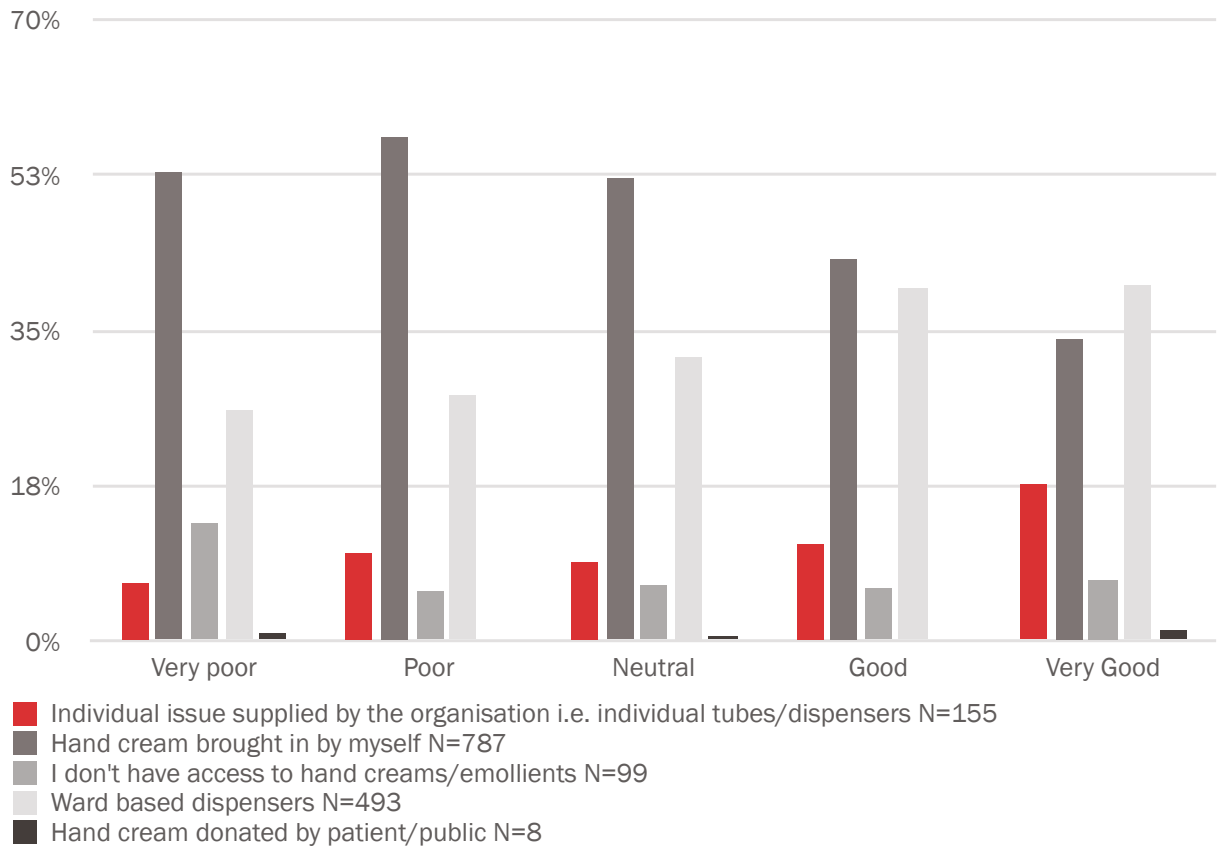
**Appendix 35: Diagnosed dermatitis and years in current post**



