

THE MANAGEMENT OF SKIN EXCORIATION DUE TO URINARY INCONTINENCE

Pam Cooper, Clinical Nurse Specialist In Tissue Viability, Department of Tissue Viability, Grampian HNS Trust-Acute Services

A 46-year-old woman was admitted to the acute medical admission unit suffering from breathlessness and reduced mobility. She had a long-standing history of arthritis, hypothyroidism and obesity. On admission it was estimated that she weighed 195kg. She was nursed on the appropriate bed frame and mattress for her weight to reduce the risk of pressure ulcers developing due to her reduced mobility.



Figure 1. Superficially broken and excoriated tissue to the sacrum and thighs.

SKIN ASSESSMENT

On assessment the staff identified that the patient had multiple breaks and areas of excoriation (superficial skin loss) particularly around her peri-anal area and she was therefore referred to the department of tissue viability.

On further inspection, the woman was found to have a 2cm x 1.5cm area of superficial skin loss to her right buttock, EPUAP grade 2 (European Pressure Ulcer Advisory Panel, 1999). The surrounding skin was very red and excoriated, with patches of

dry, brown flaking skin. This was spreading into, as well as down, her thighs (Figure 1). The cause of this was identified as urinary incontinence. She was having difficulty going to the bathroom due to her reduced mobility and unfortunately had been sitting for periods of time in her own urine. She had not had access to any body worn pads as this was a new problem and help had not been immediately given.

The clinical challenge was to assess incontinence and develop a management plan; manage skin excoriation; treat the pressure

ulcer; and reduce pain and discomfort.

TREATMENT

The initial aim was to cleanse the patient's skin and remove any residual urine. She also presented with excoriation to her underarms and her breasts. It was felt that all her skin required treatment. She was given a full bed-bath every day where she was cleansed using a non-soap product in an attempt to moisturise her very dry skin.

Incontinence management was crucial and a full plan of care was established. It was decided that the nurses should:

- ▶▶ Monitor episodes of incontinence to see if there was a pattern
- ▶▶ Supply the patient with body-worn pads to absorb urine following episodes of incontinence
- ▶▶ Cleanse her skin using a foam cleanser after each episode of incontinence. This reduced both the friction coefficient as well as preventing skin dehydration (Cooper and Gray, 2001)
- ▶▶ Cavilon barrier cream

(3M, Loughborough) was applied after each episode of incontinence. The cream provides a barrier layer over the skin, reducing the irritant effects of the incontinence without affecting the absorbency of the body worn pad.

Over a period of a few days her overall medical and physical condition improved. This enabled her to use a commode and then eventually to use the toilet. Her skin condition also made significant improvement over the next few days as the urine was no longer in prolonged contact with her skin.

This was a fairly straightforward example of incontinence-related skin excoriation that quickly disappeared once her overall condition improved. However, not all cases are so straightforward.

If you are caring for a patient who has either urinary or faecal incontinence (*Figure 2*) (or both) that affects skin integrity then consider the following:

- ▶ Determine the cause of the incontinence and observe if changes can be made to the causative factors. For example, drug or feed regimens can often cause incontinence. It may be possible to stop the regimen or change to one that may not have the same effect on the gut
- ▶ If the incontinence is a recent development then consider urinary tract infection and/or bowel infection

- ▶ Some drugs can be used to bulk up the patient's stool. This can be discussed with medical staff
- ▶ Encourage the use of body-worn pads which are designed to absorb as much of the fluid as possible and keep it away from the patient's skin
- ▶ Cleanse skin after episodes of incontinence with a foam cleanser (NHS Quality Improvement Scotland, 2003; 2005)



Figure 2. Large area of excoriation due to drug-reaction faecal incontinence.

- ▶ If skin is red and excoriated, apply barrier cream or film according to the manufacturer's instructions
- ▶ If the patient has urinary incontinence, it may be an option to catheterise but care should be taken not to do this as the first intervention
- ▶ If the patient is faecally incontinent, the use of faecal collectors may be considered. These will collect the faeces if applied properly. They can be applied to excoriated skin as the phalange is made of a hydrocolloid which is used in

the management of wounds to promote healing by providing a moist environment

- ▶ If the faecal incontinence is going to be an issue due to specific drug regimens and it is recognised that there is going to be an ongoing problem, then a faecal management system can be used (Johnstone, 2005). This is a soft flexible catheter which is inserted into the rectum. It is held in place with a small balloon. It conforms to the rectal vault and reduces the risk of necrosis, unlike rectal tubes which are associated with perforation and sphincter damage.

CONCLUSION

The management of skin reactions due to incontinence can be problematic, but if a full assessment is carried out and treatment begins immediately, the irritant effects of incontinence on skin integrity should be reduced. **WE**

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