Incontinence-Associated Dermatitis (IAD) Assessment Guide

A companion to Best Practice Principles document “Incontinence-Associated Dermatitis: Moving Prevention Forward”
What is IAD?
Incontinence Associated Dermatitis (IAD): skin damage due to exposure to urine or stool

What questions should you ask to determine the risk of IAD development?

What will you see?
- Changes in skin color
  - Light skin tones may have erythema ranging in intensity from pink to red
  - Dark skin tones may appear paler, darker, purple, dark red, or yellow
- Changes in skin integrity
  - Warmer and firmer than skin without IAD
  - May see:
    + Moist, open weeping areas of skin
    + Lesions such as raised blisters (vesicles) or small bumps (papules)

What will the patient or resident feel?
Pain, burning, itching

Where will you assess for potential skin damage?
Assess all areas front and back!

Urinary incontinence likely to affect:
folds of the labia in women, scrotum in men, groin folds, lower abdomen, front and inner thigh

Faecal incontinence likely to affect:
perianal area, gluteal fold and upper and lower buttocks, back of the thighs

<table>
<thead>
<tr>
<th>Type of Incontinence</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary incontinence</td>
<td>Perineum, perigenital area; buttocks, perianal area, crease between buttocks</td>
</tr>
<tr>
<td>Faecal incontinence</td>
<td>Perianal skin, genitalia and thigh (e.g. perineum, perigenital area; buttocks, perianal area, crease between buttocks)</td>
</tr>
</tbody>
</table>

How often is the patient or resident incontinent?
Risk increases with more frequent episodes, especially with loose stools

What other risk factors put the patient or resident at risk?
- Use of occlusive briefs or pads
- Poor skin condition
- Difficulty moving or walking
- Confusion, disorientation
- Inability to perform personal hygiene

| IAD Risk | Faecal incontinence +/- urinary incontinence creates a higher risk than urinary incontinence alone
| Loose stools pose the highest risk and severity of skin damage |

| Urine | Liquid faeces +/- urine |
|       | Formed faeces +/- urine |

Is it urine, stool, or a combination of both?

Faecal incontinence +/- urinary incontinence creates a higher risk than urinary incontinence alone
Loose stools pose the highest risk and severity of skin damage

How do I AD develop?
Determine the risk of IAD development? Should you ask to determine the risk of IAD? What questions should you ask to determine the risk of IAD? What to assess to determine the risk of IAD?

What is IAD?
- Inability to perform personal hygiene
- Confusion, disorientation
- Poor skin condition
- Use of occlusive briefs or pads

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Distinguish IAD from pressure injuries

<table>
<thead>
<tr>
<th>Parameter</th>
<th>IAD</th>
<th>Pressure Injury</th>
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</thead>
<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, burning, itching, tingling</td>
<td>Pain</td>
</tr>
<tr>
<td>Location</td>
<td>Affects perinea, perineum, perigenital area; buttocks, lower back; may extend over bony prominence or associated with location of a medical device</td>
<td>Usually over a 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 blebular</td>
<td>Distinct edges or margins</td>
</tr>
<tr>
<td>Presentation/depth</td>
<td>Intact skin with erythema (blanchable or non-blanchable, with/without superficial, partial-thickness skin loss</td>
<td>Presentation varies from intact skin with non-blanchable erythema to full-thickness skin loss</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>
</tr>
</tbody>
</table>

*During IAD, skin appearance can be similar to other skin conditions such as pressure injuries or infections; however, IAD is a unique condition that requires specific care and management.

If the patient or resident is NOT incontinent, they CANNOT have IAD.

Incontinence = risk for skin damage!
Develop and implement a plan for IAD protection and prevention:
Assess the skin regularly (minimum of every day), and more often with frequently incontinent episodes and/or liquid stool. If no improvement in 3–5 days reevaluate the plan of care.

Document your findings
- Patient’s or resident’s continence status
- Type of incontinence
- Frequency of incontinent episodes
- Identified risk factors
- Category of IAD using IAD Severity Categorisation Tool
- Skin affected—identify anatomic position (use Figure 1 as a key)
- Locations affected—identify anatomic position (use Figure 1 as a key, relate and connect terminology)
- Condition of skin integrity—colour, temperature, presence of lesions, drainage—colour and consistency (i.e. how does the skin feel)
- Level of discomfort
- Response to plan of care

3M Cavilon Skin Care Solution
Product Solutions

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**3M™ Cavilon™ Professional Skin Care Products**

### 3M™ Cavilon™ Continence Care Wipes

<table>
<thead>
<tr>
<th>Product Code</th>
<th>Size</th>
<th>Items/Box</th>
<th>Boxes/Case</th>
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<tbody>
<tr>
<td>9274</td>
<td>20cm x 30cm</td>
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<td>12</td>
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### 3M™ Cavilon™ Durable Barrier Cream

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<tr>
<td>3392GS</td>
<td>2g sachet</td>
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<tr>
<td>3391G</td>
<td>28g tube</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>3392G</td>
<td>92g tube</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
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### 3M™ Cavilon™ Advanced Skin Protectant

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<th>Boxes/Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>5050G</td>
<td>2.7 mL applicator</td>
<td>20</td>
<td>1</td>
</tr>
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</table>

Patients and residents with IAD are susceptible to secondary skin infections. When using an anti-fungal cream, cease use of Cavilon Skin Care products. If the patient/resident is not responding to treatment, seek medical opinion.