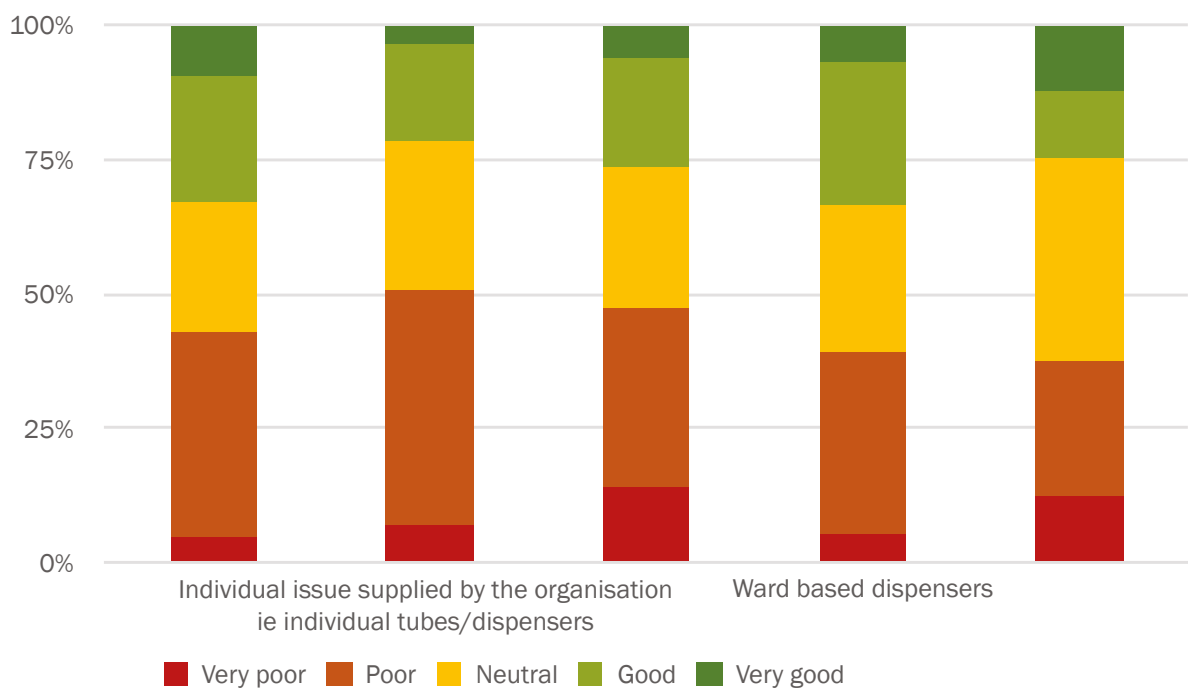
**Appendix 36: Diagnosed dermatitis and past hay fever/eczema/asthma**



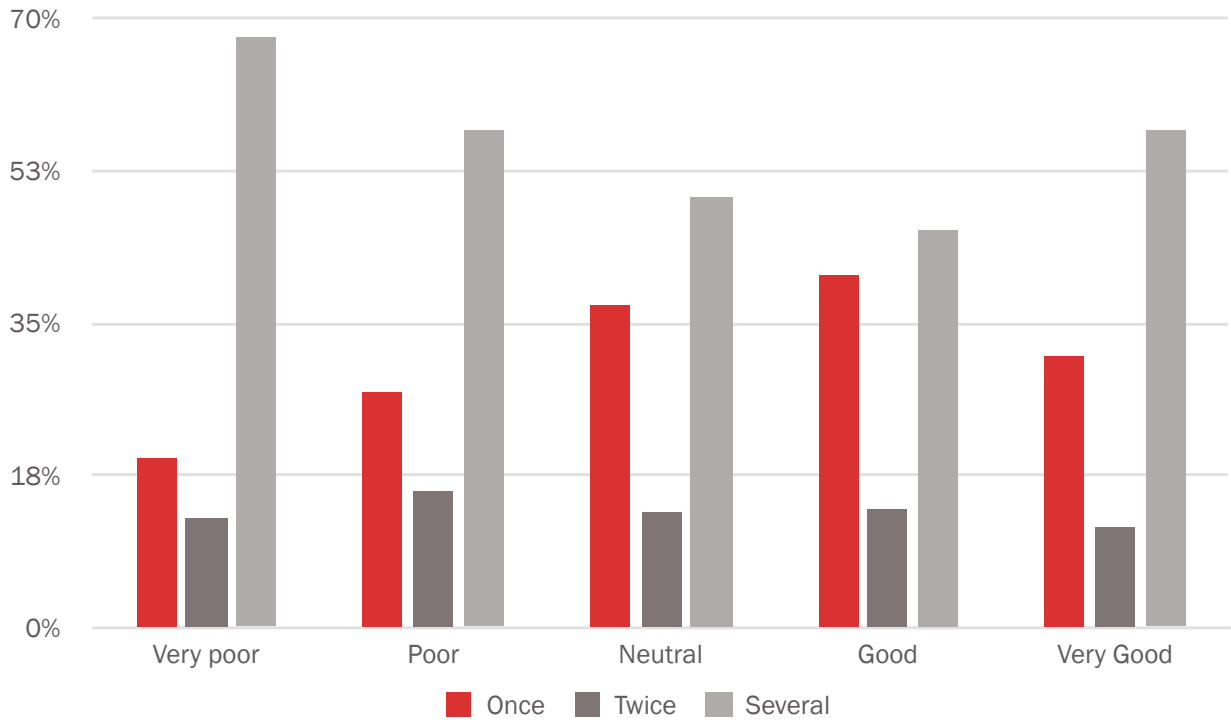
**Appendix 37: Creams access/use and skin condition**



