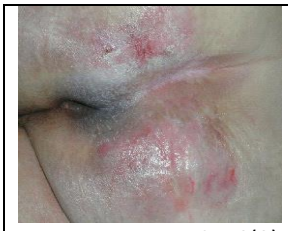
Prevention and Treatment Guidance Incontinence Associated Dermatitis

STEP 1 Skin at Risk: General care for all patients with incontinence (Urine or Formed/Soft stool)

Assess if pressure damage is present. Is the area blanching or non-blanching? Is a pressure ulcer present within a moisture lesion. Grade the pressure damage appropriately. Do not report a moisture lesion as a clinical incident unless you have concerns. Implement the skin bundle and request the appropriate equipment according to the patient's clinical needs.

- Deliver skin care immediately after each episode of incontinence
- Wash the area with a soap free cleanser PH balanced cleanser (see formulary). Pat dry (don't rub) the skin
- Apply Derma S cream after every 3rd episode of incontinence (unbroken skin).
- Derma S can be applied to broken skin.
- Make sure a well fitting incontinence pad is used (blue incontinence sheets do not manage incontinence well) and consider patients usual coping strategies. Ensure pads are not layered as this will affect the benefits to be obtained from pressure relieving/reducing mattresses.

Follow referral protocols for investigating urinary and faecal incontinence.

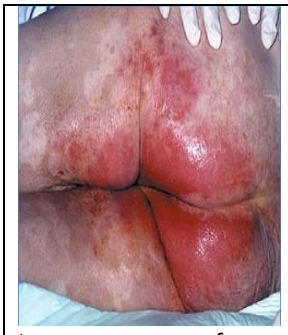


Images www.PUCLAS(3)

STEP 2 Mild Incontinence Associated Dermatitis

(Patient is incontinent of Urine or Formed /Soft stool)

- Check that above actions are all in place
- Use Derma S cream .Remember a pea sized amount approximately will cover your palm.
- Consider fungal infection – if suspected stop Derma S and request medical review/anti fungal cream prescription



Images courtesy of Convatec

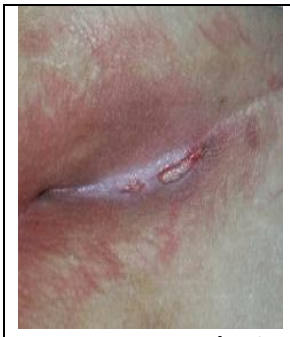
STEP 3 Faecal Incontinence-Type 6/7 stool (all skin conditions) or more severe/deteriorating erythema.

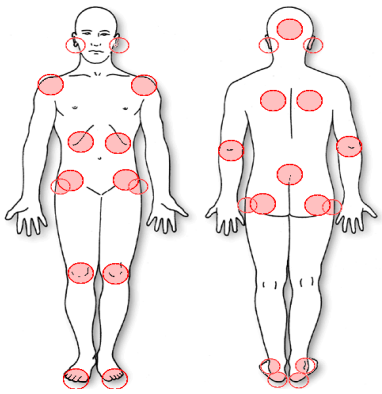
For every episode of incontinence

- Use Medi Pro spray foam cleanser to cleanse (Unbroken Skin). It has a foam and spray mode. Foam stays in place more easily on the skin and avoids splash back.
- Use Dermol 500 to cleanse if broken skin.
- Apply Medi Pro cream a uniform coating of the ointment should be applied over the whole area to be treated. A more liberal application may be required for severely moist or damaged skin.
- Medi Pro is for short term use only until the problem is resolved then refer back to Medi Derma S products.

Stop all other creams (except anti fungal cream if prescribed)
Consider flexiseal/urinary catheter if there is deteriorating skin damage.

If no improvement in 48 hours refer to tissue viability.

 **Images: www.puclas 2**	**Pressure Ulcer or Moisture Lesion?** All pressure ulcers must be graded and reported as per local pressure ulcer policy. Moisture must be present. Remember moisture lesions may be present in combination with pressure ulcer/ulcers. Usually superficial damage Diffuse multi focal skin damage with irregular margins likely to be moisture. **See over for more information.**

	Pressure Ulcer	Moisture lesion
Causes	Pressure and/or shear must be present	Moisture must be present (eg. wet skin caused by incontinence ……
Location	A wound not over a bony prominence is unlikely to be a pressure ulcer. Equipment related – under a device/tube Skin folds (may be combination) 	Moisture lesions may occur over a bony prominence eg coccyx. Pressure & shear should be excluded as causes and moisture should be present. A lesion that is limited to the anal cleft and has a linear shape is likely to be a moisture lesion. Superficial skin loss may develop from urinary/faecal incontinence and may extend to the thighs. Peri-anal redness/skin irritation is most likely to be a moisture lesion due to faeces. **Moisture lesions can be combined with pressure ulcers**
Shape	If the lesion is localised it is more likely to be a pressure ulcer. Circular wounds or with a regular shape.	Diffuse, differential superficial spots are more likely to be moisture lesions. Kissing, butterfly or mirroring effect. Anal cleft – linear shape

Depth	Dependent on category of ulcer	No necrosis
Edge	Raised edge if chronic. Cliff type margins if deep tissue loss.	Diffuse and irregular
Colour/Wound Bed	Necrosis – Slough – Granulation- Epithelial	Non uniform redness Maceration/Excoriation. Peri-anal redness
Distribution	Patchy	Isolated individual lesions.