

# HOW TO: Manage incontinence/moisture



Both incontinence and pressure ulcers are common and often co-exist. Patients with incontinence are also more likely to be immobile and elderly, both of which increase the risk of pressure ulcer development. This how to guide looks at how to prevent tissue damage using effective management of incontinence and pressure area care.

## WHO IS AT RISK?

Between 30–85% of nursing home residents are incontinent. Urinary incontinence affects over 50%, and a majority of these residents also have faecal incontinence. It is important to establish the cause of incontinence through a full assessment. This should include an examination of the urine to exclude a urinary tract infection. Where possible the cause of the incontinence should be addressed as well as the symptoms.

## WHAT HAPPENS WHEN SKIN COMES INTO CONTACT WITH TOO MUCH MOISTURE?

When the skin comes into contact with fluid (eg sweat, exudate, urine or faeces or a combination of factors) for any sustained length of time, it becomes soft and wrinkled, and eventually saturated, which makes it more susceptible to friction damage, increasing the risk of pressure ulceration.

With the ageing process, the skin becomes thinner and is more prone to the effects of incontinence, which can result in the skin becoming increasingly vulnerable to damage.

## WHY DO FAECES AND URINE DAMAGE SKIN?

Intact healthy skin provides a natural barrier which prevents bacterial growth. In patients with urinary incontinence, the urea in urine can change the skin environment, encouraging bacteria to grow. In faecal incontinence, the faeces contain harmful enzymes that breakdown the skin's barrier, again allowing bacteria and fungal growth.

When both urine and faeces come into contact with the skin they change the natural pH (making it alkaline), which causes the skin to become reddened and to breakdown. This skin irritation is known as maceration, incontinence associated dermatitis (IAD) or excoriation, which can be very painful for individuals.

If the skin is not protected from exposure to urine and faeces, this can lead to the development of a lesion. If a lesion develops, it is important to establish whether this is due to excessive moisture, pressure damage or a combination of the two (see centre spread). It is important to implement a skin care programme, using barrier products to avoid the development of lesions.

## HOW CAN YOU PROTECT THE SKIN?

The maintenance of skin integrity is vital for the prevention of pressure ulcers and moisture lesions. The aim is to keep the skin clean and dry. This can be achieved through the use of the following:

- Protective skin barrier products
- Gentle cleansers
- Simple moisturisers
- Incontinence products — eg incontinence pads.
- Faecal management systems.

A barrier cream or film can act as a waterproof physical barrier between the skin and other substances. This can be used in combination with incontinence pads. It is important to select a pad with the most suitable level of absorbency and shape for the individual. Please note that indwelling catheters should be considered as a last resort due to the risk of infection. Also when using incontinence pads, thick creams and ointments should be avoided as they affect the ability of the pad to absorb fluid and make increase the risk of damage.

Following an episode of incontinence, the area should be cleaned using a foam cleanser (or similar). The skin should then be carefully dried and either a moisturiser or skin barrier applied depending on the condition of the skin and amount/frequency of incontinence. Faecal management systems can be considered in cases of severe or high volume diarrhoea or for any bedridden or immobile patient with a moisture lesion to prevent contact with faeces at the site of the lesion.

# How to manage wet skin

## 1 Too moist

- a. Use a barrier film or cream to keep fluid away from the skin.
- b. Use a faecal management system if the cause is profuse or prolonged diarrhoea.
- c. Use incontinence products when required.
- d. Use an appropriate surface to manage the skin temperature and humidity.

## Which barrier product to select?

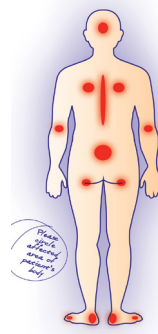
### Barrier films

- Available as a spray, wipes and foam applicator
- Can be applied to broken or irritated skin and dry to create a breathable and transparent film on the skin

### Barrier creams

- Available as a spray, sachet or tube
- Can be used on intact or irritated skin, but not on broken skin
- Ideally the cream should be absorbed into the skin and not leave a sticky residue

Document use of all barrier films and creams. Mark area applied on the body map



## Pressure ulcer or moisture lesion?



### Moisture lesions due to incontinence will:

- Be superficial
- Have multiple lesions
- Sometimes present as a 'kissing' lesion — the same pattern on both buttocks where they touch
- Be irregular in shape and have ill-defined, wandering edges
- Often purple in colour
- Often occur over fatty tissue in the buttock area — not necessarily over a bony prominence
- Have skin that may be shiny and wet



### Pressure ulcers are caused by pressure, shear or friction and typically present as:

- Partial thickness skin loss and full thickness skin loss
- Occurring over a bony prominence
- Having distinct edges
- Limited to one spot

## Do's and don'ts

### Do

- ✓ Perform an assessment using appropriate tools to establish the cause of the problem
- ✓ Record episodes of incontinence to assess severity
- ✓ Establish a skin care routine with timely cleansing of soiled and wet skin
- ✓ Use barrier products if the skin is reddened or broken to act as a barrier to further irritation
- ✓ Use incontinence products and faecal management systems to help avoid contact with urine and faeces
- ✓ Smooth incontinence pads prior to use to prevent creases and ridges, which may cause pressure damage
- ✓ Inspect skin at regular intervals, eg during assistance with personal hygiene
- ✓ Use foam cleansers when cleansing following episodes of incontinence
- ✓ Encourage the patient to drink to maintain hydration, which also dilutes the urine
- ✓ Identify incontinent and immobile patients 'at risk' of pressure ulcer development. Pads should be changed during the night and regular positional changes undertaken
- ✓ Seek advice from the local incontinence advisor