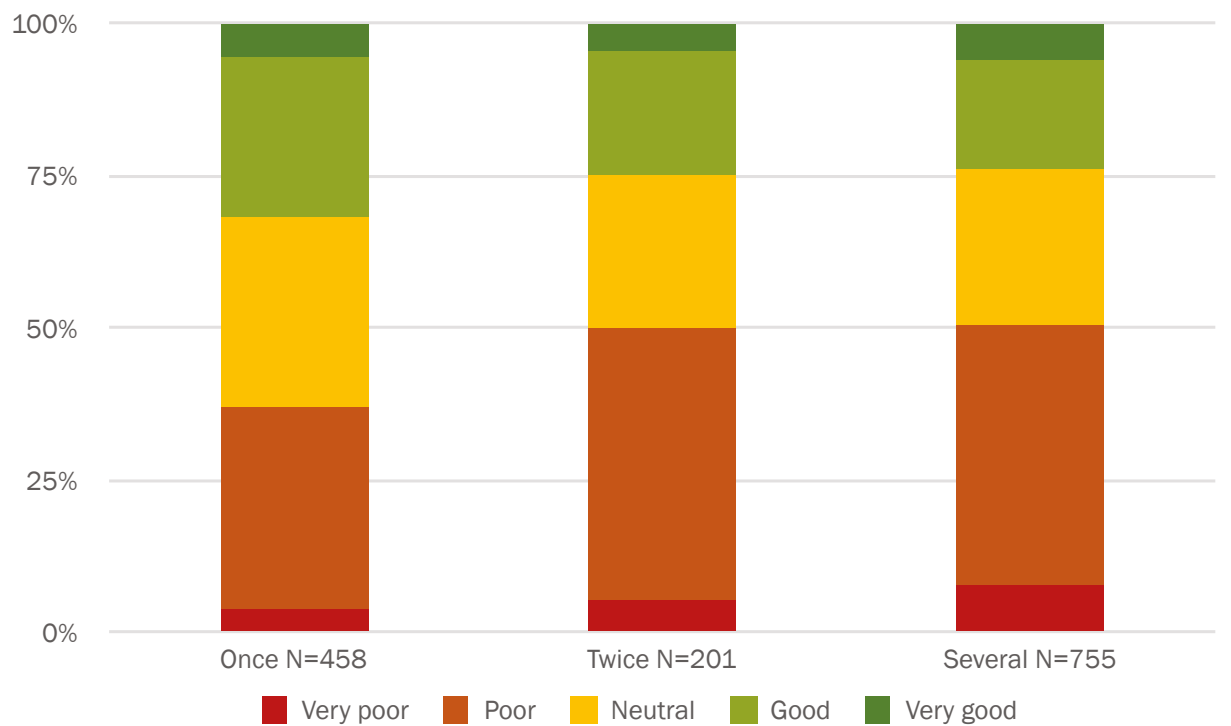
**Appendix 38: Creams access/use and skin condition**



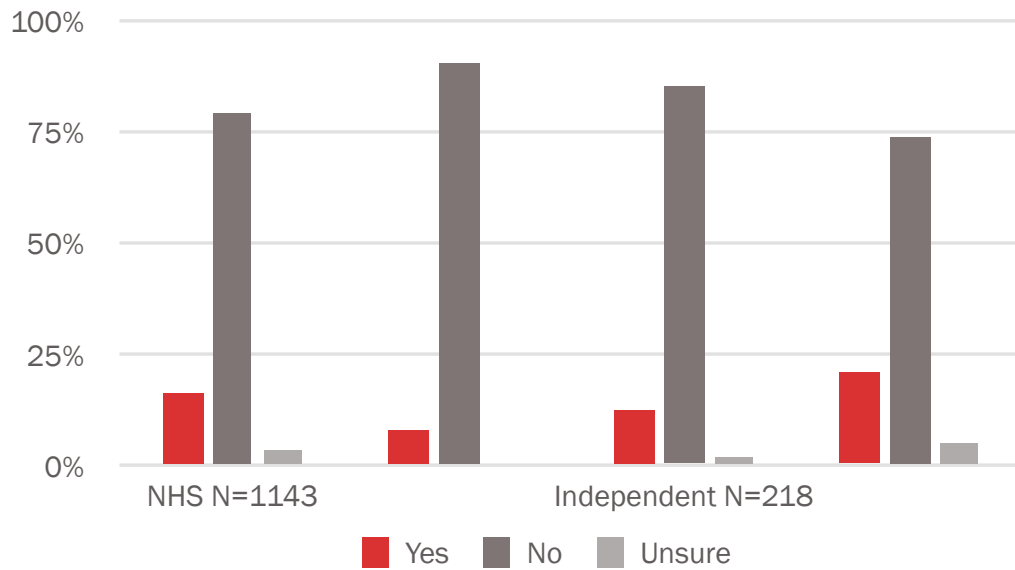
**Appendix 39: Creams usage and skin condition**



