

Non-rinse skin cleansers: the way forward in preventing incontinence related moisture lesions?

- **Objective:** The use of non-rinse skin cleansers in the care of patients who are at risk of tissue breakdown is not new within the National Health Service (NHS). Back to the Floor Continence Care Rounds (introduced in 2012 to facilitate bedside continence care education) at University Hospitals Birmingham had identified that in the current climate of austerity and efficiency savings, the use of non-rinse cleanser was being randomly rationed. Our objective was to determine whether the introduction of a smaller tube of non-rinse cleanser with targeted education would improve usage and ultimately improve the skin of incontinent patients.
- **Method:** There were five clinical areas randomised into two groups. In group 1 three clinical areas were provided with targeted education and new sizes of tubes of non-rinse skin cleanser. In group 2, the two remaining clinical areas acted as control groups, one receiving targeted education only and the remaining had no education or new sized tubes. The incidence of incontinence associated moisture lesions from each clinical area was monitored for 13 weeks pre and post study period.
- **Results:** The in-depth study undertaken at University Hospitals Birmingham, over a 6-month period, confirmed a trend in staff committing to the ethos of prudence, and in turn compromising the use of the most effective treatment and prevention of incontinence associated moisture lesions. The ability of the Trust staff to recognise and respond to a change in practice and the responsiveness of a commercial provider to the proposed new methodology has resulted in a significant reduction in incontinence associated moisture lesions across the trust. The clinical areas included in the study demonstrated a 70–76.9% reduction in moisture lesion incidence compared to an 8.3–13.6% reduction in the control groups.
- **Conclusion:** The results strongly suggest that a reduction in incontinence associated moisture lesions can be achieved by a simple change in nursing regime. The combination of solid education provision, alongside a more appropriate size of product, has demonstrated significant patient benefit, greater adherence in practice and a reduction in waste. The integrity of the patients' tissue was preserved and staff were satisfied with their input and the patients' progress. The outcomes of this study will have an impact on patient benefit and on the efficiency for trusts resulting in greater patient satisfaction and a more appropriate use of limited resources.
- **Declaration of interest:** SCA provided 20ml tubes of TENA Wash Cream free of charge and the TENA Nurse Advisor for support during the education provision element of the study.

incontinence; incontinence associated moisture lesions; non-rinse skin cleaners; pressure ulcers; education

Commissioning for Quality and Innovation is the payment framework followed by the National Health Service (NHS) in the UK. It enables commissioners to reward excellence by linking a proportion of English health-care providers' income to the achievement of local quality improvement goals. A goal high on the agenda is to reduce the number of health-care acquired pressure ulcers (PUs), as avoidable PUs are a key indicator of the quality of care being provided.

NHS England joined with other partners such as NHS Midlands and East to support a reduction of PUs, with the initial aim of reducing prevalence throughout the winter 2013/14 by 50%, which in turn would improve the care of vulnerable patients.¹

Stop the Pressure: an update from NHS England referred to the work of Bennett et al. (2004):

'the majority of pressure ulcers are preventable. As well as causing long-term pain and distress for patients, treatment for each pressure ulcer costs an average of £4,638—which causes a financial burden on the NHS of between £1.4 and £2.1 billion per year.'

Both incontinence and PUs are common and often co-exist. Patients with incontinence are more likely to be elderly and immobile, both of which increase the risk of PU development. The incidence of urinary and faecal incontinence is notoriously difficult to ascertain, partly due to underreporting, because they

F. J. Harries,¹ RN, DN Cert, DPSN Com. Urology Specialist Continence Nurse;

P. A. Begg,^{1,2} PhD, MSc, MBA, RHAD, BSc (Hons) Professor and Honorary Research Fellow;

¹ University Hospitals Birmingham NHS Foundation Trust.

² The Royal Orthopaedic Hospital Birmingham NHS Foundation Trust.

Email: fran.harries@uhb.nhs.uk

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are such emotive and embarrassing conditions, not only to the individual but to their family and carers. The Bladder and Bowel Foundation (2008)³ study, suggested 14 million people have a bladder-associated problem and 6.5 million people a bowel-associated problem. This equates to more than the number of reported people with asthma, diabetes and epilepsy added together at that time.

