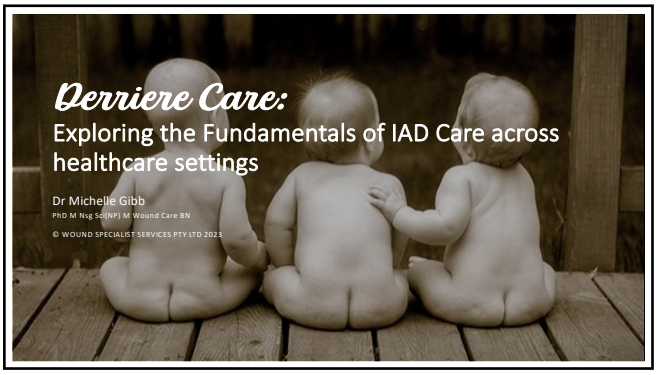


1

Learning objectives

At the end of this session, it is expected that you will be able to:

- Understand the impact of IAD
- Recognise the symptoms of IAD
- Distinguish between IAD and pressure injuries
- Identify strategies to manage & prevent IAD
- Understand the implications of IAD & the new quality indicators

WOUND SPECIALIST Services

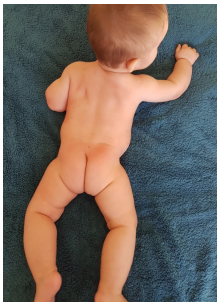
2

What is Incontinence-Associated Dermatitis (IAD)?

Urine +/- faeces = IAD

Other names

Nappy rash	Nappy dermatitis	Irritant dermatitis	Moisture lesions	Perineal dermatitis	Perineal rash



3

How common is IAD?

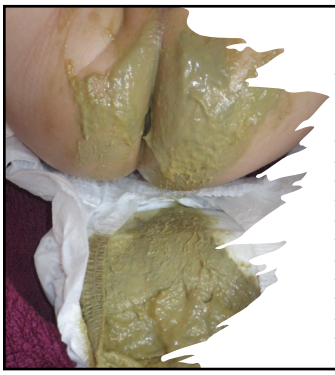
- Prevalence ranges from 20 - 40%
- Of 25% of patients with incontinence, 42% had IAD

IAD + unrelieved pressure results in a

5-fold increase in pressure injury risk

WOUND SPECIALIST Services

4

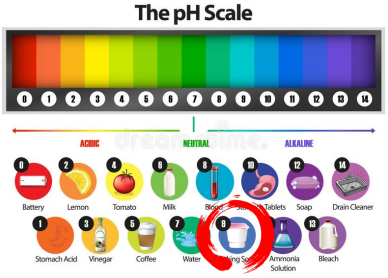


Risks for IAD

- Type of incontinence
  - Faecal incontinence (diarrhoea/formed stool)
  - Double incontinence (faecal and urinary)
  - Urinary incontinence
- Frequency of incontinence
- Use of occlusive containment products
- Poor skin condition
- Compromised mobility
- Poor cognitive awareness
- Inability to perform self-care
- Pain
- Temperature
- Medications
- Poor nutritional status
- Critical illness

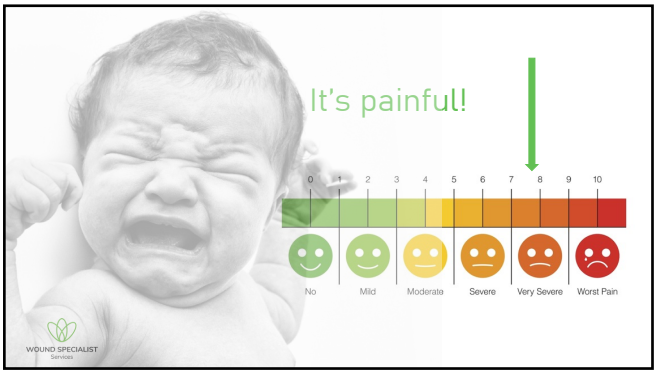
5

How does incontinence cause IAD?



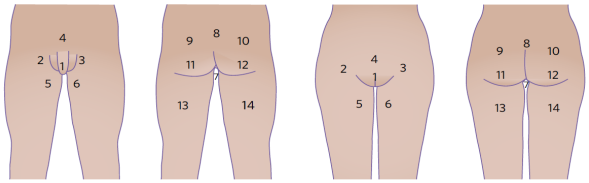
WOUND SPECIALIST Services

6



7

Where is IAD found?