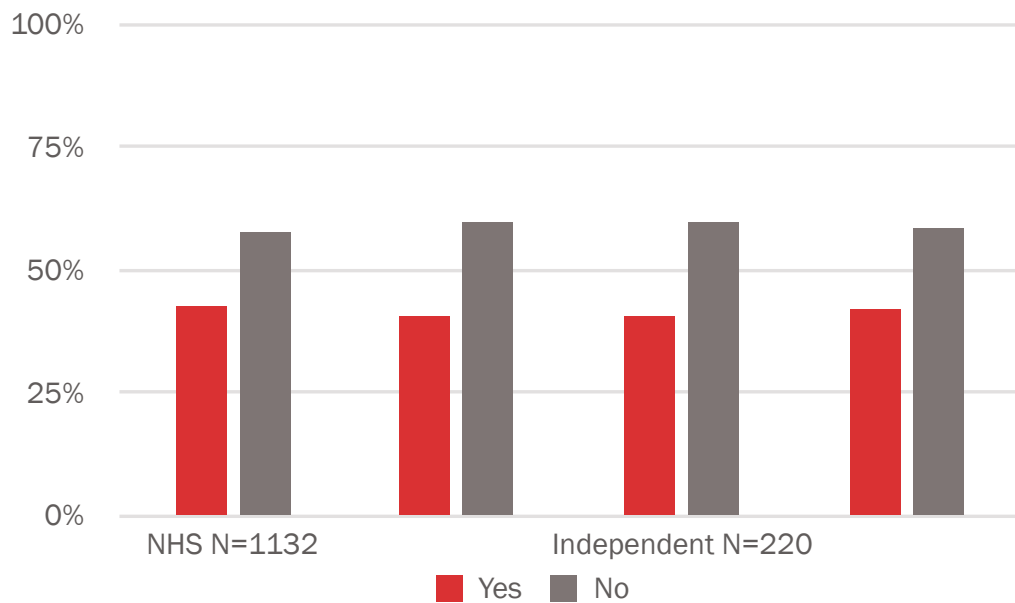
**Appendix 40: Creams usage and skin condition**