The majority of current knowledge about the effects on the skin, however, has arisen from studies using incontinence pad materials on animals, healthy infants and on body areas such as the forearm or the back of adults.⁴ Skin irritation within the pad occlusion area has often been termed incontinence-associated dermatitis, but the more inclusive term ‘incontinence-associated skin damage’ may be more appropriate when describing skin problems on the buttocks, hips and sacrum, where skin surface damage may also be caused by pressure, shear or friction.

Repeated wetting and drying of skin makes this area more vulnerable to substances that are usually harmless, for example bile salts. The excessive moisture that accompanies urinary and faecal incontinence results in the skin becoming over hydrated or macerated, making it more susceptible to bacterial infiltration.⁵ Over hydrated skin is also more prone to physical damage; for example dry skin requires twice as much friction to cause damage compared with skin that has been exposed to moisture for prolonged periods.⁶

Numerous publications report that the frequent cleansing of patient skin following an incontinence episode compromises skin integrity. It is therefore recommended that soaps and shower gels, which are detergents, are not used because the natural oils of the skin will be removed and the alkaline nature of the soap is likely to exacerbate any existing dermatitis.⁷ It is advocated that non-rinse cleansers are used instead. These products are gentle, emulsion-based creams which help cleanse the skin and can be soothing, preventing the need to rub the skin and cause further injury.⁸

TENA Wash Cream cleanses the skin gently, removing urine and faecal matter while moisturising, deodorising and applying a protective barrier film. The wash cream is used to maintain the acid mantle of the skin while preventing further damage. It is suggested that the pH balance helps maintain the skin at a slightly acidic pH, while creating a barrier to chemical damage and resistance against dehydration and bacterial invasion.⁹

As part of a planned review of continence care, University Hospitals Birmingham, one of the largest acute trusts in the UK, acknowledged an issue on wards where staff were not using the agreed method of cleansing with TENA Wash Cream. The trust purchases the wash cream in 250ml tubes, but

usage throughout wards is variable. Staff reported that they were avoiding the use of this product due to cost issues as a consequence of wastage, as the tubes are too large for use with short-term patient stays and are discarded on patient discharge to avoid the risk of cross contamination. On questioning all clinical areas, there was an overwhelming preference for using the product if it was supplied in a smaller unit of issue.

On speaking with the manufacturer, smaller tubes were not available for purchase due to licensing issues (specifically, not being able to print all the required information on a smaller tube). The company expressed interest in helping to address this problem and agreed to investigate the viability of producing smaller tubes if we could demonstrate the need. A study was proposed involving both SCA and University Hospitals Birmingham. This joint public/private sector study was approved by the Ethics Committee.

Aim

The aim of the study was to investigate if the introduction of 20ml tubes of wash cream as part of the regular skin care of incontinent patients would lead to the reduction of incontinence associated moisture lesions.

Primary objectives

To evaluate the skin condition of patients in identified clinical areas before the delivery of clinical education and the introduction of the 20ml tubes of wash cream, by collecting 13 weeks of data on incontinence associated moisture lesion incidence. Data would then be collected for a further 13 weeks to evaluate the impact on skin conditions in incontinent patients following clinical education and introduction of the smaller tubes.

Secondary objectives

To evaluate current skin care practice for incontinent patients in our hospital.

To deliver skin care, including correct classification of moisture lesions supporting the educational messages of the trust tissue viability team and correct use of wash cream education to identified clinical areas.¹⁰

To evaluate nursing staff perceptions with regard to change in practice, including:

- The nursing staff’s perception of the impact of incontinence on the condition of patient’s skin
- The nursing staff’s ability to differentiate between incontinence associated moisture lesions and Grade II PUs
- The nursing staff’s perception of the impact on nursing time

To evaluate patient perceptions with regard to their care experience.

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Method

The trust's Pressure Ulcer Action Group identified five clinical areas for inclusion in the trial. A sixth clinical area was deselected as another study was already taking place which could potentially compromise the data. The five ward areas included older adult medicine, stroke, general medicine, oncology and colorectal specialities.

The study compared the incidence of incontinence associated moisture lesions before and after the introduction of smaller tubes of non-rinse cleanser with and without additional education.

A statistician randomly identified the older adult medicine, general medicine and oncology wards to receive education and 20ml tubes of wash cream. The stroke ward was identified to receive education only and the colorectal ward to receive neither, both acting as control groups.

