Consistency is the Key to Treating Severe Incontinence-Associated Dermatitis (IAD)

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Introduction

Incontinence-associated dermatitis (IAD) is physically painful and emotionally upsetting. Incontinence which has not been managed in a home setting can result in severe skin breakdown in a short time period. Patients presenting to healthcare facilities with skin breakdown due to incontinence require immediate, appropriate and consistent care plans to reverse their condition. Recent evidence shows that even though most healthcare professionals see the value in standard protocols for managing incontinence, these care plans can often be difficult to administer on a regular basis.

Background

Recent evidence indicates that approximately 20% of acute care patients are incontinent and that 42.5% of incontinent patients have some type of skin injury. This same study noted that patients with fecal incontinence, poor nutritional status, and hypoalbuminemia have higher rates of skin injury.

A separate study noted that patients with fecal incontinence and impaired mobility were 37.5 times as likely to develop pressure ulcers than were continent patients. Gray and Bliss reported that approximately 50% of patients with urinary or fecal incontinence are affected by IAD, and further emphasized the importance of distinguishing between pressure-related and incontinence-associated injuries in order to properly treat the conditions and ensure positive patient outcomes.

Methodology

In this patient case report, a 72-year-old male patient with non-insulin dependent diabetes mellitus was admitted to the hospital with generalized weakness and bilateral cellulitis of the lower legs. For 4 days prior to the discovery of his condition by caretakers and his subsequent admission to the hospital, the patient had been too weak to get out of a chair and had been incontinent. On admission, he had severe excoriation of the buttocks, groin, scrotum, and thighs, and he complained of severe pain and burning.

Treatment Plan

A Foley catheter was inserted, and the trial use of incontinence-care barrier cloths impregnated with 3% dimethicone commenced. The staff were instructed to use this product exclusively for each incontinent episode and as part of the morning and evening care regimen.

Results

Rapid progress was observed. By day 2, epithelialization of the right buttock and left thigh was observed. Patient stated that burning and pain had decreased remarkably and that cloths felt very soothing to his tender bottom. The staff were reeducated, and the use of other skin products was discontinued. The barrier cloths were used each time the patient was incontinent. The patient’s condition improved rapidly, but relapse occurred after the staff switched back to the previous standard of care for incontinence. This case study demonstrates the importance of compliance with hospital skin-care protocols to achieve optimal results.

Conclusion

The care plan implemented in this case study resulted in improved skin outcomes and improved comfort for the patient. The intervention focused on treating the patient’s condition, perineal dermatitis. Treatment for pressure ulcers or fungal infection was not indicated. The treatment plan included management of urinary incontinence with the use of a Foley catheter and the use of an incontinence-care barrier cloth impregnated with 3% dimethicone to prevent and treat perineal dermatitis.

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Learning Objectives

❖ Understand the importance of early skin-care interventions for patients with urinary and fecal incontinence.
❖ Note the difference between incontinence-associated and pressure-related perineal skin injuries and the need to implement separate patient care plans.
❖ Recognize that positive patient outcomes can be achieved by implementing a consistent skin-care program for incontinent patients, which involves consistent cleansing of the patient’s skin and the application of a moisture barrier.

References