**Appendix 41: Employer and 'Have you had a skin check?'**

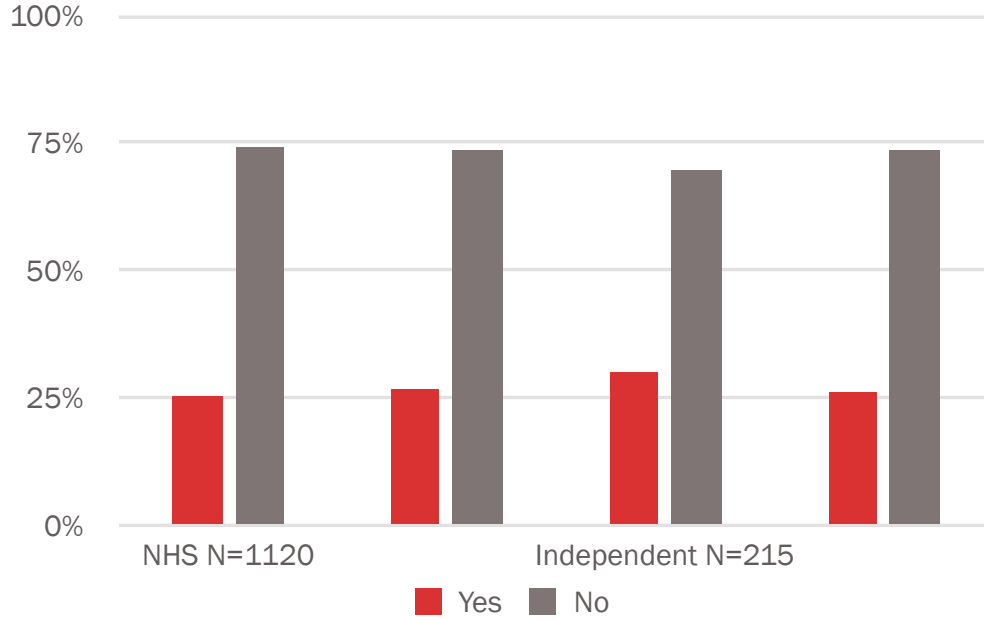


**Appendix 42: Employer and 'Have you had training on how to protect your hands at work?'**

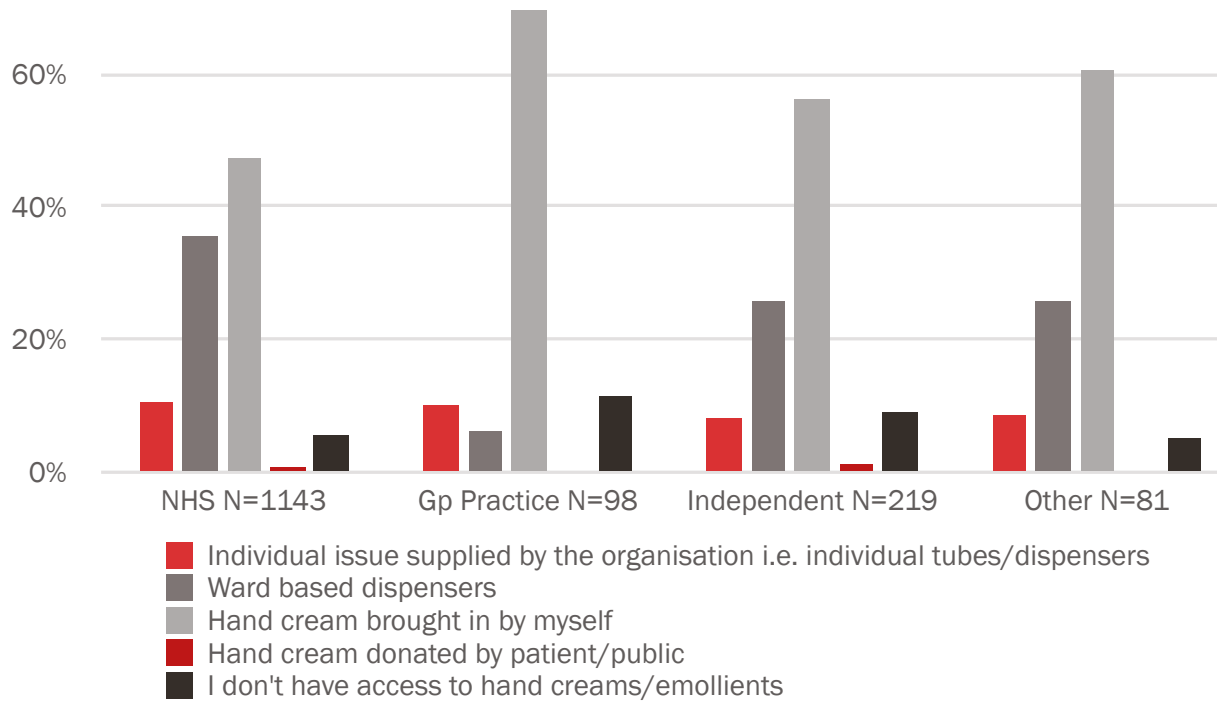




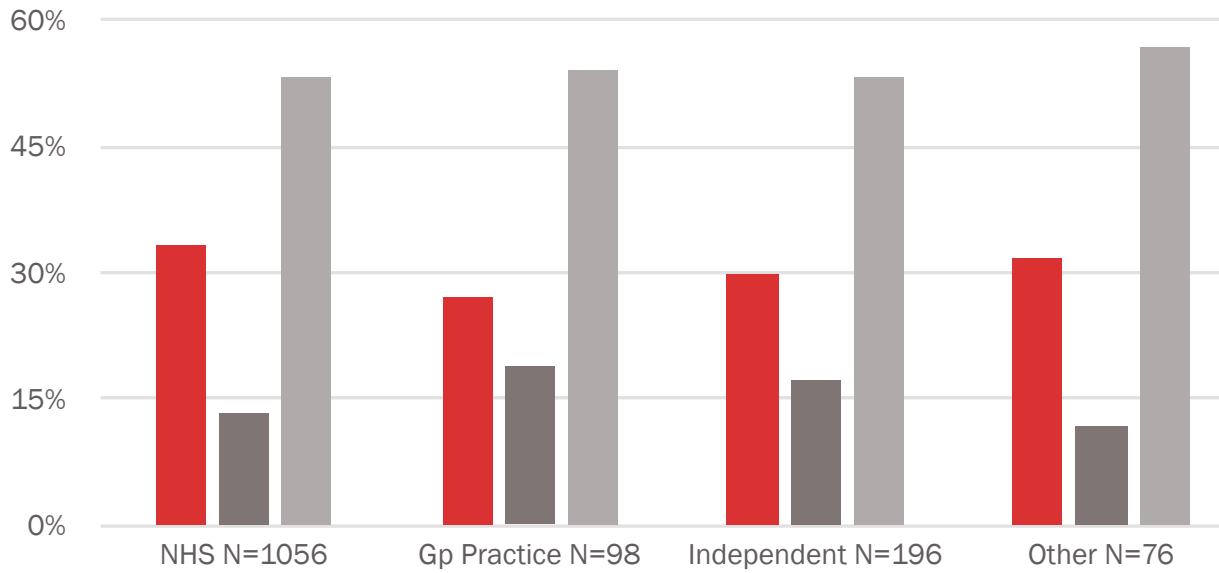
**Appendix 43: Employer and ‘Have you had training on how to spot the early signs of dermatitis?’**



