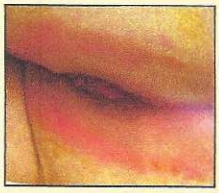
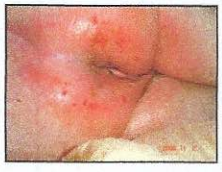
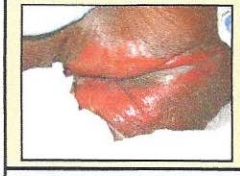
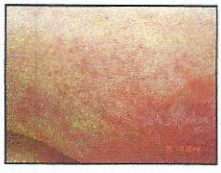
Incontinence-Associated Dermatitis Intervention Tool (IADIT)

Skin Care for Incontinent Persons

The #1 priority is to address the cause of incontinence. Use this tool until incontinence is resolved.

1. **Cleanse incontinence ASAP and apply barrier.**
2. **Document condition of skin at least once every shift in nurse's notes or per organization's policy for documenting skin breakdown.**
3. **Notify primary care provider when skin injury occurs and collaborate on the plan of care.**
4. **Consider use of external catheter or fecal collector.**
5. **Consider short term use of urinary catheter only in cases of IAD complicated by secondary infection.**

	Definition	Intervention
HIGH-RISK	Skin is not erythematous or warmer than nearby skin but may show scars or color changes from previous IAD episodes and/or healed pressure ulcer(s). Person not able to adequately care for self or communicate need and is incontinent of liquid stool at least 3 times in 24 hours.[1]	1. Use a disposable barrier cloth containing cleanser, moisturizer, and protectant.[2,3] 2. If barrier cloths not available, use acidic cleanser (6.5 or lower), **not soap** (soap is too alkaline); cleanse gently (soak for a minute or two – **no scrubbing**); and apply a protectant (ie: dimethicone, liquid skin barrier or petrolatum). 3. If briefs or underpads are used, allow skin to be exposed to air for 30 minutes twice a day by positioning semi-prone. Use containment briefs only for sitting in chair or ambulating – not while in bed. 4. Manage the cause of incontinence: a) Determine why the person is incontinent. Check for urinary tract infection, b) Consider timed toileting or a bladder or bowel program, c) Refer to incontinence specialist if no success.[4]
EARLY IAD 	Skin exposed to stool and/or urine is dry, intact, and not blistered, but is pink or red with diffuse (not sharply defined), often irregular borders. In darker skin tones, it might be more difficult to visualize color changes (white, yellow, very dark red/purple) and palpation may be more useful. Palpation may reveal a warmer temperature compared to skin not exposed. People with adequate sensation and the ability to communicate may complain of burning, stinging, or other pain.	
MODERATE IAD 	Affected skin is bright or angry red – in darker skin tones, it may appear white, yellow, or very dark red/purple. Skin usually appears shiny and moist with weeping or pinpoint areas of bleeding. Raised areas or small blisters may be noted. Small areas of skin loss (dime size) if any. This is painful whether or not the person can communicate the pain.	↑ ***Include treatments from box above plus:*** 5. Consider applying a zinc oxide-based product for weepy or bleeding areas 3 times a day and whenever stooling occurs. 6. Apply the ointment to a non-adherent dressing (such as anorectal dressing for cleft, Telfa for flat areas, or ABD pad for larger areas) and gently place on injured skin to avoid rubbing. Do not use tape or other adhesive dressings. 7. If using zinc oxide paste, **do not scrub the paste completely off** with the next cleaning. Gently soak stool off top then apply new paste covered dressing to area. 8. If denuded areas remain to be healed after inflammation is reduced, consider BTC ointment (balsam of peru, trypsin, castor oil) but remember balsam of peru is pro-inflammatory. 9. Consult WOCN if available.
SEVERE IAD 	Affected skin is red with areas of denudement (partial-thickness skin loss) and oozing/bleeding. In dark-skinned persons, the skin tones may be white, yellow, or very dark red/purple. Skin layers may be stripped off as the oozing protein is sticky and adheres to any dry surface.	↑ ***Include treatments from box above plus:*** 10. Position the person semiprone for 30 minutes twice a day to expose affected skin to air. 11. Consider treatments that reduce moisture: low air loss mattress/overlay, more frequent turning, astringents such as Domeboro soaks. 12. Consider the air flow type underpads (without plastic backing).
FUNGAL-APPEARING RASH 	This may occur in addition to any level of IAD skin injury. Usually spots are noted near edges of red areas (white, yellow, or very dark red/purple areas in dark-skinned patients) that may appear as pimples or just flat red (white or yellow) spots. Person may report itching which may be intense.	Ask primary care provider to order an anti-fungal powder or ointment. Avoid creams in the case of IAD because they add moisture to a moisture damaged area (main ingredient is water). In order to avoid resistant fungus, use zinc oxide and exposure to air as the first intervention for fungal-appearing rashes. If this is not successful after a few days, or if the person is severely immunocompromised, then proceed with the following: 1. If using powder, lightly dust powder to affected areas. Seal with ointment or liquid skin barrier to prevent caking. 2. Continue the treatments based on the level of IAD. 3. Assess for thrush (oral fungal infection) and ask for treatment if present. 4. For women with fungal rash, ask health care provider to evaluate for vaginal fungal infection and ask for treatment if needed. 5. Assess skin folds, including under breasts, under pannus, and in groin. 6. If no improvement, culture area for possible bacterial infection.

