Managing Fecal and Urinary INCONTINENCE

Presented by Jeff Souza RN, BSN, WOCN
with Capital Nursing Education

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SkinPreservation
Caring for skin through intelligent product solutions

Shield HealthCare

MEDICAL SUPPLIES FOR CARE AT HOME SINCE 1957

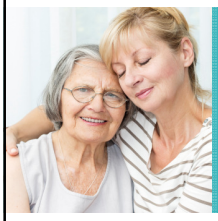
About the Presenter
Jeff Souza RN, BSN, WOCN

- Became a Board Certified WOCN in 1983 after attending the Cosler School at the University of Southern California.
- Has served in leadership positions in both homecare and outpatient providers.
- A speaker, author and advocate for home and community medical care.
- With over 30 years of experience in the dynamic healthcare environment he brings the creativity needed to deliver services throughout the changing healthcare market.
- Currently enrolled at the Samuel Merritt University, School of Nursing, Family Nurse Practitioners Masters program.

Objectives

1. Explain the difference between incontinence-associated dermatitis (IAD) and pressure ulcers (PU)
2. Describe the effect of excessive moisture on skin integrity
3. List three (3) types of urinary incontinence and describe one (1) possible intervention for each cause

Definition



Incontinence is the involuntary loss of urine or feces of sufficient magnitude to comprise a problem for the patient or caregiver.

Wound, Ostomy, and Continence Nurses Society™

Prevalence

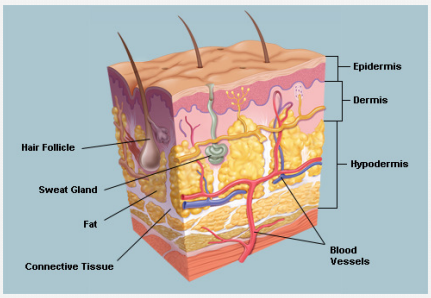
- **13 million** people in the USA suffer from UI
- Costs over **26 billion dollars** annually
- Prevalence of UI and FI **increases with age**
- Women affected **twice as often** as men

Incontinence is one of the leading causes of institutionalism in the elderly

Significance of Incontinence

- Suffering of the patient
- Prevalence of skin care problems across all care settings
- Cost to healthcare system

SKIN: Anatomy



Elements of Skin's Moisture Barrier

- Stratum corneum
- Lipid matrix: slows movement of water and electrolytes
- Water: hydrates corneocytes
- pH: (usually 5.0-5.9) forms an acid mantle
- Temperature: regulates permeability
- Bacterial flora: competes with pathogens to prevent infection

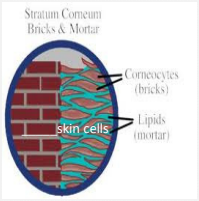


Figure: cerave.com/barrier.htm

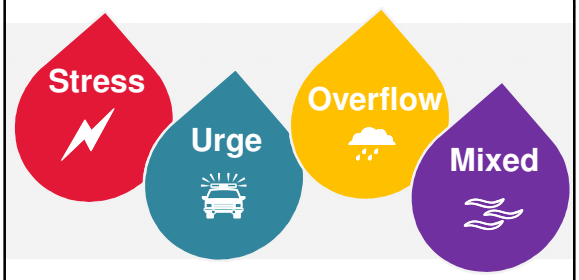
Effects of Moisture on Skin

- Maceration
- Incontinence Dermatitis
- Bacterial Infection
- Exposure To Caustic Agents
- Fungal Infection

Normal Micturition

- Normal - 3-4 hours/day & 1 x/noc
- Abnormal - voiding interval of ≤ 2 hours or ≥ 8 voids/day
- Bladder stores urine (500-700 cc)
- Complex series of events

Types of Urinary Incontinence



Stool Frequency & Characteristics

Frequency: Highly individual from 1-2/day to one movement every 3-4 days

BRISTOL STOOL SCALE

Type I Stool		Small hard lumps; pellet-like in appearance
Type II Stool		Hard sausage shaped lumps
Type III Stool		Sausage-like but with cracks on the surface
Type IV Stool		Smooth, soft and formed
Type V Stool		Soft formed pieces
Type VI Stool		Mushy, puffy, ragged pieces and edges
Type VII Stool		Liquid with no formed pieces

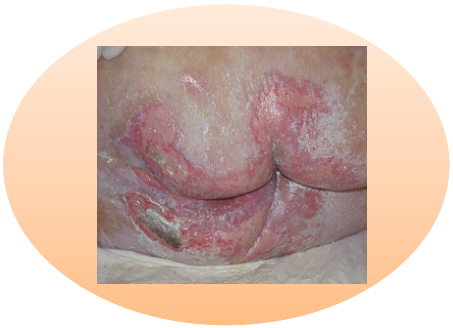
Fecal incontinence may occur with any type of stool, but is often associated with increased fluidity.