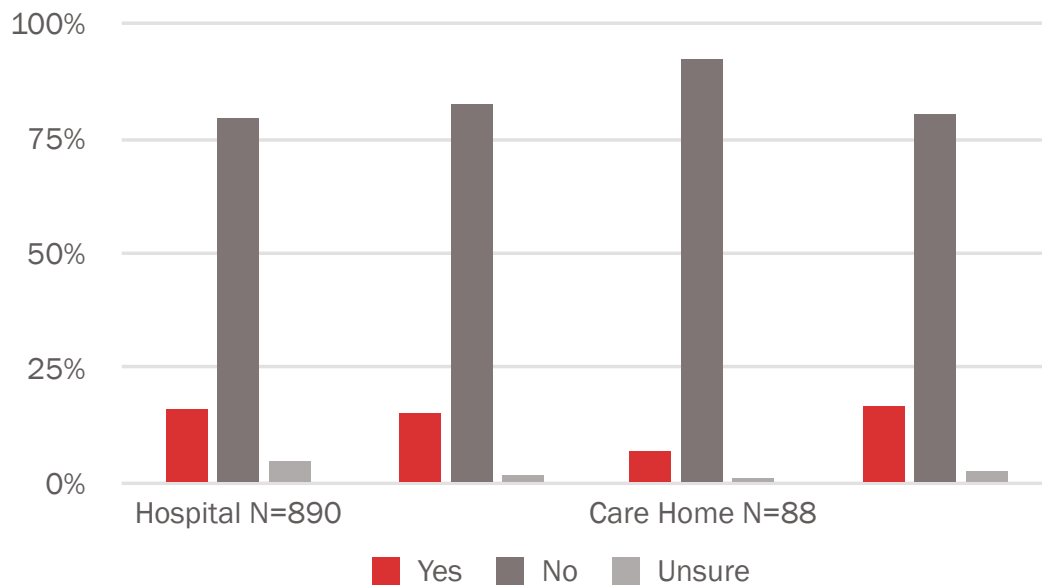
**Appendix 44: Employer and creams access/use**



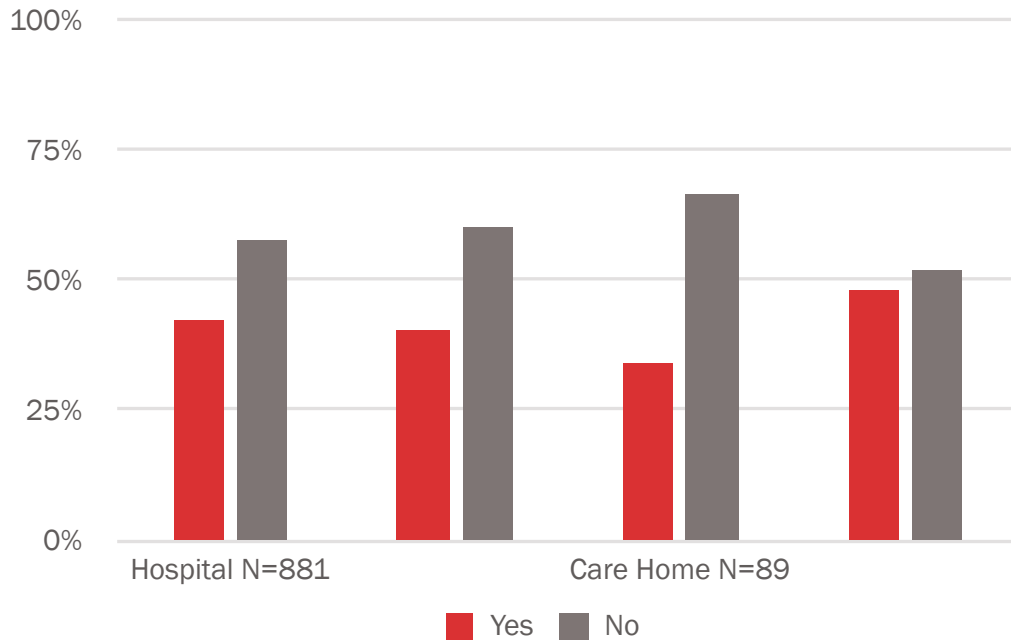
**Appendix 45: Employer and creams usage**