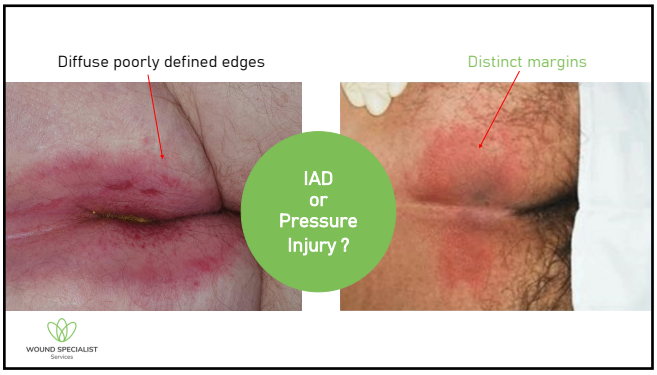
1. Genitalia (labia/scrotum)
2. Right groin fold (crease) between genitalia and thigh
3. Left groin fold (crease between genitalia and thigh)
4. Lower abdomen/suprapubic
5. Right inner thigh
6. Left inner thigh
7. Perinanal skin
8. Gluteal fold (crease between buttocks)
9. Left upper buttock
10. Right upper buttock
11. Left lower buttock
12. Right lower buttock
13. Left posterior thigh
14. Right posterior thigh

8

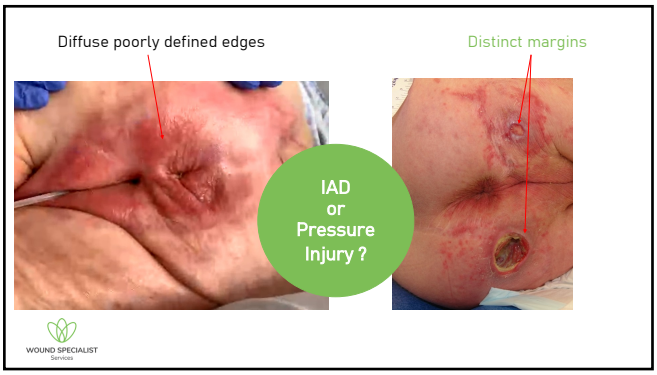
How to identify IAD

Parameter	IAD	Pressure Injury
History	Urinary +/- faecal incontinence	Exposure to pressure/shear
Symptoms	Pain, burning, itching, tinging	Pain
Location	Perineum, perigenital area, buttocks, gluteal fold, medial & posterior aspect of upper thighs, lower back, may extend over bony prominence	Usually over a bony prominence or associated with medical device
Shape / edges	Diffuse, poorly defined edges, may be blotchy	Distinct edges or margins
Presentation / depth	Intact skin with erythema (blanchable or non-blanchable), with/without superficial, partial thickness skin loss	Varies from intact skin with non-blanchable 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

9

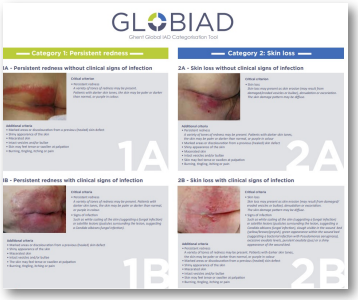


10



11

IAD Severity Classification



(Beeckman et al., 2015)

WOUND SPECIALIST
Services

12

CATEGORY 1: PERSISTENT REDNESS

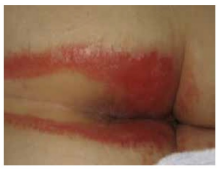
Category 1A: Persistent redness without clinical signs of infection

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/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain



(Beeckman et al., 2015)

13

Category 1B: Persistent redness with clinical signs of infection

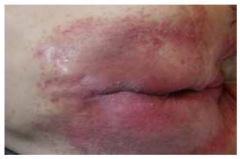
Critical criteria

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/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain



(Beeckman et al., 2015)

14

CATEGORY 2: SKIN LOSS

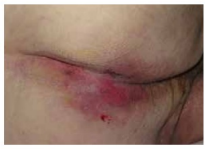
Category 2A: Skin loss without clinical signs of infection

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/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain



(Beeckman et al., 2015)

15

Category 2B: Skin loss with clinical signs of infection (Beeckman et al., 2015)

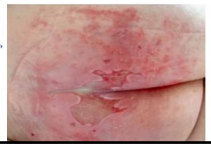
Critical criteria

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.

