SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Aged Care and Rehabilitation, Cancer and Palliative Care, Child and Adolescent Health, Infection Control, Medicine, Surgery, Perioperative and Anaesthetic, and Women's and Babies
KEY TERMS	Dermatitis, faecal incontinence, nappy rash, urinary incontinence
SUMMARY	Procedure for the prevention and management of Incontinence Associated Dermatitis (IAD)

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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1. POLICY STATEMENT

The 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

Incontinence Associated Dermatitis (IAD)	Inflammation of the skin associated with exposure to leaked urine or stool[2].
Cleansers (skin)	Are an alternative to soap and water and are designed to maintain normal (slightly acidic) pH and moisture content of the skin.
Incontinent aids	Multilayer disposable garments containing a superabsorbent polymer. The polymer is designed to wick and trap moisture in the containment device.
Emollient	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.
Humectant	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 overused can cause dehydration of the lower layer of the skin.

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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)
- classify the category of the IAD using the GLOBAID IAD Monitoring tool (refer to Appendix 6).

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™ (e.g. Shield Wipes) and petrolatum and protective skin barriers[2]. Barrier films such as Cavilon No Sting™ barrier film may also be used[3]. Refer to Appendix 4 for list of suggested protecting products and application considerations.

Contain

Containment or diversion of urine and stool, containment devices include:

External collection devices such as male external catheters or faecal containment devices. 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.

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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 broken 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

1	Gupta, A & Skinner, A 2004 Management of diaper dermatitis. *Journal of Dermatology,* vol. 43 (11) November 2004
2	Black, J, Gray, M, Bliss, D, Kennedy-Evans, K, Logan, S, Baharestani, M, Colwell, J, Goldbery, M, Ratliff, C. 2011 MASD Part 2: Incontinence associated dermatitis and intertriginous dermatitis A consensus. *Journal of Wound ostomy and Continence Nursing,* 38 (4) 359-370.
3	Guest, J., Greener, M., Vowden, K., Vowden, P 2011 Clinical and economic evidence supporting a transparent barrier film dressing in incontinence associated dermatitis and peri-wound skin protection, *Journal of Wound Care,* 20 (2), 76-84
4	Joanna Briggs Institute 2007 Topical skin care in aged care facilities, *Best Practice,* 11 (3), 1-4
5	Hartmann Australia Education material 2016

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6	Nordqvist, C. & Wilson, DR (2017), Emollients: What are they and how can we use them? Medical news today http://www.medicalnewstoday.com/articles/182953.php
7	Beeckman D et al. Proceedings of the Global IAD Expert Panel. Incontinence Associated Dermatitis: moving prevention forward. Wounds International 2015.

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 - Bare Below the Elbows- Hand Hygiene

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
July 2012	Draft	ISLHD/SESLHD Wound Care committee Draft for comment May 2012
August 2012	Draft	Endorsed Greg Keogh Stream Director- Surgery, Anaesthetic and PerOperative Services
September 2012	1	The SESLHD Clinical & Quality Council endorsed the Wound Care – Incontinence Associated Dermatitis procedure, subject to the document being reformatted to a procedure, not a policy.
September 2017	2	SESLHD Wound Care committee
November 2017	2	SESLHD Clinical and Quality Council endorsed for publishing
October 2018	3	Minor Review to include information relating to Comfort Shield Wipes by SAGE in Appendix 4.
December 2022	4	Minor review. Links and hyperlinks updated. Minor grammatical changes. Approved by Executive Sponsor.

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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 damage1.
- 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).

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Appendix 2 - Differences between Incontinence Associated Dermatitis (IAD) and Pressure Injuries

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

Reference: Beeckman D et al. Proceedings of the Global IAD Expert Panel. Incontinence Associated Dermatitis: moving prevention forward. *Wounds International* 2015.

