FACEBOOK LIVE

PRESSURE ULCERS VS IAD: AVOIDING THE CONFUSION

THURSDAY
18 NOVEMBER

7.30-8.30

FACEBOOK LIVE

JOURNAL OF COMMUNITY NURSING
JCN

SIOBHAN McCOULOUGH

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PRESSURE ULCERS VS INCONTINENCE ASSOCIATED DERMATITIS (IAD): AVOIDING THE CONFUSION

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AIMS OF THE SESSION

- To discuss the differences between incontinence associated dermatitis (IAD) caused by moisture associated skin damage (MASD) and pressure ulcers, in order to report accordingly
- Outline how IAD may occur as a result of MASD
- Outline the importance of assessment and classification of IAD
- Understand what a pressure ulcer is
- Introduce you to the National Institute for Health and Care Excellence (NICE) endorsed S.M.A.R.T resource.

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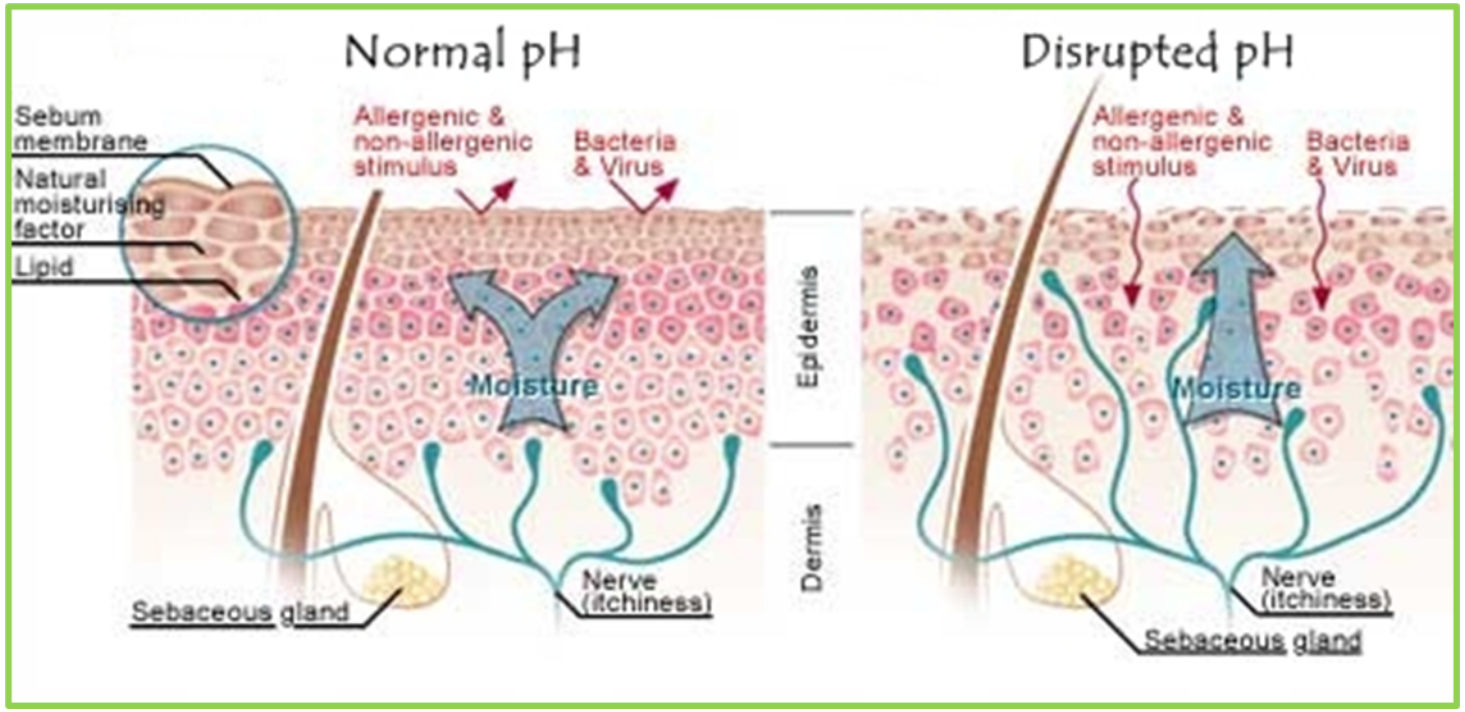
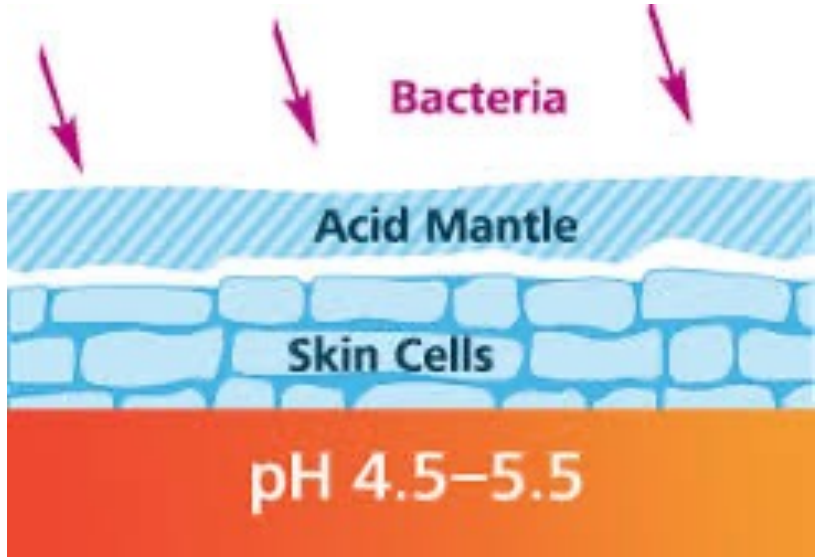
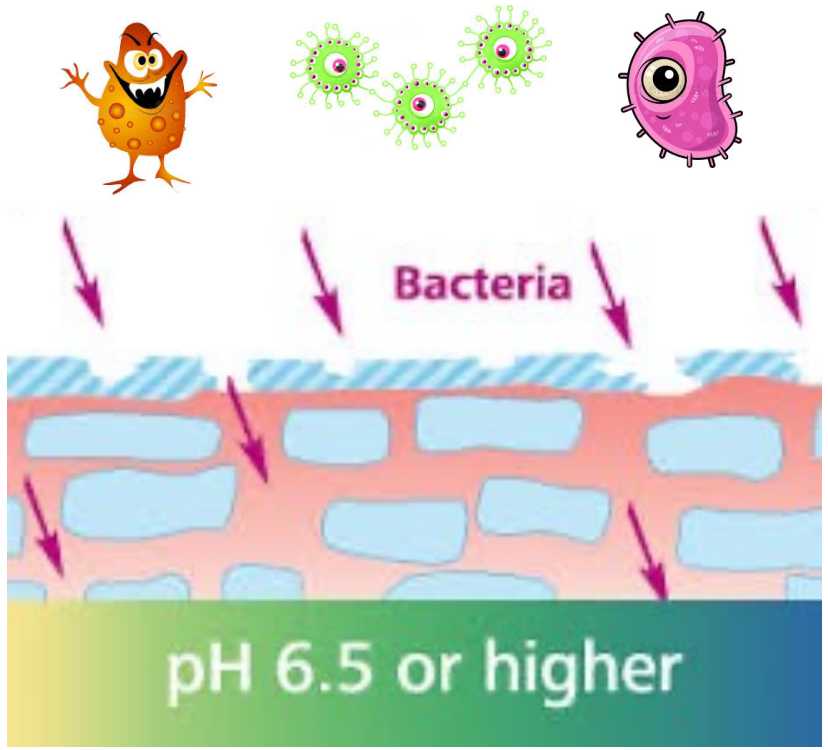
WHAT IS MASD?