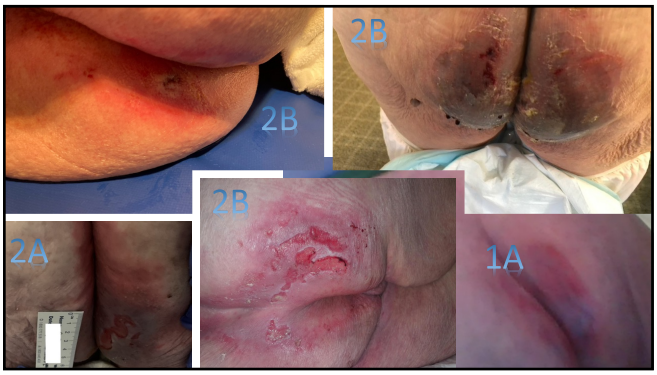
Signs of infection
Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection), slough visible in the wound bed (yellow/brown/greyish), green appearance within the wound bed (suggesting a bacterial infection with Pseudomonas aeruginosa), excessive exudate levels, purulent exudate (pus) or a shiny appearance of the wound bed.

Additional criteria

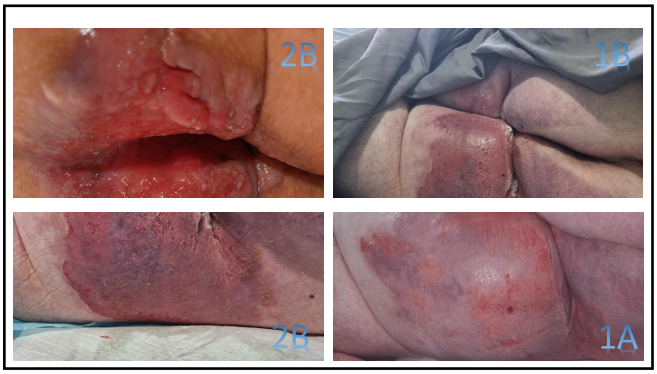
- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles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



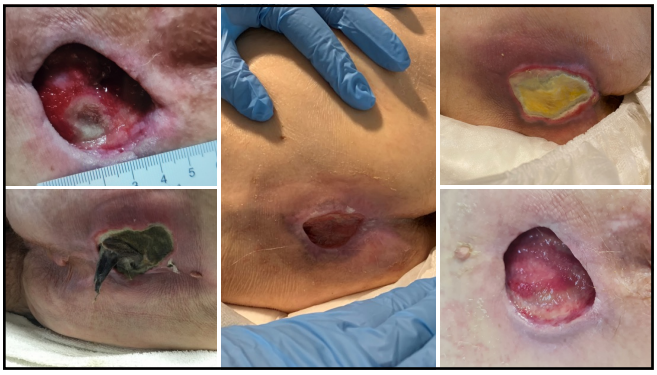
16



17



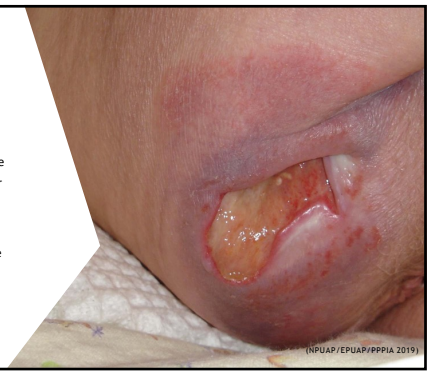
18



19

What is a PI?

