Dispelling the Petroleum Jelly Myth

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Recently, a hospital with which I have been associated removed petroleum jelly from the patient-care units to prevent its use on patients receiving oxygen. The ban was based on the National Fire Protection Association's (NFPA) 1996 edition of its Standard for Health Care Facilities, which states, "Oil, grease, or other flammable contaminants shall not be used with oxygen equipment" (item 8-6.2.2.2), and "Flammable and combustible liquids shall not be permitted within the site of intentional expulsion" (item 8-6.2.2.3). The hospital's administration inferred that petroleum jelly presented a fire hazard. Ironically, no ban was placed on petroleum-based products such as antibiotic ointments, petroleum jelly gauze, and hand or body lotion, which are commonly used in caring for patients receiving oxygen. No problems had been reported with these products.

Many nurses on staff were bewildered and concerned about the ban. They had used petroleum jelly for years to lubricate, soothe, and protect skin and mucous membranes. In many nurses' experiences, water-soluble products, which were permitted, were not effective moisturizers. Staff nurses took their concern about the "petroleum jelly prohibition" to the nursing research committee, enlisting their help in validating or refuting the scientific basis of the ban.

The newly formed committee, whose primary goal was to promote evidence-based practice, completed an exhaustive literature search. This provided no evidence of problems associated with using petroleum jelly for patients, whether they were receiving oxygen or not. At one committee meeting, attempts to ignite a glob of petroleum jelly were unsuccessful—the petroleum jelly simply melted into a large puddle. An Internet inquiry and phone calls to staff nurses working at hospitals in the area and across the nation generated a long list of hospitals with no restriction on petroleum jelly use and a short list of hospitals who were queried had ever heard of an adverse incident caused by petroleum jelly. An informal phone survey to nationally recognized nurses produced similar responses. For example, Marianne Chulay, DNSc, RN, FAAN, past-president of the American Association of Critical-Care Nurses, and Cathie Guzzetta, PhD, RN, FAAN, author of several books on the nursing care of critically ill patients, both used petroleum jelly for patient care and neither had ever encountered or heard of a problem with it. The physician chair of the NFPA Technical Committee on Gas Delivery Equipment offered his personal interpretation of items 8-6.2.2.2 and 8-6.2.2.3. He construed 8-6.2.2.2 as referring to oxygen equipment hardware, such as valves and regulators, and 8-6.2.2.3 as literally pertaining to liquids only (personal communication, December 10, 1996). He cautioned, however, that his opinion should not be considered an official commentary.
Despite the above evidence, safety committee and risk management personnel were reluctant to allow petroleum jelly for patients receiving oxygen. The hospital safety manager requested assistance from an independent physician researcher to resolve the issue. The researcher noted that petroleum jelly "is neither a contaminant nor a liquid" and urged that "the present uses of petroleum jelly, with its many solidly demonstrated benefits to patients, be continued without restriction until such time as solid scientific evidence becomes extant which would indicate a potential hazard to patients, staff, or premises" (memorandum from Ivan Danhof, December 5, 1996). Finally, the ban was lifted.

At the most recent meeting of the NFPA Technical Committee on Gas Delivery Equipment, it was proposed that the wording of 8-6.2.2.2 be changed to, "Oil, grease and other flammable substances should not be used in or on oxygen equipment." If approved, this wording will be included in the January 1999 issue of the NFPA's Standard for Health Care Facilities. The revision should help eliminate confusion over petroleum jelly, which may be considered safe for use on patients receiving oxygen, but not in or on the oxygen equipment itself.

By questioning the prohibition, providing evidence of the safety of petroleum jelly, and being persistent, the nurses at this hospital were able to return petroleum jelly to the patient care units.

-Elizabeth H. Winslow, PhD, RN, FAAN

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