During the pre-study period the lead nurse for continence collected incontinence associated moisture lesion incidence data from each clinical area on a weekly basis for 13 weeks from January until March 2014. The trust tissue viability team collected PU data.

As there is no widely accepted, valid or reliable tool for the assessment of this form of skin damage, the prevalence of incontinence associated moisture lesions is difficult to measure. For the purpose of this study the European Pressure Ulcer Advisory Panel (EPUAP)/National Pressure Ulcer Advisory Panel (NPUAP) tool¹⁰ was used, as it was already in use throughout the hospital to assess and monitor PU incidence.

To benchmark our findings, previous studies were reviewed; Brown reported 35% prevalence in a sample of 166 adults in an acute medical setting¹¹ and Ehman et al. reported 36% in a sample group of 45 adult patients in an intensive care setting.¹²

Education

Throughout April teaching was provided for all grades of nursing staff, both day and night working, in the identified clinical areas. The TENA nurse advisor or the lead nurse for continence provided this on each ward. This was to ensure the inclusion of as many staff as possible. All staff before receiving the education completed a pre-evaluation questionnaire. The presentations lasted no more than 30 minutes, providing elementary anatomy and physiology of the skin, addressing why the care of incontinent patients is so important and to introduce a wash cream skin care protocol. The teaching package was designed to complement PU education already being provided throughout the hospital by the Tissue Viability Team. The same key messages were delivered to each member of the nursing teams.

The 20ml tubes of wash cream were delivered to

the clinical areas identified by the statistician on completion of the education period. The lead nurse for continence then collected a further 13 weeks data of incontinence associated moisture lesion incidence on a weekly basis from all the identified clinical areas.

Incontinence associated moisture lesions and PUs require different clinical intervention; therefore early recognition and the use of appropriate intervention (i.e. appropriate containment and skin care) may prevent incontinence associated moisture lesions occurring in the first place. The education package therefore supported the messages that were already being disseminated by the Trust tissue viability team including 'to be able to differentiate between moisture lesions and pressure ulcers' (i.e. the location, shape and depth of any skin damage).¹³

In addition to correct classification of skin damage, the educational session was designed to inform nursing staff of the evidence available supporting the use of non-rinse skin cleansers. Soap and water is commonly used, but it is known that repeated exposure to alkaline surfactants results in skin irritation. The action of washing can also contribute to the mechanical damage of the skin.

The skin care regime advised the cleansing of soiled skin promptly after soiling episodes using the wash cream, avoiding excessive rubbing of the skin. In the case of heavy faecal soiling plain warm water was advised and the skin gently patted dry before application of the wash cream. A circle of cream the size of a ten pence coin was applied to a dry, or a slightly dampened wipe if the patient preferred, was advocated. Should further skin protection become necessary, Cavilon Durable Barrier Cream (3M) and Cavilon No-Sting Barrier Film (3M) were advised as per the trust's tissue viability team's guidelines.

Excessively dry skin develops cracks and fissures that can be as ineffective a barrier as an over hydrated one.¹⁴ If very dry skin is present, both emollient and barrier cream therapy may be necessary.¹⁵ However, staff were reminded of the potential for any skin sensitivity.

To evaluate the patients' and nurses' experiences of the change in practice, a further questionnaire was provided for the participating clinical areas.

Results

Study findings

Only PUs Grade II and above are recorded nationally, therefore, incontinence associated moisture lesion prevalence is not. This data might suggest therefore that incontinence associated moisture lesions should be recorded in order to prevent some Grade II PU arising, especially as all types of moisture lesions are often misclassified as Category II pressure ulcers as suggested by Defloor et al.¹⁶

At the time of delivering education

All staff commented upon the wastage of the 250ml tubes of wash cream. Often, several tubes could be found on one patient's locker leaving no stock for other patients. Some senior sisters were rationing its use to prevent escalating cost inefficiencies.

Most staff felt that there was no specific protocol for the hygiene needs of incontinent patients despite there being trust tissue viability, urinary continence and bowel care guidelines on the hospital intranet. However, most nursing staff were aware of the SKIN tool documentation (developed by the tissue viability team, following the publication of Whitlock et al.)¹⁷ in use and the Waterlow PU risk assessment/prevention tool.

