<table>
<thead>
<tr>
<th>NAME OF DOCUMENT</th>
<th>Wound - Incontinence Associated Dermatitis (IAD)</th>
</tr>
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<td>National Safety and Quality Health Service Standards: Standard 1 Governance for Safety and Quality in Health Service Organisations Standard 8 Preventing and Managing Pressure Injuries</td>
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</tbody>
</table>
| EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR | Dr Greg Keogh  
Greg.keogh@health.nsw.gov.au  
SESLHD Director- Surgery, Anaesthetics and Per-Operative Services |
| AUTHOR            | SESLHD/ISLHD Wound Care Committee  
Carol.stott@health.nsw.gov.au |
| POSITION RESPONSIBLE FOR THE DOCUMENT | Sally Peters  
SESLHD Clinical Stream Nurse Manager – Innovation and Improvement  
sally.peters@health.nsw.gov.au |
| KEY TERMS         | Dermatitis, faecal incontinence, nappy rash, urinary incontinence |
| SUMMARY           | Procedure for the prevention and management of Incontinence Associated Dermatitis (IAD) |
1. **POLICY STATEMENT**

This procedure is applicable to adults and children at risk of Incontinence Associated Dermatitis (IAD). All patients who are incontinent of urine and/or faeces must have an appropriate skin care regimen in place to prevent IAD. If IAD is present, treatment is to commence to manage IAD by the use of an appropriate skin care routine.

An appropriate skin care regime is in place for all neonates and infants, as their skin is thinner than that of adults and produces fewer secretions and is therefore at greater risk of skin breakdown and IAD\(^1\).

Any patient who experiences incontinence (excluding neonates and infants who are not toilet trained), should have the reason for their incontinence investigated and appropriate management strategies in place.

- In the first instance seek medical advice on cause of incontinence.
- Review the patient’s incontinence management plan to ensure optimal care of their condition.

2. **BACKGROUND**

Skin problems can occur with incontinence, as the urea and ammonia in urine can affect the slightly acidic pH balance of skin, causing it to become too alkaline. With Urinary incontinence, water in the urine contributes to over-hydration of the skin; the wet skin becomes soggy. This leads to tissue-softening so the skin is easily ‘burnt’.

Perspiration can also add to the risk of irritation and painful skin breakdown. Wet skin has a lower temperature than dry skin; wet skin under a pressure load has less blood flow than dry skin.

Faecal incontinence will lead to active faecal enzymes on the skin, which contribute to skin damage. Faecal bacteria can penetrate the skin, increasing the risk of secondary infection.

3. **DEFINITIONS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Incontinence Associated Dermatitis (IAD)</td>
<td>Inflammation of the skin associated with exposure to leaked urine or stool(^2).</td>
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<tr>
<td>Cleansers (skin)</td>
<td>Are an alternative to soap and water and are designed to maintain normal (slightly acidic) pH and moisture content of the skin.</td>
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<tr>
<td>Incontinent aids</td>
<td>Multilayer disposable garments containing a superabsorbent polymer. The polymer is designed to wick and trap moisture in the containment device.</td>
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<tr>
<td>Emollient</td>
<td>Are non-cosmetic moisturisers which come in the form of creams, ointments, lotions and gels. Emollients help skin to feel more comfortable and less itchy. They keep the skin moist and flexible, helping to prevent cracks.</td>
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<tr>
<td>Humectant</td>
<td>Is an ingredient that draws water molecules out of its environment towards itself. They attract water from the atmosphere and from the lower layers of the skin to the skin surface. If over used can cause dehydration of the lower layer of the skin.</td>
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</table>
4. RESPONSIBILITIES

4.1 Employees will:
- Ensure that they work within their scope of practice and attend relevant education related to this procedure.

4.2 Line Managers will:
- Ensure all clinical staff are given the opportunity to attend LHD wound management education and that all nursing staff work within this procedure and have appropriate resource and stock items to implement the recommendations within this procedure.

5. PROCEDURE

5.1 Identify patients who are at risk of IAD and put in place preventative strategies to prevent IAD (refer to Appendix 1)

5.2 If an injury to the skin occurs, staff need to identify:
- that the injury to the skin is IAD and not a pressure injury (refer to Appendix 2)
- that the injury to the skin is not fungi infection (refer to Appendix 3)

5.3 Clean skin after each episode of incontinence as soon as possible using a pH skin friendly cleaner to prevent changes to normal skin pH. When IAD is identified the regimen must be adjusted.

5.4 The recommended skin care regimen in patients with incontinence includes a four step regimen of cleanse, moisturise, protect and contain\(^1\,^2\).

**Cleanse**
Ideally, using a no rinse formulation such as incontinence or perineal cleansers, disposable wipes, 3-in-1 sprays, or a cleanser that contains a surfactant e.g. Conveen: EasiCleanse™. Gentle mechanical actions to be used when cleansing, avoiding scrubbing or use of towels\(^1\,^2\). Avoid soap and water to reduce potential skin damage\(^1\).

