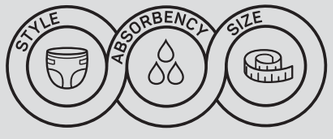
Continence Management Pathway

Prevention and management of Incontinence Associated Dermatitis (IAD) consists of assessment and continence promotion strategies, combined with adopting a structured skin care regimen to clean, protect and care for the skin.[1]

STEPS TO PROMOTE PELVIC REGION SKIN INTEGRITY

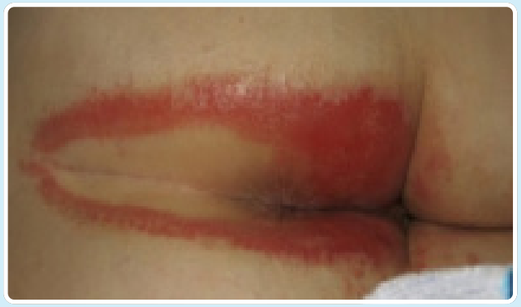
	LIGHT URINARY INCONTINENCE	MODERATE TO SEVERE URINARY INCONTINENCE	URINARY & FAECAL OR FAECAL	PRODUCTS
CLEAN, PROTECT & CARE	After each continence aid change, gently clean, protect and care for the skin with pH balanced **MoliCare Skin 3in1 Wet Wipes** to support and maintain the acid protection mantle.			
CLEAN		At each continence aid change, gently cleanse perineal area with pH skin balanced[2] **MoliCare Skin Moist Skin Care Tissues** or **MoliCare Skin Wash Lotion** and water.	At each episode of incontinence, gently debulk faecal matter with cloth (toilet paper).	
			Spray pH balanced **MoliCare Skin Cleansing Foam** directly on to the affected area. Allow to disperse and wipe away with **MoliCare Skin Moist Skin Care Tissues**. Repeat if necessary.	
		Gently pat dry and assess skin and report any redness, skin breakdowns, or infection.		
PROTECT		Skin at a higher risk of irritation requires skin care formulations designed to penetrate the deeper layers of the skin. Apply pH skin balanced **MoliCare Skin Barrier Cream** or **Protection Foam** to protect the skin from moisture and irritants, and provide nourishment. Use as part of usual hygiene care and after each episode of incontinence. • Apply pea to walnut size amount depending on skin area. • Use after each change of continence product. Always treat the skin gently and avoid friction.		
AVOID IAD	Apply a correctly sized continence aid with an absorbency level suited to the assessed needs of the individual. Use a skin friendly continence aid to reduce the risk of IAD.	 Remember to check the style, absorbency and size of the product.		
	Implement pressure injury prevention plan.[3]			
REPORT	Report and document any change in conditions.			

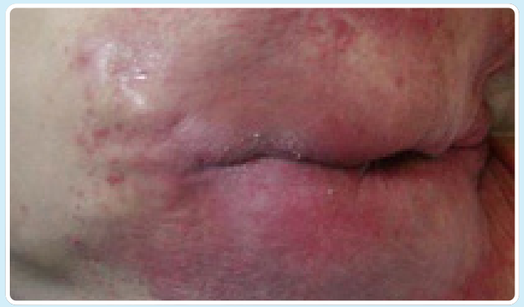
Continence Management Pathway

ASSESS SKIN DAILY

GLOBIAD Ghent Global IAD Categorisation Tool

CATEGORY 1 – PERSISTENT REDNESS





1A Persistent redness **without** clinical signs of infection

1B Persistent redness **with** clinical signs of infection

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.

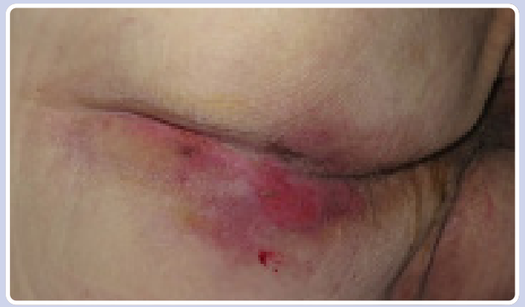
SIGNS OF INFECTION

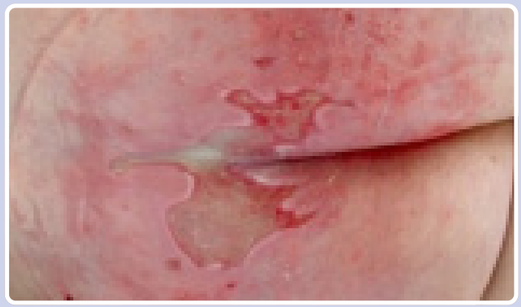
- White scaling of the skin (suggesting a fungal infection)
- Satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection).

ADDITIONAL CRITERIA

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

CATEGORY 2 – SKIN LOSS





2A Skin loss **without** clinical signs of infection

2B Skin loss **with** clinical signs of infection

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

- White scaling of the skin (suggesting a fungal infection)
- 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 or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

References:

1. National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2009, Washington DC: NPUAP.
2. pH 5.5 = average pH value of total MoliCare Skin range. The pH value of the respective products may vary.
3. Wound Ostomy and Continence Nurses Society (WOCNS), Guideline for Prevention and Management of Pressure Ulcers. 2010, Mount Laurel (NJ): WOCNS.

The categories do not necessarily relate to the natural history of IAD and are not intended to suggest how IAD may develop or progress.
This categorisation tool may prove useful in the monitoring of IAD prevalence and incidence, and for research purposes.

Reference: Beeckman D., et. al.. The Ghent Global IAD Categorisation Tool (GLOBIAD). Skin Integrity Research Group - Ghent University 2017.

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