Adverse Effects of Stool on Skin

Fecal enzymes

Stool Consistency

Fecal Incontinence



Assessment

- History
- Physical Exam
- Diagnostic Testing

Treatment

- Lifestyle Changes
- Behavioral Interventions

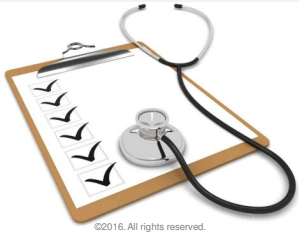
CLEANSE

MOISTURIZE

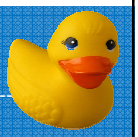
PROTECT

GOALS
of Perineal Skin Care

- Skin to be clean
- Skin to have minimal exposure to irritants



CLEANSE the skin



When frequent bathing necessary, current evidence suggests…

- Gentle cleansing: ***NO scrubbing*** [1]
- pH close to acid mantle of skin (5.5)
- minimize potential irritants, scents, etc.
- Towel drying has been found to compromise moisture barrier, consider no-rinse formulation for frequent bathing[2]
- Surfactants, used to remove dirt and bacteria, can also increase transepidermal water loss[3]

Skin Care Products
Moisture Barriers

- **Skin sealants** (solvent with a polymer)
  - Alcohol based
  - "No Sting" available for denuded skin
- **Spray**
- **Lotion** (thinner; increased ratio of water to oil)
- **Cream** (oil based)
- **Paste** (ointments with fine powder added)
- **Ointment** (emulsified oil in water)

MOISTURIZE the skin

- **Emollients**
  - Usually oils
  - Makes skin soft and smooth
- **Humectants**
  - Glycerin, urea
  - Actively binds the available water in the epidermis
- **Occlusive skin conditioners**
  - Petrolatum, mineral oil, paraffin
  - Coats epidermis to prevent evaporation

PROTECT with Skin Protectant

- **Skin protectants should**
  - Act as a "moisture barrier", protecting skin from deleterious effects of exposure to irritants and excess moisture
  - Maintain hydration and favor skin's normal transepidermal water loss (TEWL)
  - Avoid maceration when left on for prolonged period of time

Types of Skin Protectants

- **Petrolatum:** Blend of castor seed oil and hydrogenated castor oil

- **Dimethicone:** Silicone based oil

- **Zinc Oxide:** White powder, mixed with cream or ointment based

Comparison of SKIN PROTECTANTS

Petrolatum:
- Good protection against irritant
- Avoided maceration
- Poor skin hydration

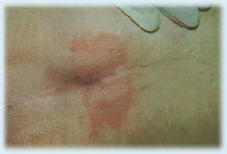
Dimethicone:
- Variable protection against irritant
- Avoided maceration
- Good skin hydration

Zinc Oxide:
- Good protection against irritant
- Did not avoid maceration
- Poor skin hydration

All-in-One Products

- These **clean, moisturize, and protect** in one step application
- Available as cloths and spray-on applications
- When placed at bedside, reduces process to simple, single step
  - ↓ time needed by staff to apply
  - ↓ discomfort for patient caused by rubbing and wiping during procedure

Moisture or Pressure?



Stage I Pressure Ulcer

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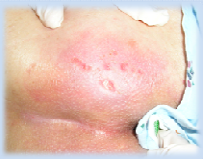


Incontinence-Associated Dermatitis

Assessment: IAD vs. Pressure Ulcers

IAD	Pressure Ulcers
Etiology: continued skin exposure to urine, feces or both	**Etiology**: ischemia from pressure
Location: diffuse rash	**Location**: circumscribed and usually over bony prominences
Color: red or bright red	**Color**: red to bluish/purple
Depth: partial-thickness; (ie. limited to epidermis and/or dermis); two dimensional	**Depth**: partial or full-thickness; three dimensional; deep tissue injury
Necrosis: none	**Necrosis**: may be present
Symptoms: pain and itching	**Symptoms**: pain and itching

Gray, 2007

Incontinence-Associated Dermatitis

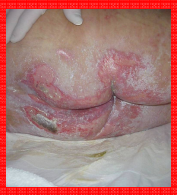
CAUTION CAUTION CAUTION

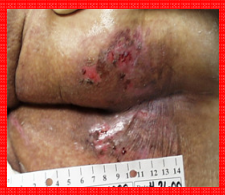
DO NOT use the pressure ulcer staging system to describe

Incontinence-Associated Dermatitis!