The training sessions identified that some staff had attended educational sessions provided by the tissue viability nurses and had a good knowledge of the identification of PUs, but were still unsure about the accurate identification of incontinence associated moisture lesions. They were aware, however, that Cavilon products are compatible with wash cream. Bank and agency nurses reported that educational opportunities are not always available to them.

At the time of demonstrating the correct application of the wash cream, it was sometimes found to be difficult to apply effectively due to the flimsy quality of the disposable dry wipes being used. The wipes folded back on themselves during the application resulting in a 'wipe on', wipe off' effect. This in turn resulted in several wipes being used together to get the required tension, resulting in another cost inefficiency. TENA Soft Wipes were therefore introduced into the study for evaluation.

Some staff reported having used the wash cream incorrectly. They had tried adding the wash cream to a bowl of warm water. Consequently, they felt the product was named incorrectly.

The educational sessions provoked positive discussion in regard to promotion of continence and good management of incontinence. However, it also provoked strong discussion about whose responsibility it should be to care for patients' hygiene needs following an incontinence episode, trained or untrained nurses? Some nursing auxiliaries felt current university-based nurse training encouraged a belief that this fundamental role was not one for qualified nursing staff.

The delivery of the education within the study timetable proved very time intensive, and only 50% of staff in each clinical area were seen due to the difficulties of releasing staff even though the education was being delivered in each clinical area. As there were two educators, it was decided that the trust lead continence nurse would relieve a member or members of the ward nursing team in order for them to receive the training so that patient care was not compromised. This change in role, identified to the lead

Fig 1. Incontinence associated moisture lesions per clinical area. Effect of training and product provision on incidence of incontinence associated moisture lesions

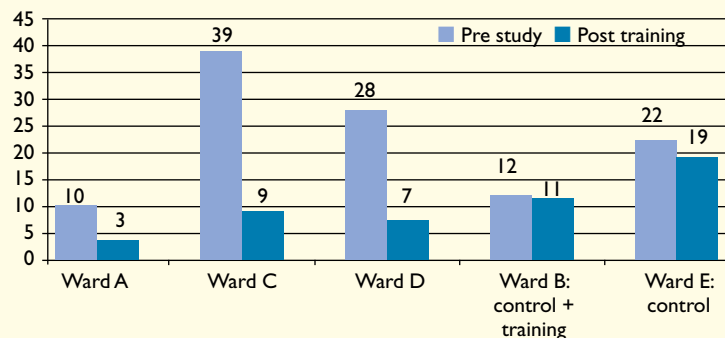
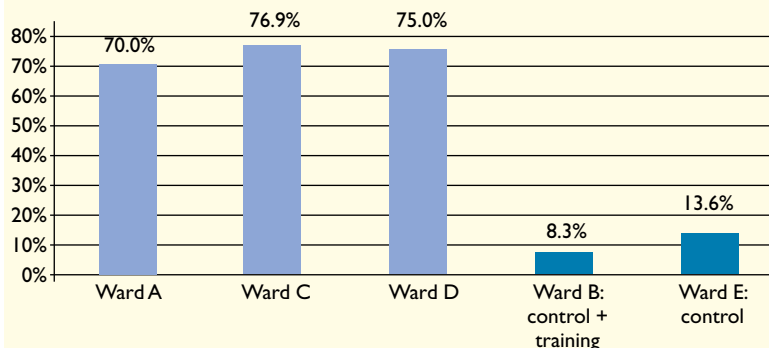


Fig 2. Reduction of incontinence associated moisture lesions



continence nurse, an inadequate supply of suitable toileting aids and the need to investigate this further. It also became apparent that the nursing staff to patient ratio may have been deficient in some clinical areas. Caring for patients with bladder and bowel dysfunction is often very time consuming. However, dependency rating studies are already under way in all clinical areas to ensure appropriate staffing levels.

Outcomes

From the results displayed in Fig 1 and 2 wards A, C and D had the largest reduction in incontinence associated moisture lesion incidence, 70%, 76.9% and 75%, respectively, which were wards that received education and the smaller tubes of wash cream. The control wards had the lowest reduction in incidence, ward B had 8.3% and ward E 13.6%, which would suggest both education and correct product are necessary for a positive outcome.