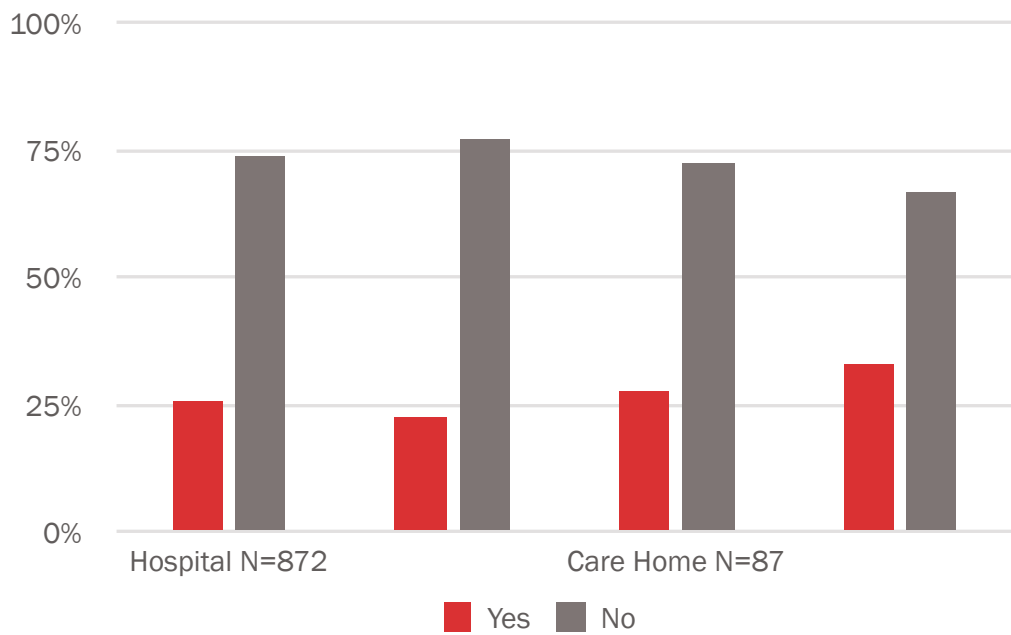
**Appendix 46: Job setting and 'Have you had a skin check?'**



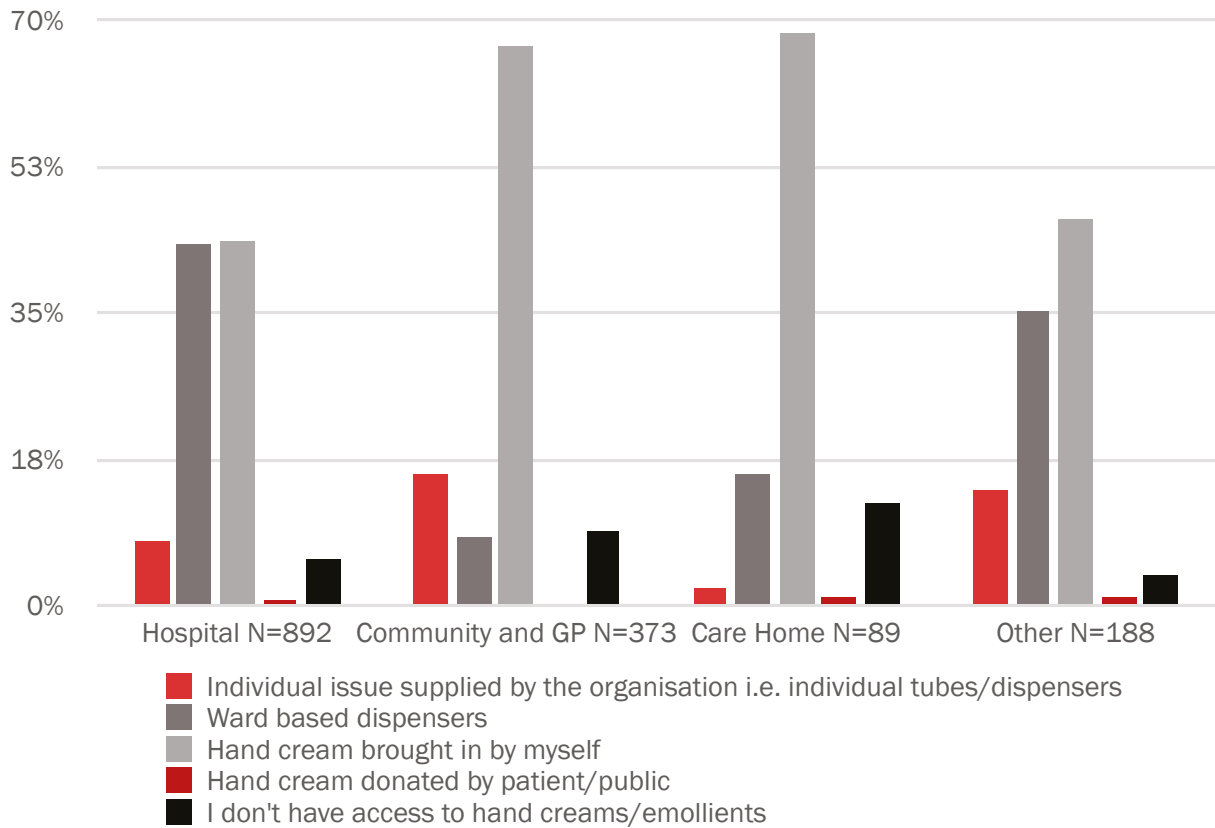
**Appendix 47: Job setting and 'Have you had training on how to protect your hands at work?'**