### Do not

- ✗ Use traditional soap and water when cleansing following episodes of incontinence
- ✗ Use multiple incontinence pads as they are likely to reduce the efficacy of pressure redistributing equipment
- ✗ Use creams and talcum powders under barrier products
- ✗ Assume incontinence in the older person is inevitable



### GREEN

**Where skin is intact and well hydrated:** Inspect skin regularly, prevent prolonged exposure to moisture and manage skin temperature.



### AMBER

**Skin at risk of breakdown:** Use appropriate products to maintain skin integrity. Select suitable support surface if due to pressure damage.



### RED

**Skin has broken down:** Document area of damage and assess wound. If the wound is caused by moisture it is more likely to be a moisture lesion. Do not confuse with a pressure ulcer. Ensure you know the difference as all pressure ulcers must be reported (use Safety Cross).

## DIFFERENTIATING BETWEEN PRESSURE ULCERS AND MOISTURE LESIONS

Moisture will contribute to the development of a pressure ulcer. However, it is important to understand the difference between a pressure ulcer and a moisture lesion as the treatment approaches will be different (see centre spread).

**Moisture lesions are due to exposure of excessive moisture and are not caused by pressure or shear.**

Assessment of patients at risk of moisture damage should include:

- A routine skin assessment
- A continence assessment
- A nutritional assessment (eg MUST tool) to identify individuals that are malnourished and dehydrated, both of which will delay the healing of any skin damage
- Falls and manual handling assessment — patients may need assistance to get to the toilet

The results of these assessments should help to identify if the individual is at risk of developing a moisture lesion. In addition, a pressure ulcer risk assessment should also be undertaken.

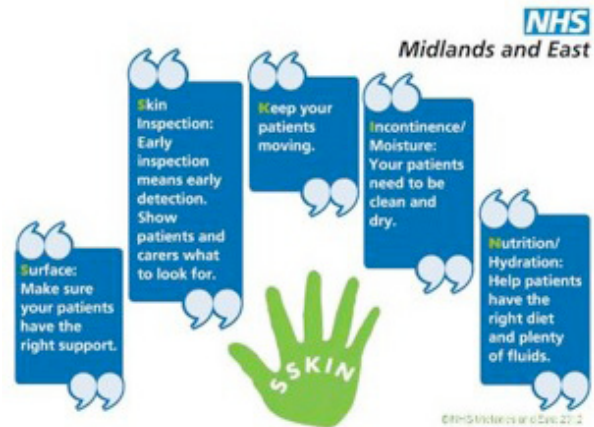
If a patient develops a moisture lesion, it is important to establish the cause and assess the level of tissue damage. If the skin is red and irritated (excoriated), this can be categorised using the tool developed by the National Association of Tissue Viability Nurses Scotland. This contains clinical images to help identify the cause and grade the tissue damage (mild to severe). It also offers advice on how to manage the problem.

## HOW THIS GUIDE CAN BE USED TO PREVENT PRESSURE ULCERS

Causes of incontinence are multifactorial and are usually related to lifestyle factors, physical problems or an underlying medical condition. By identifying the cause of the incontinence and using body worn pads or faecal management systems to prevent urine and faeces from coming into contact with the skin, it is possible to keep the skin healthy. Good skin care using an appropriate skin cleansing routine and barrier products is the most important aspect of prevention and treatment of incontinence associated dermatitis. This should be supported by regular skin inspection to identify early signs of skin damage.

## SSKIN Bundles

Keeping patients moving is just one step of a simple five-step care plan (called a SSKIN bundle) to ensure all patients receive the appropriate care to prevent pressure damage. This includes:



## Using the Safety Cross

Using the pressure ulcer safety cross to measure incidents of pressure damage can help to raise awareness and change attitudes to pressure damage. Keep the safety cross in a public area so that everyone can see it on a regular basis. This will show how many patients have developed a pressure ulcer in the care home. It should be used to record all pressure ulcers, regardless of grade and should help to identify improvements in care and reduce the number of pressure ulcers occurring.

## KEY POINTS

1. Incontinence is not an inevitable consequence of old age and should be treated whenever possible
2. Skin should be kept clean dry and well hydrated
3. Patients should be encouraged to drink regularly to maintain hydration, reduce the risk of constipation and reduce the concentration of urine.

## KEY RESOURCES

- Best Practice Statement (2012) Caring for the Older Person's Skin 2012. <http://www.wounds-uk-com>
- Excoriation tool. [http://www.healthcareimprovementscotland.org/our\\_work/patient\\_safety/tissue\\_viability\\_resources/excoriation\\_tool.aspx](http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/excoriation_tool.aspx)
- SSKIN bundle. <http://www.stopthepressure.com/sskin/>
- Safety cross (<http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/PressureUlcers/>)