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Appendix 3 - Incontinence Associated Dermatitis Verses Fungal infection skin changes

Condition	Affected area	Colour	Edges	Skin Condition	Other
IAD	Perianal area, pad area, lower abdomen and back	Pink to intense redness	Diffuse edges	Incontinence must be present	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
Fungal	Groin area, buttocks	Intensely red Glistening rash Satellite lesions	Scaling edges	Flaking, peeling or cracking skin	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

Reference: Hartmann Australia 2016

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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 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.

- **Comfort Shield Wipes by SAGE** are used for treatment and prevention of Incontinence Associated Dermatitis (IAD) and Moisture Associated Skin Damage (MASD).

  Recommended Skin Care Management:

  IAD

  Urinary Incontinence:

  Apply Comfort Shield wipe only after each episode of incontinence.

  Use of soap and water is NOT necessary.

  Faecal Incontinence:

  1. Clean excessive faecal matter from area with water and rediwipe.
  2. Continue clean up with one to two Comfort Shield Wipes.

  Note: Continue to use wipes clean, treat and protect as long as incontinence continues.

  MASD

  Use one to two Comfort Shield Wipes in affected area (may be groin, apron, breast folds) twice daily.
  Consider use of Zetuvit or Combine between skin folds to manage moisture.

  Note: Continue to use Comfort Shield wipe on affected areas until healed.

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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.

References:
Clinical Excellence Commission IAD Best Practice Principles 2021
https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0015/424401/Incontinence-Associated-Dermatitis-IAD-Best-Practice-Principles.pdf

Continence Foundation of Australia 2010 Patient Education Brochure
https://continence.my.salesforce.com/sfc/p/#A0000000KUc9/a/5K0000002htI/ZjW3OqzKSmtLd9mBxwmzjRrtH_hSV2X.8cIGZ3OnuHI

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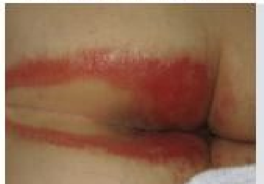
Appendix 6 – Ghent Global IAD Monitoring Tool (GLOBIAD)

Incontinence associated dermatitis, like pressure injury, can be classified into stages based on its clinical presentation. The GLOBIAD-M tool is a validated and reliable tool that can be used to support clinical decision making for IAD support.

Category 1: Persistent redness

1A - Persistent redness without clinical signs of infection

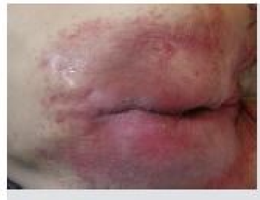


Critical criterion
- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Additional criteria
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

1A

1B - Persistent redness with clinical signs of infection



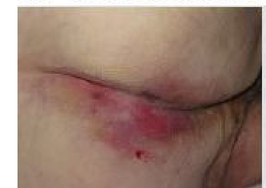
Critical criteria
- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.
- Signs of infection
  Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection).

Additional criteria
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and bullae
- The skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

1B

Category 2: Skin loss

2A - Skin loss without clinical signs of infection

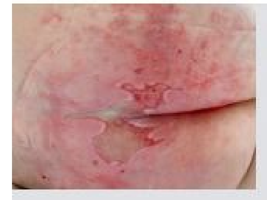


Critical criterion
- Skin loss
  Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.

Additional criteria
- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

2A

2B - Skin loss with clinical signs of infection



Critical criteria
- Skin loss
  Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.
- Signs of infection
  Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection), slough visible in the wound bed (yellow/brown/greyish), green appearance within the wound bed (suggesting a bacterial infection with Pseudomonas aeruginosa), excessive exudate levels, purulent exudate (pus) or a shiny appearance of the wound bed.

Additional criteria
- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

2B

Reference: Van den Bussche et al 2018, The Ghent Global IAD Monitoring Tool (GLOBIAD-M) to monitor the healing of incontinence-associated dermatitis (IAD): Design and reliability study. *International Wound Journal*, 15(4): 555-564.

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