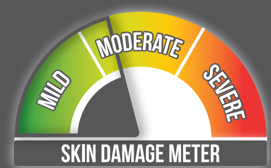
# Prevention and Management of Incontinence-Associated Dermatitis

The effective prevention and management of Incontinence-Associated Dermatitis (IAD) is more important than ever in light of the COVID-19 pandemic. Early and preventative use of **MEDI DERMA-S** and **MEDI DERMA-*PRO*** can be effective in preventing more severe cases of IAD (Use in line with the Skin Damage Meter below).

## EXTENT OF SKIN DAMAGE

**Skin Preparation:** Wash skin with an emollient/soap substitute and rinse. Pat dry before application.
In severe cases of IAD, use **MEDI DERMA-*PRO* Foam and Spray Incontinence Cleanser**

### PREVENTION/MILD*



**MEDI DERMA-S**
**Total Barrier Cream** can be used before signs of **IAD** appear to prevent the development of **Mild IAD**.

Erythema (redness) of skin, dry and intact but irritated and at risk of breakdown.

**MEDI DERMA-S Total Barrier Cream**

Apply every third wash/twice a day.

A pea-sized amount will cover an area approximately the size of the palm of a hand.

### MODERATE*

Erythema with less than 50% damaged skin.

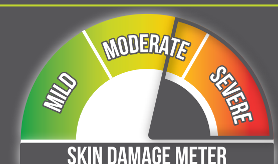
Oozing and/or bleeding may be present.

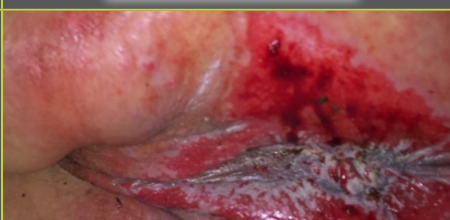
**MEDI DERMA-S Total Barrier Film**

Apply once a day.

**There is no need to re-apply after every cleanse.*

### SEVERE**



Erythema with more than 50% damaged skin.

Oozing and/or bleeding usually present.

**MEDI DERMA-*PRO* Ointment and Cleanser**

Use **MEDI DERMA-*PRO* Foam & Spray Incontinence Cleanser**, pat dry and apply **MEDI DERMA-*PRO* Skin Protectant Ointment** at every cleanse or wash.

**If using anti-fungal cream for infected area, wait for cream to dry then apply* **MEDI DERMA-*PRO*** *Skin Protectant Ointment.*

**WHAT TO LOOK FOR?**

Changes in the severity and/or frequency of faecal incontinence - loose stools can lead to severe skin damage and may increase the risk of pressure damage - early intervention may be required. In severe cases where there is no improvement within a week contact the community or tissue viability nurse.

*Note : Regular skin assessment is important - reassess the severity of the damage and step-up or step-down treatment as appropriate, in line with the Skin Damage Meter (Mild, Moderate or Severe).*
**Images of mild and moderate Incontinence - Associated Dermatitis courtesy of Sheffield Teaching Hospitals NHS Trust. **Image of severe skin damage courtesy of Maria Hughes.*

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# Pressure Ulcers vs Incontinence-Associated Dermatitis (IAD): A Differentiation Guide

**Moisture-Associated Skin Damage (MASD)**
MASD is an umbrella term used to describe inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture[1] i.e. urine, faeces, wound exudate, perspiration and stoma effluent.

**Incontinence-Associated Dermatitis (IAD)**
Skin damage as a result of continuous exposure to urine and/or faeces is known as Incontinence-Associated Dermatitis (IAD), one of the commonly recognised causes of MASD. It typically presents as localised redness, with areas of partial thickness skin loss. Whereas pressure ulcers are localised damage to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure,or pressure in combination with shear.[2]

**Pressure Ulcers & Incontinence-Associated Dermatitis (IAD)**
Skin damage, particularly around the sacral area, is often considered to be due to pressure damage, when frequently it is a result of IAD. These two conditions can present simultaneously in an individual, so must be correctly identified to plan appropriate prevention and treatment strategies.

## Differentiation Guide

| Cause | Pressure Ulcer<br>Established cause - Pressure and/or shear | Incontinence-Associated Dermatitis (IAD)<br>Established cause - Continuous exposure to urine and/or faeces |
|---|---|---|
| Location | Most likely over a bony prominence | Can occur over a bony prominence if moisture present - exclude pressure and shear. A linear (straight) lesion limited to the anal cleft is likely a moisture lesion. Peri-anal redness/irritation is most likely a moisture lesion due to faeces. |
| Shape/Edges | Regular shape with a more defined wound edge | Diffusely scattered, irregularly shaped.<br>If a 'kissing' lesion is observed across two adjacent surfaces, at least one is likely due to moisture. |
| Colour | Non-blanching redness or blue/purple discolouration is likely due to pressure damage.<br>Red granulation, soft/black necrotic or sloughy tissue in the wound bed indicates a pressure ulcer. | If redness or discolouration is uneven, moisture damage is the likely cause.<br>Pink or white surrounding skin indicates maceration |
| Depth | Can vary in depth from unbroken non-blanching erythema to full thickness tissue loss extending to tendon or bone | Superficial – Partial thickness skin loss, but may enlarge when infection is present |
| Necrosis | Presence of necrosis (black scab or softening blue, brown, grey or yellow tissue) indicates a pressure ulcer | Moisture lesions do not contain necrotic tissue. Where there is **necrotic tissue** within the IAD, this will be due to a **combination** of both pressure and moisture damage and should be reported as a pressure ulcer.[4] |


*References:* **1.** *Grey M, Black JM, Baharestani MM, et al (2011) Moisture associated skin damage: an overview and pathophysiology. J Wound Ostomy Continence Nurse 38(3): 233–41.* **2.** *National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.).Cambridge Media: Osborne Park, Australia; 2014.* **3.** *Beeckman D, Woodward, S & Gray, M. (2011). Incontinence-associated dermatitis: Step-by-step prevention and treatment. British journal of community nursing. 16(8): 382-9.* **4.** *NHS Improvement (2018) Pressure ulcers: revised definition and measurement Summary and recommendations.*