**Moisturise**
Most cleansers also contain a moisturiser. If a separate moisturiser is used, a moisturiser that contains an emollient is preferred to one that contains a humectant\(^1\,^2\).

**Protect**
Use an occlusive moisturiser such as zinc oxide, Dimethicone™ and petrolatum and protective skin barriers\(^2\). Barrier films such as Cavilon No Sting™ barrier film may also be used\(^3\). For list of suggested protect products and application considerations.

**Contain**
Containment or diversion of urine and stool, containment devices include:
- **External** collection devices such as male external catheters or anal pouches. Follow instructions as per manufacturer’s recommendations for techniques in application
- **Absorptive** incontinence pads must be changed frequently. In the presence of faecal incontinence, incontinence-pads can ‘hold’ the faeces close to the skin precipitating the IAD
- **Diversion** of urine or stool may involve insertion of indwelling urinary catheter or indwelling faecal drainage system\(^1\,^2\). Follow the manufacturer’s recommendations in the assessment and use of these devices.

5.5 Creams used are to be applied as per manufacturer’s instructions. Refer to Appendix 4 for suggested creams.
5.6 If incontinence pads are used, all creams used must be completely rubbed into skin, if cream is left on the skin it will block the absorption of urine or faeces into the incontinent pads.

5.7 If skin is denuded and cream will not adhere, a light sprinkling of ‘stoma powder/hydrocolloid powder’ to the area after cleansing will facilitate application of cream.

5.8 Do not use any products which contain alcohol on excoriated skin as this will cause extreme pain.

5.9 Avoid the use of dry toilet paper, opting for cleansers as outlined above.

5.10 Ensure assessment of pain related to IAD skin care and cleaning.

5.11 Educate parents/carers on the management of IAD when appropriate – refer to appendix 5.

5.12 Contact the wound/stoma or continence CNC should the above strategies not be effective.

CAUTION: Any patients undergoing radiotherapy or MRI are not to have any ZINC based products used on their skin on that day.

6. DOCUMENTATION

6.1 If skin broken and dressing required, record in

- MR Wound Assessment and management form S0056 for in-patients and out-patient clinics or eMR equivalent (when available)
- eMR WATEP Community Health Outpatient Communication (CHOC) for Ambulatory Primary Health Care (APHC)

6.2 If skin unbroken, record in eMR progress notes

7. AUDIT

Nil required

8. REFERENCES

8.1 External References


4. Joanna Briggs Institute 2007 Topical skin care in aged care facilities, Best Practice, 11 (3), 1-4

5. Hartmann Australia Education material 2016


8.2 **Internal References**

- SESLHDPR/297 Wound - assessment and management
- SESLHDPR/547 Wound – Skin Assessment and Care/Management
- SESLHDPR/437 Wound Management - managing pain at dressing change
- SESLHDPR/343 Hand Hygiene, hand care and bare below the elbows
- SESLHDPR/357 Standard and Transmission Based (Additional) Precautions with Infectious Diseases

9. **REVISION AND APPROVAL HISTORY**

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
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<tbody>
<tr>
<td>July 2012</td>
<td>Draft</td>
<td>ISLHD/SESLHD Wound Care committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Draft for comment May 2012</td>
</tr>
<tr>
<td>August 2012</td>
<td>Draft</td>
<td>Endorsed Greg Keogh Stream Director- Surgery, Anaesthetic and Per-Operative Services</td>
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<tr>
<td>September 2012</td>
<td>1</td>
<td>The SESLHD Clinical &amp; Quality Council endorsed the Wound Care – Incontinence Associated Dermatitis procedure, subject to the document being reformatted to a procedure, not a policy.</td>
</tr>
<tr>
<td>September 2017</td>
<td>2</td>
<td>SESLHD Wound Care committee</td>
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<tr>
<td>November 2017</td>
<td>2</td>
<td>SESLHD Clinical and Quality Council endorsed for publishing</td>
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Appendix 1 - Prevention of IAD

- Continence aids (pads, pants, or pouches for males) must fit firmly yet comfortably to contain leakage and not rub on the skin.
- Putting on a well-fitting continence product correctly will ensure that it is reliable, works well and has minimal movement to prevent chafing, and that plastic does not come into contact with the skin.
- Avoid plastic pants as they ‘sweat’ and do not permit natural drying. Natural materials such as cotton feel cooler because they offer better air circulation, helping to avoid skin irritation.
- Incontinent aids must be changed frequently:
  - As they can hold heat and moisture against the skin which will lead to skin breakdown precipitating the IAD
  - In the presence of faecal incontinence, incontinence-pads can ‘hold’ the faeces close to the skin precipitating the IAD.
- Avoid soap and water to reduce potential skin damage.¹
- Clean skin after each episode of incontinence as soon as possible, using a pH skin friendly cleanser.
- Do not rub skin too hard as this can cause skin breakdown.
- Apply appropriate protector product - for intact skin before signs of IAD
  - Cavilon Durable Barrier Cream
  - Cavilon no sting barrier film
  - White paraffin (do not use if patient wearing incontinent pad).
Appendix 2 - Differences between Incontinence Associated Dermatitis (IAD) and Pressure Injuries