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1. Bliss DZ, Zehrer C, Savik K, et al. Incontinence-associated skin damage in nursing home residents: a secondary analysis of a prospective, multicenter study. *Ostomy Wound Manage*. 2006;52:46–55.
2. Institute for Healthcare Improvement. Prevent Pressure Ulcers: How-To Guide. May 2007. Available at: http://www.ihi.org/nr/rdonlyres/5ababb51-93b3-4d88-ae19-be88b7d96858/0/pressureulcerhowtoguide.doc, accessed 10/21/07.
3. Gray M, Bliss DB, Ermer-Seltun J, et al. Incontinence-associated dermatitis: a consensus. *J Wound Ostomy Continence Nurs*. 2007;34:45-54.
4. Junkin J, Selekof JL. Prevalence of incontinence and associated skin injury in the acute care inpatient. *J Wound Ostomy Continence Nurs*. 2007;34:260-269.

BRADEN SCALE

PREDICTING PRESSURE INJURIES

Patient's Name _____ Evaluator's Name _____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of con-sciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort..				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

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Braden QD Scale

Intensity and Duration of Pressure				Score
Mobility The ability to independently change & control body position	**0. No Limitation** Makes major and frequent changes in body or extremity position independently.	**1. Limited** Makes slight and infrequent changes in body or extremity position **OR** unable to reposition self independently (includes infants too young to roll over).	**2. Completely Immobile** Does not make even slight changes in body or extremity position independently.	
Sensory Perception The ability to respond meaningfully, in a **developmentally** appropriate way, to pressure-related discomfort	**0. No Impairment** Responsive **and** has no sensory deficits which limit ability to feel or communicate discomfort.	**1. Limited** Cannot always communicate pressure-related discomfort **OR** has some sensory deficits that limit ability to feel pressure-related discomfort.	**2. Completely Limited** Unresponsive due to diminished level of consciousness or sedation **OR** sensory deficits limit ability to feel pressure-related discomfort over most of body surface.	
Tolerance of the Skin and Supporting Structure				
Friction & Shear ***Friction:*** occurs when skin moves against support surfaces ***Shear:*** occurs when skin & adjacent bony surface slide across one another	**0. No Problem** Has sufficient strength to completely lift self up during a move. Maintains good body position in bed/chair at all times. Able to completely lift patient during a position change.	**1. Potential Problem** Requires **some** assistance in moving. Occasionally slides down in bed/chair, requiring repositioning. During repositioning, skin often slides against surface.	**2. Problem** Requires **full** assistance in moving. Frequently slides down and requires repositioning. Complete lifting without skin sliding against surface is impossible **OR** spasticity, contractures, itching or agitation leads to almost constant friction.	
Nutrition *Usual* diet for age – assess pattern over the most recent 3 consecutive days	**0. Adequate** Diet for age providing **adequate** calories **&** protein to support metabolism and growth.	**1. Limited** Diet for age providing **inadequate** calories **OR** **inadequate** protein to support metabolism and growth **OR** receiving supplemental nutrition any part of the day.	**2. Poor** Diet for age providing **inadequate** calories **and** protein to support metabolism and growth.	
Tissue Perfusion & Oxygenation	**0. Adequate** Normotensive for age, **&** oxygen saturation ≥ 95%, **&** normal hemoglobin, **&** capillary refill ≤ 2 seconds.	**1. Potential Problem** Normotensive for age **with** oxygen saturation <95%, **OR** hemoglobin <10 g/dl, **OR** capillary refill > 2 seconds.	**2. Compromised** Hypotensive for age **OR** hemodynamically unstable with position changes.	
Medical Devices				
Number of Medical Devices	**Score 1 point for each medical device* up to 8 (Score 8 points maximum)** ****Any diagnostic or therapeutic device that is currently attached to or traverses the patient's skin or mucous membrane.***			
Repositionability/ Skin Protection	**0. No Medical Devices**	**1. Potential Problem** All medical devices can be repositioned **OR** the skin under each device is protected.	**2. Problem** Any one or more medical device(s) can**not** be repositioned **OR** the skin under each device is not protected.	
			Total **(≥ 13 considered at risk)**	

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