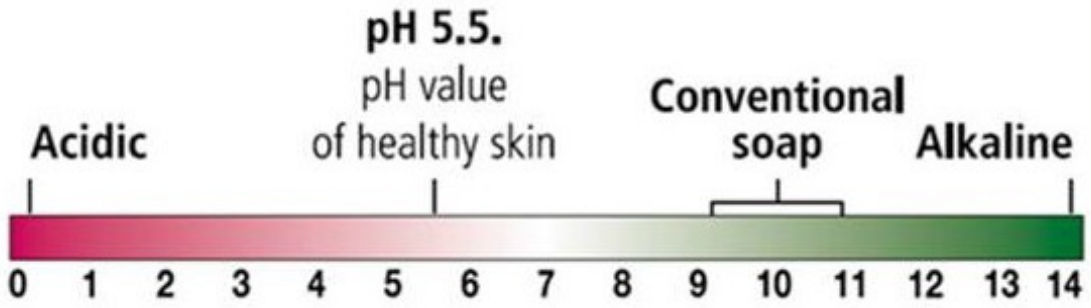
THE ACID MANTLE

- Mixture of secretions from the sebaceous glands on the surface of the skin
- Contributes to a normally acidic skin pH of 4.5 to 5.5
- Acts as our natural barrier.

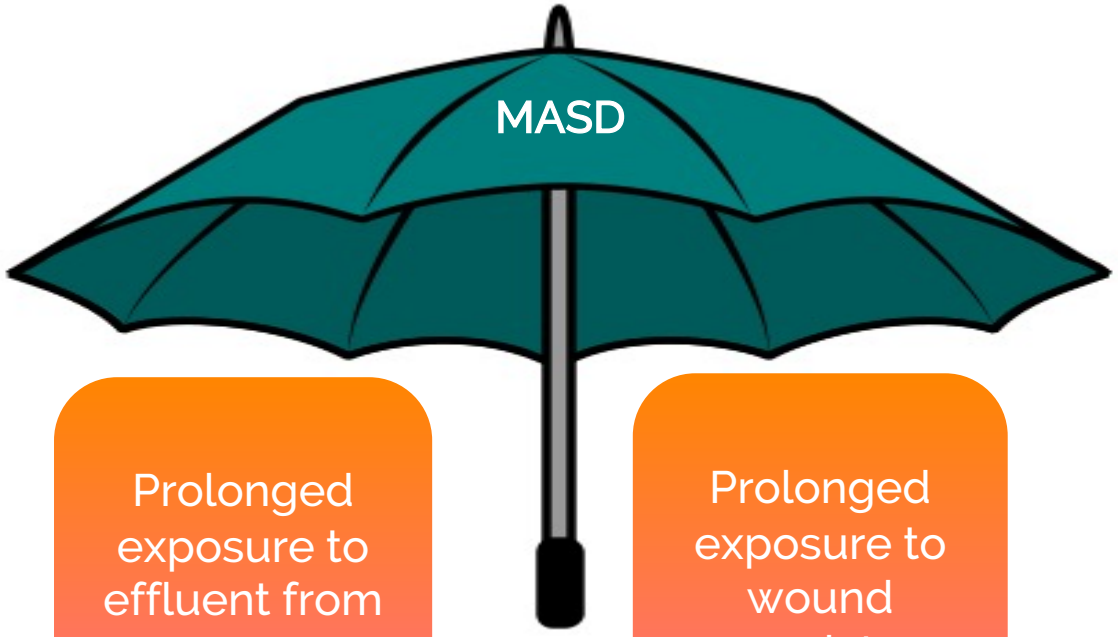



Bacteria
Acid Mantle
Skin Cells
pH 4.5–5.5


Bacteria
pH 6.5 or higher


pH 5.5.
pH value
of healthy skin
Acidic
Conventional
soap
Alkaline
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

MASD



Prolonged exposure to urine and or faeces.

Moisture lesions

Diaper dermatitis

IAD

Prolonged exposure to effluent from ostomy.

Peristomal dermatitis

Prolonged exposure to wound exudate.

Periwound dermatitis

Prolonged exposure to perspiration in skin folds.