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>IAD</th>
<th>PRESSURE INJURY</th>
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<tbody>
<tr>
<td>History</td>
<td>Urinary and/or faecal incontinence</td>
<td>Exposure to pressure/shear</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Pain, itching, burning, tingling</td>
<td>Pain</td>
</tr>
<tr>
<td>Location</td>
<td>Affects perineum, peri genital area; buttocks; gluteal fold; medial and posterior aspects of upper thighs; lower back; may extend over bony prominence</td>
<td>Usually over bony prominence or associated with location of a medical device</td>
</tr>
<tr>
<td>Shape/Edges</td>
<td>Affected area is diffuse with poorly-defined edges/may be blotchy</td>
<td>Distinct edges or margins</td>
</tr>
<tr>
<td>Presentation/Depth</td>
<td>Intact Skin with Erythema (blanching or non-blanching), with/without superficial, partial thickness skin loss</td>
<td>Presentation varies from intact skin with non-blanching erythema to full-thickness skin loss. Base of wound may contain non-viable tissue</td>
</tr>
<tr>
<td>Other</td>
<td>Secondary superficial skin infection (e.g. Candidiasis may be present)</td>
<td>Secondary soft tissue infection may be present</td>
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### Appendix 3 - Incontinence Associated Dermatitis Verses Fungal infection skin changes

<table>
<thead>
<tr>
<th>Condition</th>
<th>Affected area</th>
<th>Colour</th>
<th>Edges</th>
<th>Skin Condition</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAD</td>
<td>Perianal area, pad area, lower abdomen and back</td>
<td>Pink to intense redness</td>
<td>Diffuse edges</td>
<td>Incontinence must be present</td>
<td>Incontinence-associated dermatitis (IAD) is an inflammation of the skin that occurs when urine or stool comes into contact with perineal or peri-anal skin</td>
</tr>
<tr>
<td>Fungal</td>
<td>Groin area, buttocks</td>
<td>Intensely red Glistening rash Satellite lesions</td>
<td>Scaling edges</td>
<td>Flaking, peeling or cracking skin</td>
<td>Red, scaling, itchy rash Satellite lesions More likely to occur in warm, moist, creased areas, including arm pits and groin Especially common in the obese, or those who have diabetes. People who are on antibiotics are also at higher risk</td>
</tr>
</tbody>
</table>

Reference: Hartmann Australia 2016
Appendix 4 - Treatment of IAD

Options for protective creams:

- **Calmoseptine**
  Apply a small amount to cover the area completely. Repeat after each bowel movement or when the skin becomes wet with urine or drainage. It is not necessary to remove all of the cream when soiling occurs, just where the cream has been removed as part of cleansing.

- **Cavilon** no sting barrier film
  After cleaning skin spray or wipe over broken area, repeat after each episode of incontinence.

- **Critic durable barrier cream** (this should only be used if incontinence has settled or patient is not wearing incontinent pads)
  Apply a small amount and gently rub into the skin. Reapply after each bowel movement or when the skin becomes wet with urine or drainage.

- **1, 2, 3 cream** made by pharmacy- recipe as follows:
  - Aluminium acetate 1 part
  - White paraffin 2 parts
  - Zinc 3 parts
  *1, 2, 3 cream needs to be applied in a thick layer not rubbed into the skin
  Note (this should only be used if patient is not wearing incontinent pads)

- **Sudocrem**
  Apply a small amount (fingertip size) and gently rub completely into the skin. Reapply after each bowel movement or when the skin becomes wet with urine or drainage.

Removal of these barrier creams can be done using an appropriate skin cleanser. Mineral, vegetable, baby oil or olive oil may facilitate removal also.
Appendix 5 - Patient education information Everyday Care for Healthy Skin

- Choose continence products carefully so they fit well, feel good and are secure against leakage
- Change continence pads and pants when needed
- Ensure your skin is cleaned promptly with a good cleanser
- Be gentle; cleanse the skin with care and pat dry
- Avoid harsh skin products that contain alcohol, perfumes or disinfectants – they can be drying and cause rashes
- Avoid using talcum powder and use barrier creams sparingly
- Be aware of your natural bladder and bowel ‘routines’, rather than always relying on a continence pad
- Be alert to a possible Urinary Tract Infection e.g. any burning or stinging from urinating. Seek medical assistance
- Eat a diet with lots of variety including protein, fruit and vegetables
- Drink plenty of fluids especially water
- Check often for signs of skin breakdown (redness, itching, flaking) and act promptly, including getting professional advice

Reference: Continence Foundation of Australia 2010 Patient Education Brochure