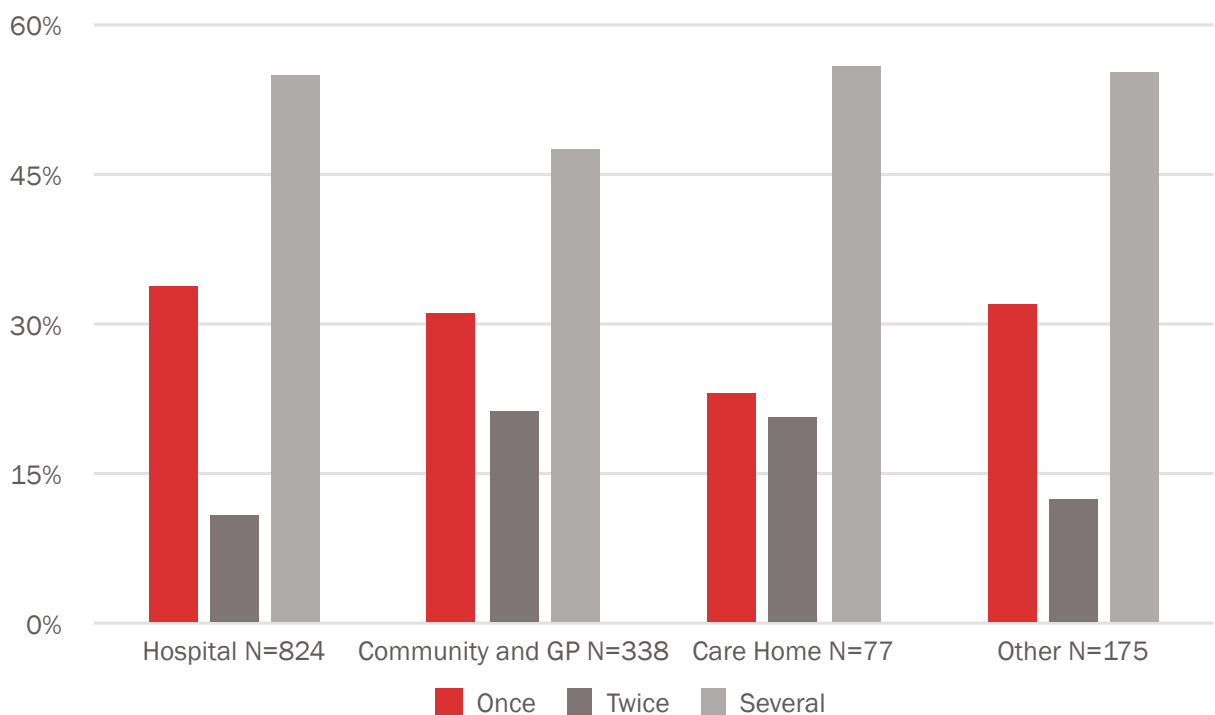
**Appendix 48: Job setting and 'Have you had training on how to spot the early signs of dermatitis?'**



**Appendix 49: Job setting and creams access/use**



**Appendix 50: Job setting and creams usage**





In collaboration with:



SC Johnson Professional have supported the development, publication and distribution of this RCN survey and collaborated with the RCN to ensure wide promotion. The sponsors have not had any editorial input into the content, other than a review for factual inaccuracies.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

RCN Online  
[rcn.org.uk](http://rcn.org.uk)

RCN Direct  
[rcn.org.uk/direct](http://rcn.org.uk/direct)  
0345 772 6100

Published by the Royal College of Nursing  
20 Cavendish Square  
London  
W1G 0RN

020 7409 3333

May 2020  
Publication code 009 244



Royal College  
of Nursing

**2020** | International Year  
of the Nurse and Midwife