- Localised injury to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device.
- Result of intense and/or prolonged pressure or pressure in combination with shear



WOUND SPECIALIST Services

(NPUAP/EPUAP/PPPIA 2019)

20

Pressure Injury Staging

PI's are staged as:

- Stage I
- Stage II
- Stage III
- Stage IV

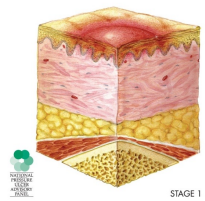
The higher the stage number the deeper the tissue involvement

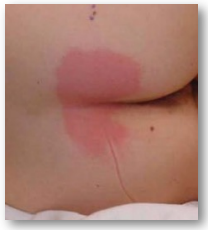
- Unstageable
- Suspected Deep Tissue Injury

WOUND SPECIALIST Services

21

Stage 1 Pressure Injury

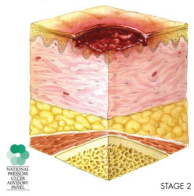


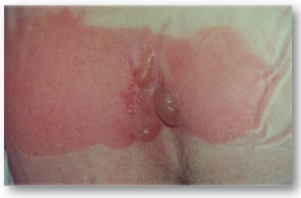


(NPUAP/EPUAP/PPPIA 2014)

22

Stage 2 Pressure Injury



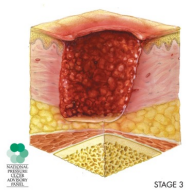


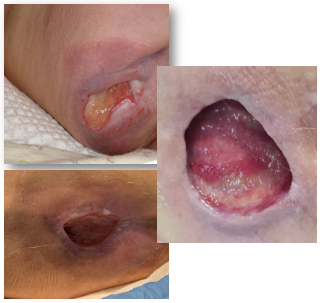
WOUND SPECIALIST Services

(NPUAP/EPUAP/PPPIA 2014)

23

Stage 3 Pressure Injury



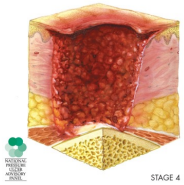


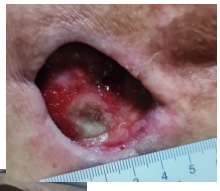
WOUND SPECIALIST Services

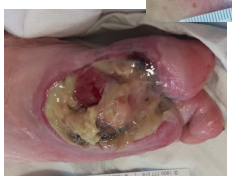
(NPUAP/EPUAP/PPPIA 2014)

24

Stage 4 Pressure Injury





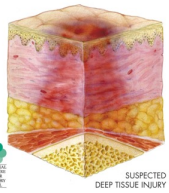


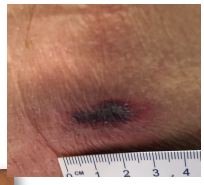
WOUND SPECIALIST Services

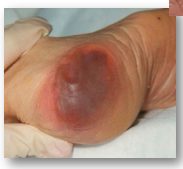
(NPUAP/EPUAP/PPPIA 2014)

25

Suspected Deep Tissue Injury





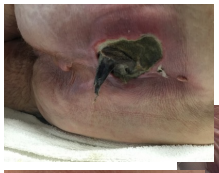


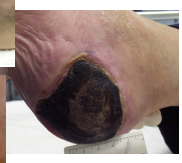
WOUND SPECIALIST Services

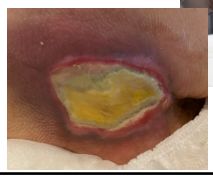
(NPUAP/EPUAP/PPPIA 2014)

26

Unstageable





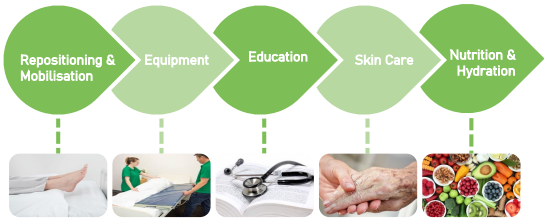


WOUND SPECIALIST Services

(NPUAP/EPUAP/PPPIA 2014)

27

Pressure Injury Management & Prevention Strategies



28

Assessment & Monitoring

SET TREATMENT GOALS

AIM FOR AN IMPROVEMENT WITHIN 2 WEEKS

REASSESS EVERY TWO WEEKS TO MONITOR PROGRESS INCLUDING SIZE

WOUND SPECIALIST Services

(EPUAP/NPIAP/PPPIA, 2019)

29

Management & prevention strategies for IAD

- Manage incontinence
- Implement a structured skin care regimen

30

Management & prevention strategies

CLEANSE, PROTECT, RESTORE

WOUND SPECIALIST Services

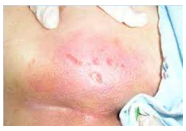
31

How do you manage episodes of incontinence ?