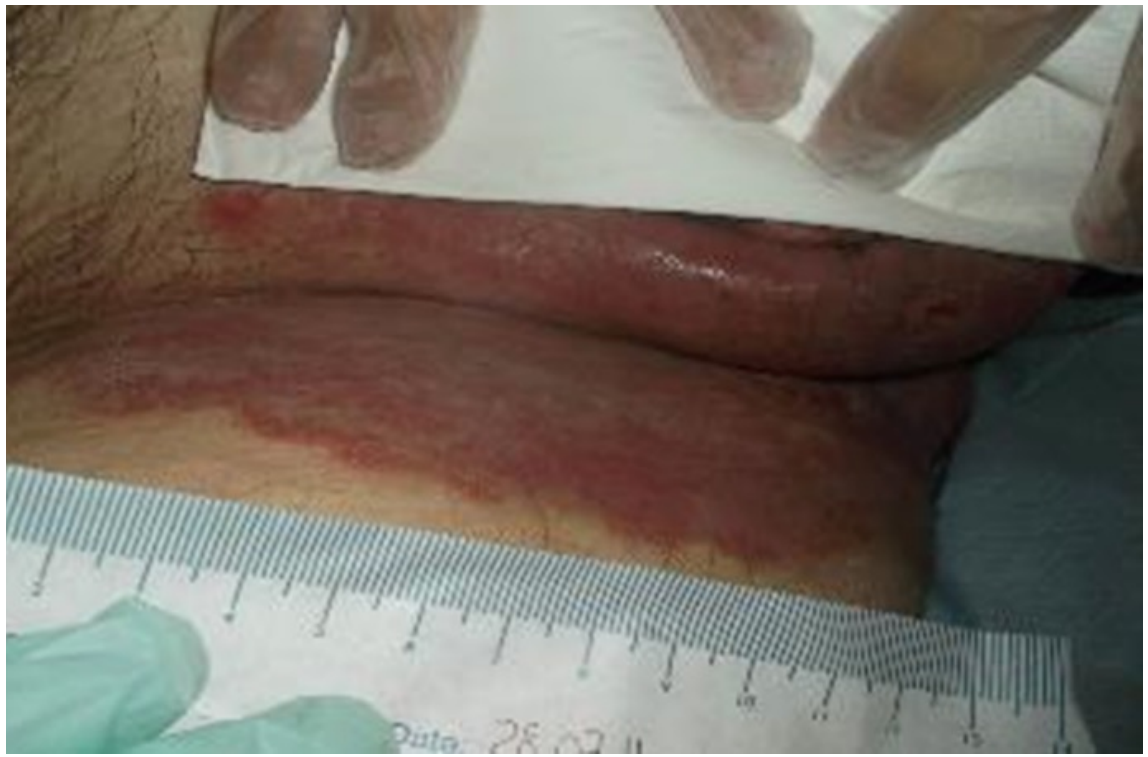
Intertrigo/ITD
Intertriginous dermatitis

Mucus/saliva

PROLONGED/CONTINUOUS EXPOSURE OF THE SKIN TO MOISTURE

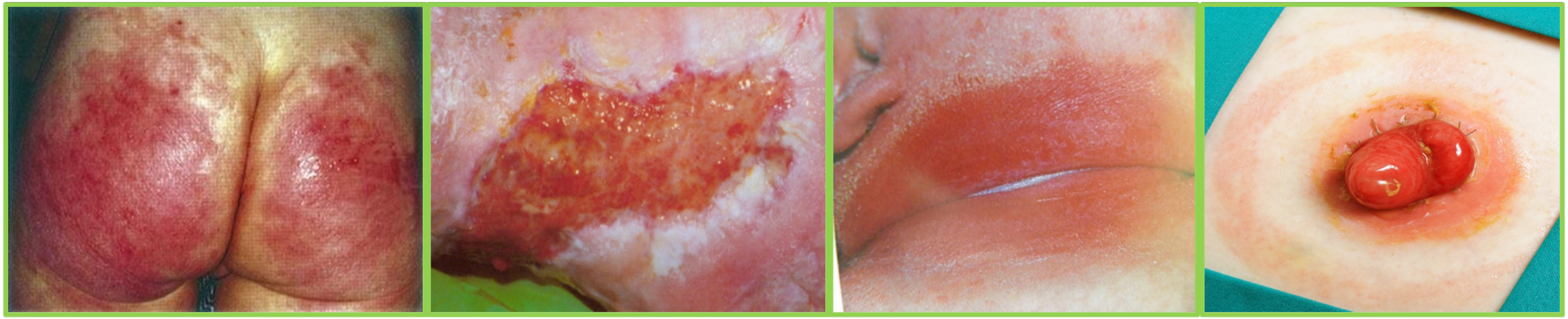
Loss of barrier/protective function:

- Over hydration of the skin disrupts the barrier properties of the stratum corneum and allows irritants to penetrate the epidermis
- Once the skin is over-hydrated it is more prone to physical damage including friction and shear.



SOURCES OF MOISTURE ASSOCIATED SKIN DAMAGE

Incontinence | Wound exudate | Perspiration | Stoma output



Mucus and saliva can also contribute to MASD in some patient groups.