Post-trial questionnaire comments

The post-evaluation questionnaires revealed that most staff were not aware of any structured skin care protocol or regime and felt that the assessing nurse decided upon the patient care plan. However, there

Table 1. Wash cream post evaluation questionnaire results

Question	Answer	Auxiliary nurses	Qualified nurses
Patient Care Gently cleanses the skin	Strongly disagree	—	—
	Disagree	9%	—
	Agree	75%	43.5%
	Strongly agree	16%	56.5%
Moisturises the skin	Strongly disagree	—	—
	Disagree	8%	—
	Agree	67%	48%
	Strongly agree	25%	52%
Less skin redness	Strongly disagree	5%	—
	Disagree	34%	9%
	Agree	43%	52%
	Strongly agree	18%	39%
Demonstrates a skin protecting effect	Strongly disagree	2%	—
	Disagree	23%	13%
	Agree	61%	52%
	Strongly agree	14%	35%
Easy to apply	Strongly disagree	2%	—
	Disagree	16%	9%
	Agree	64%	35%
	Strongly agree	18%	56%
Reduces odour	Strongly disagree	5%	—
	Disagree	18%	9%
	Agree	59%	43%
	Strongly agree	18%	48%
More comfortable & dignified	Strongly disagree	—	—
	Disagree	20%	9%
	Agree	66%	41%
	Strongly agree	14%	50%
Do you believe the wash cream supported in prevention of skin breakdown?	Strongly disagree	5%	—
	Disagree	20%	13%
	Agree	64%	43.5%
	Strongly agree	11%	43.5%
Nursing Staff Ease of use	Strongly disagree	5%	—
	Disagree	14%	4%
	Agree	54%	44%
	Strongly agree	27%	52%
Were the TENA wipes better than ones currently used?	Strongly disagree	9%	—
	Disagree	29%	26%
	Agree	44%	44%
	Strongly agree	18%	30%

Acknowledgements

The patients, all the staff involved in this study and Linda Halsted, Nurse Advisor who participated in the provision of education during the study.

was a strong awareness of the SKIN tool being used throughout the hospital. Of those participating in the study, only two members of staff mentioned use of the hospital continence assessment document and these were auxiliary nurses. Only one nurse mentioned that ensuring the use of the most appropriate pad absorbency would assist in the prevention of incontinence associated moisture lesions and again this nurse was an auxiliary nurse. Several auxiliary nurses mentioned regular toileting and use of barrier creams as aids to incontinence associated moisture lesion prevention.

It also became apparent following the Continence Benchmark exercise, carried out throughout the hospital post study, that many nurses were still confused with regard to prevention. This was possibly as a consequence of a significant amount of education having been provided by the tissue viability team in the drive to reduce the numbers of PUs. Many of the nursing teams confused PU prevention strategies with incontinence associated moisture lesion prevention strategies. There was a common theme that repositioning, regular turning and the use of correct pressure relieving mattresses would prevent incontinence associated moisture lesions occurring.

Nevertheless, the wards that had received the education as part of the trial demonstrated excellent knowledge in the Continence Benchmark exercise.

The 20ml tubes of wash cream proved popular but most felt them to be slightly too small favouring availability of a range of sizes including 120mls, especially as the majority thought the ten pence coin size amount of cream may not be enough (Table 1).

It was not felt that the use of the wash cream had any negative impact upon nursing time spent with the patient.

Discussion

The study has demonstrated that many nurses do consider implications of using products for patients, as the majority of nurses involved in the study felt the 20ml tubes of wash cream to be more cost-effective and better for individual patient use, reducing the risks of cross contamination.

This study has clearly demonstrated that non-rinse cleansers do make a significant difference in preventing incontinence related moisture lesions, as there was a 70–76.9% reduction in incontinence related moisture lesions. The staff questionnaire also demonstrates an overwhelming 91% agreement from auxiliary nurses and 100% from qualified nurses that wash cream gently cleanses and moisturises the skin, while 75% of auxiliary nurses and 87% of qualified nurses agreed a skin-protecting effect was demonstrated.

Challenges

Despite most nurses demonstrating a positive attitude towards the study, there was a very small minority group who still felt soap and water was best, commenting: ‘the cream is too greasy, has an unpleasant smell and doesn’t clean, it just smudges.’ However, this group had not received the education element of the study, which may suggest a misconception of the application technique and were pre-judging the wash cream before understanding the benefits. Patients were content with the use of the wash cream.