32

Cleanse

- Close to skin pH & perfume-free skin cleansers
- Do not rub, pat dry
- Cleanse daily and after every episode of incontinence
- Avoid standard alkaline soaps
- Choose liquid skin cleansers or pre-moistened body tissues or foam cleansers
- Use soft, disposable non-woven cloth
- Gently dry skin if needed after cleansing



33

Protect

- Apply a skin protectant
- Ensure skin protectant is compatible with other skin care products
- Apply to all areas in contact with urine and/or faeces
- Appropriate continence aid

WOUND SPECIALIST Services

34

Restore

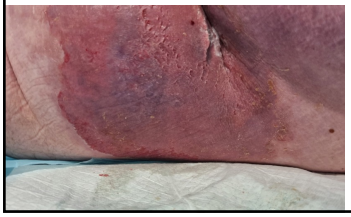
- Maintaining skin barrier function using a leave-on skin care product (moisturiser)

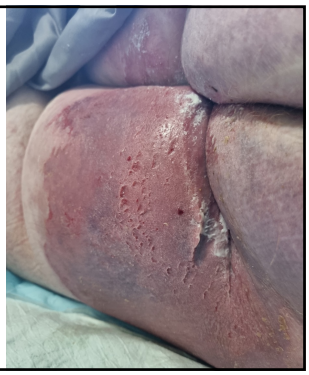
WOUND SPECIALIST Services

35

Skin infection & IAD

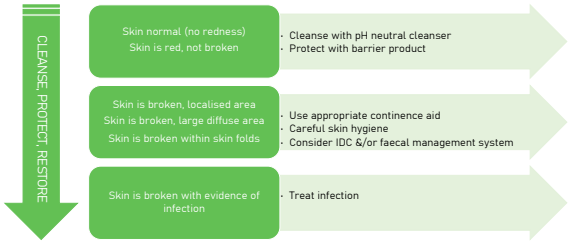
- Obtain a bacterial wound swab
- Topical antifungal / corticosteroid and/or antibiotic ointment or cream used in conjunction with skin protectant





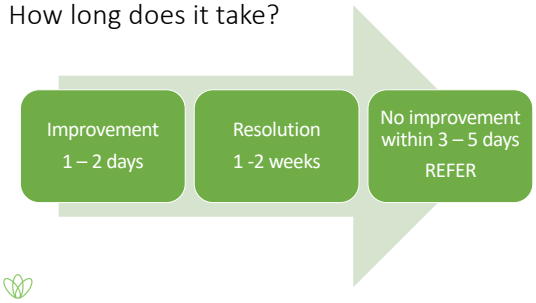
36

Wound care plan



37

How long does it take?



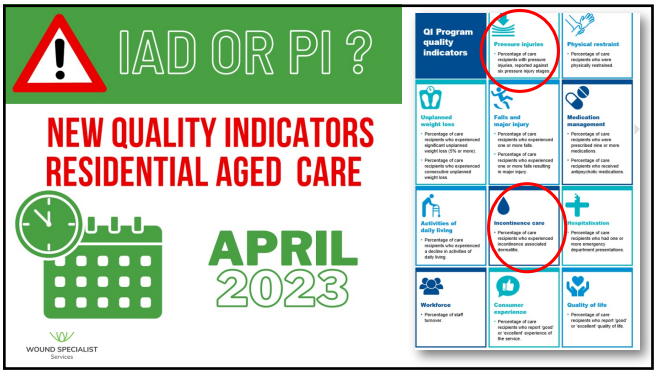
WOUND SPECIALIST Services

38

What products to use for prevention & management of IAD?

- Clinically proven to prevent and/or treat IAD
- Close to skin pH
- Low irritant potential / hypoallergenic
- Does not sting on application
- Transparent or can be easily removed for skin inspection
- Removal/cleansing considers caregiver time & patient comfort
- Does not increase skin damage
- Does not interfere with function of continence aids
- Compatible with other products
- Acceptable to the consumer
- Minimises number of products, resources & time
- Cost-effective