Incontinence-Associated Dermatitis

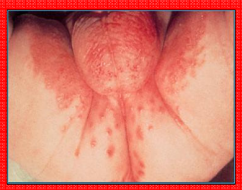
- **Severe IAD** – "Affected skin is red with denuded areas (partial-thickness skin loss) and oozing/bleeding. Skin layers may be stripped off as the oozing protein is sticky and adheres to any dry surface."

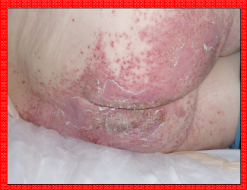




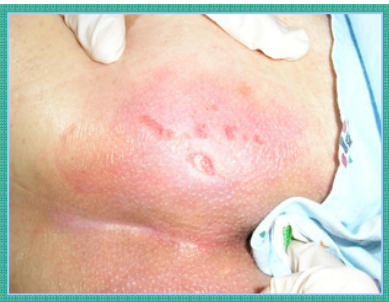
Incontinence-Associated Dermatitis

- **Fungal-Appearing Rash**





Incontinence-Associated Dermatitis



Catheters and pads are **not the first and only treatment** for incontinence.

They should only be used to make other treatments more effective or when other treatments have failed.

Containment DEVICES

- **External devices**
  - Absorbent products (pads, shields, briefs)
  - Containment devices (urinals, commodes, external collection pouches)
- **Internal devices**
  - Suprapubic catheters
  - Indwelling urinary catheters
  - Fecal management systems

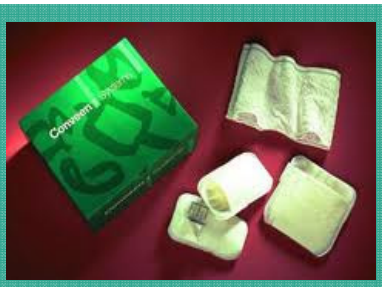
Product TECHNOLOGY

1960	***Disposable incontinence containment*** first introduced
1984	Development of ***super-absorbent materials*** using sodium polyacrylates in infant diaper market (Campbell)
1987	***Gelling material superior to cloth*** and non-gelling disposable diaper materials in pH control of the skin and the severity of diaper dermatitis (Campbell)
1997	***Design*** (rather than the amount of materials used) improved skin barrier function (Akin and colleagues)
1997	How *super-absorbent materials were* ***layered*** (not amount of polyacrylate) was key factor in maintaining skin barrier function

Protective Undergarments Absorptive Devices

Adult Style BRIEFS

Shields, Liners, Guards, Inserts



OTHER CONSIDERATIONS…

- ✓What is it made of?
- ✓Is it going to leak?
- ✓Does it fit the patient?
- ✓Does it control odor?
- ✓Does it control fecal incontinence?
- ✓How well do these products wick the urine away from the skin?

Other Methods | URINARY CONTAINMENT

Male (non-invasive)

- Condom caths

- Retracted penis pouches

- Penile clamps

Female (non-invasive)

- External urinary collection device

- Invasive-Intravaginal support devices (cones, pessaries)

Management Program for Incontinence

- **Needs to include:**
  - Dietary and fluid management
  - Bowel training or stimulated defecation program
  - Bladder retraining
    - Prompted voiding
    - Scheduled voiding program
  - Indwelling catheter management
  - Intermittent catheterization program
  - Pelvic muscle reeducation
  - Containment or absorptive devices
  - Skin care regime

How Can We Help the Incontinent Patient?

- Assessing their need
- Toileting every 2 hours
- Giving them reassurance and confidence
- Be empathetic!!
- Provide them with familiar products…those they use at home, when possible
- Make them comfortable
- Work as a team with the patient to make this a less burdensome issue

This concludes our presentation. Thank you for joining us.

Questions?

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Click on the "Register" tab to submit the form.

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