Limitations of the study

The study was additional to the normal workload of the lead nurse for continence nurse and was found

to be challenging. The study was time intensive and required a huge commitment from all involved. The study would not have been successful if it had not had the support of the chief nurse and senior nursing team. To facilitate the data collection of incontinence associated moisture lesions a 'link nurse' was identified in each clinical area. The lead nurse for continence then correlated the data.

Differentiating incontinence associated moisture lesions and a PU is a challenging area of clinical practice. Gray et al.¹⁸ a multinational group of clinicians, reviewed publications over the previous 5 years. The review revealed a small but growing body of evidence showing progress in our understanding of the epidemiology, pathophysiology, diagnosis and treatment of this clinically relevant condition. Nevertheless, research remains limited and ongoing work is needed to enhance our understanding of incontinence associated moisture lesions and to establish evidence-based protocols for its prevention and treatment. The EPUAP/NPUAP (2009) tool¹⁰ was used during this study; the guidelines were revised in 2014 and have now been adopted throughout the hospital.

Recommendations

- A strong nursing culture advocating that the toileting needs of patients and management of incontinence is the responsibility of both qualified and unqualified nursing staff
- For organisations to consider the educational needs of bank and agency nursing staff and how these needs may be met
- For organisations to be creative when delivering education, to ensure a wider audience is captured when the release of staff from the clinical area is difficult.

Conclusion

Patients who are identified to be at high risk of developing incontinence associated moisture lesions, should be assessed by a competent professional with good knowledge of the continence assessment process. Skin assessment, hygiene care and continence management are fundamental nursing activities. If prevention strategies are put into place in a timely manner, incontinence associated moisture lesions can be avoided. Continence, tissue viability and colorectal nurse specialists have differing areas of expertise which can be used in collaboration in order to provide optimal care. Where joint working is difficult, agreed guidelines promoting best practice should be employed.¹⁹ Furthermore, PU prevention when linked to the use of a skin care regime and education has also been shown to reduce the incidence of PUs in hospitalised patients with incontinence and was associated with a 5% reduction in the cost of PU management.²⁰

The skin care practices employed in this study may also be easily extended to other areas of skin

Table 1. Wash cream post evaluation questionnaire results (continued)

Question	Answer	Auxiliary nurses	Qualified nurses
Able to provide preventative Skincare	Strongly disagree	9%	13%
	Disagree	18%	61%
	Agree	64%	26%
	Strongly agree	9%	—
Requires less time to use than traditional soap & water	Strongly disagree	9%	13%
	Disagree	18%	61%
	Agree	50%	26%
	Strongly agree	23%	—
Do you feel you now have clarification on how to care for skin of incontinent patients?	Strongly disagree	2%	—
	Disagree	18%	—
	Agree	62%	—
	Strongly agree	18%	—
Do you feel your ability to differentiate between moisture lesions & G2 pressure ulcers has improved?	Strongly disagree	7%	65%
	Disagree	16%	35%
	Agree	57%	—
	Strongly agree	20%	—
A ten pence coin size/10ml dose of wash cream has been advocated do you feel:	Too much	2%	61%
	Not enough	80%	39%
	Just the right amount	18%	—
Do you feel the 20ml tubes are more cost effective?	Yes	66%	74%
	No	34%	26%
Do you feel the 20ml tubes are better for individual use & reduce risk of cross contamination?	Yes	75%	86%
	No	25%	14%
The wash cream is currently available in 250ml tubes. Would you prefer	20ml tubes	36%	22%
	120ml tubes	46%	65%
	250ml tubes	18%	13%
Were patients content with their skincare?	Strongly disagree	—	—
	Disagree	5%	—
	Agree	84%	86%
	Strongly agree	11%	14%
Did patients find the Patient Leaflet helpful?	Strongly disagree	5%	—
	Disagree	25%	—
	Agree	65%	70%
	Strongly agree	5%	30%
Did you receive pre-study education from the TENA Nurse Advisor &/or Continence Nurse Specialist?	Yes	59%	83%
	No	41%	17%

susceptible to damage from moisture, for example tracheostomy, oxygen therapy and wound drain sites, exuding wounds and skin perspiration, particularly in larger patients. ■