39



40

What data you need to collect

- Number of care recipients assessed for incontinence care (minus those excluded below)
- Number of care recipients excluded because they were absent from the service for the entire quarter
- Number of care recipients excluded from IAD assessment because they DID NOT have incontinence
- Number of care recipients with incontinence
- Number of care recipients with incontinence who experienced IAD
- Number of care recipients with incontinence who experienced IAD, reported against the 4 IAD sub-categories:
  - 1A: Persistent redness without clinical signs of infection
  - 1B: Persistent redness with clinical signs of infection
  - 2A: Skin loss without clinical signs of infection
  - 2B: Skin loss with clinical signs of infection

41

When to start collecting data

WOUND SPECIALIST
Services

42

Example: Typical Ville Aged Care Home

Urinary incontinence >1/day
Persistent redness with no clinical signs of infection (Category 1A)

1

Urinary incontinence >1/day
No signs of IAD

2

Faecal incontinence >1/week
Skin loss with no clinical signs of infection (Category 2A)

3

WOUND SPECIALIST Services

43

How to report

Care recipient A	Care recipient B	Care recipient C
Number of care recipients assessed for incontinence care = 3		
Number of care recipients who experienced incontinence = 3		
Number of care recipients excluded because they were absent = 0		
Number of care recipients excluded from IAD assessment because they did not have incontinence = 0		
Number of care recipients with incontinence who experienced IAD = 2		
Number of care recipients who experienced IAD, reported against the 4 sub-categories:		
Category 1A: Persistent redness without clinical signs of infection = 1		
Category 1B: Persistent redness with clinical signs of infection = 0		
Category 2A: Skin loss without clinical signs of infection = 1		
Category 2B: Skin loss with clinical signs of infection = 0		

WOUND SPECIALIST Services

(Department of Health & Aged Care, 2023)

44

Get ready

1. Undertake a baseline continence assessment
2. Undertake ongoing screening for incontinence
3. Document findings in care record & undertake collaborative care planning
4. Implement appropriate strategies based on care recipient's needs & preferences
5. Recognise & manage adverse clinical events associated with incontinence

WOUND SPECIALIST Services

45

Summary

- Preserving skin integrity is the best way to prevent PIs & IAD from occurring
- There is a difference between PIs & IAD
- If the consumer is NOT incontinent, it is not IAD
- IAD & PI can co-exist
- Both IAD & PI must be assessed & monitored
- If either condition fails to improve or deteriorates, refer for specialist advice

46

Thank you

Dr Michelle Gibb

Founder & Director

Wound Specialist Services

P: 07 3289 3102

E: info@woundservice.com.au

W: https://woundservice.com.au/

47

References

Beeckman, D., Campbell, J., Campbell, K., Chimentao, D., Coyer, F., Domansky, R., Gray, M., Hevia, H., Junkin, J., Karadag, A., Kottner, J., Arnold Long, M., McNichol, L., Meaume, S., Nix, D., Sabasse, M., Sanada, H., Yu, P., Voegeli, D., & Wang, L. (2015). Proceedings of the Global IAD Expert Panel. Incontinence-associated dermatitis: moving prevention forward. *Wounds International*. www.woundsinternational.com

Campbell, J., Gosley, S., Coleman, K., & Coyer, F. (2016). Combining pressure injury and incontinence-associated dermatitis prevalence surveys: an effective protocol? *Wound Practice and Research, 24*(3), 170-177.

Rippon, M., Colegrave, M., & Ousey, K. (2016). Incontinence-associated dermatitis: reducing adverse events. *British Journal of Nursing, 25*(18), 1016-1021.

Wilson, L., Kapp, S., & Santamaria, N. (2019). The direct cost of pressure injuries in an Australian residential aged care setting. *International Wound Journal, 16*, 64-70. doi:10.1111/iwj.12992

Graves, N., & Zheng, H. (2014). Modelling the direct health care costs of chronic wounds in Australia. *Wound Practice and Research, 22*(1), 20-24, 26-33.

Australian Wound Management Association. (2012). *Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury*. Osborne Park, WA: Cambridge Media.

Santamaria, N., Gerdtz, M., Kapp, S., Wilson, L., & Gefen, A. (2017). A randomised controlled trial of the clinical effectiveness of multi-layer silicone foam dressings for the prevention of pressure injuries in high-risk aged care residents: The Border III Trial. *International Wound Journal, 15*, 482-490.

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. (2019). *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline.* International Guideline. Haesler, E. (ed). EPUAP/NPIAP/PPPIA.

WOUND SPECIALIST Services

48