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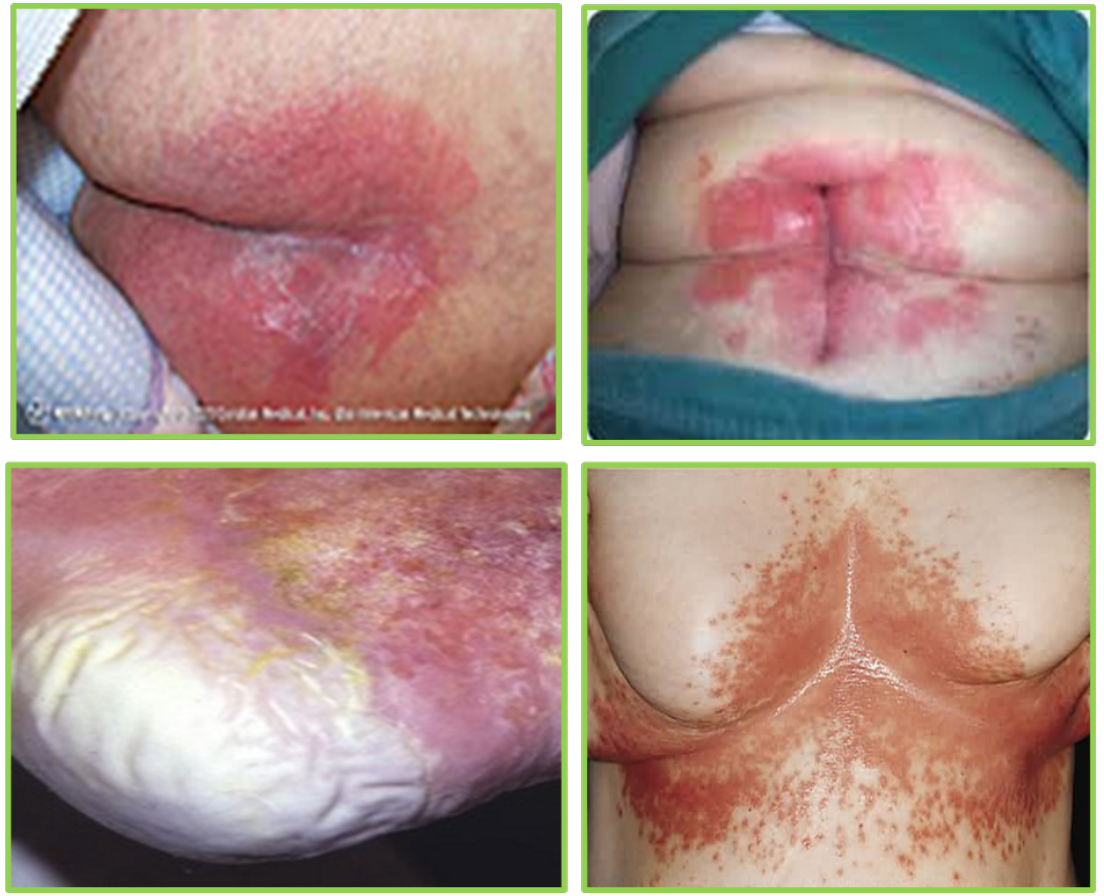
SIGNS OF MOISTURE ASSOCIATED SKIN DAMAGE

- Erythema
- Excoriation
- Maceration
- Itching/scratch marks
- Secondary infection
- Pain.

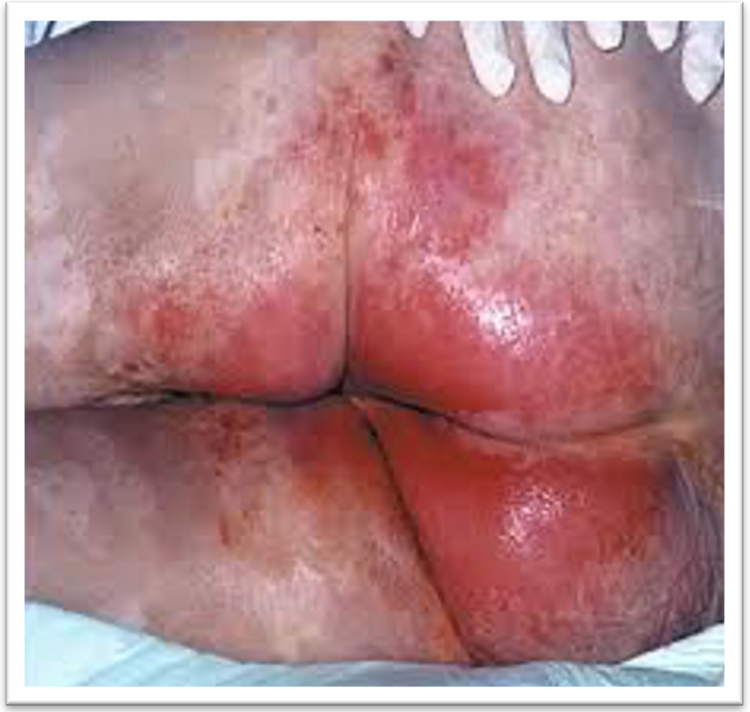


WHAT IS IAD?

WHAT IS IAD?

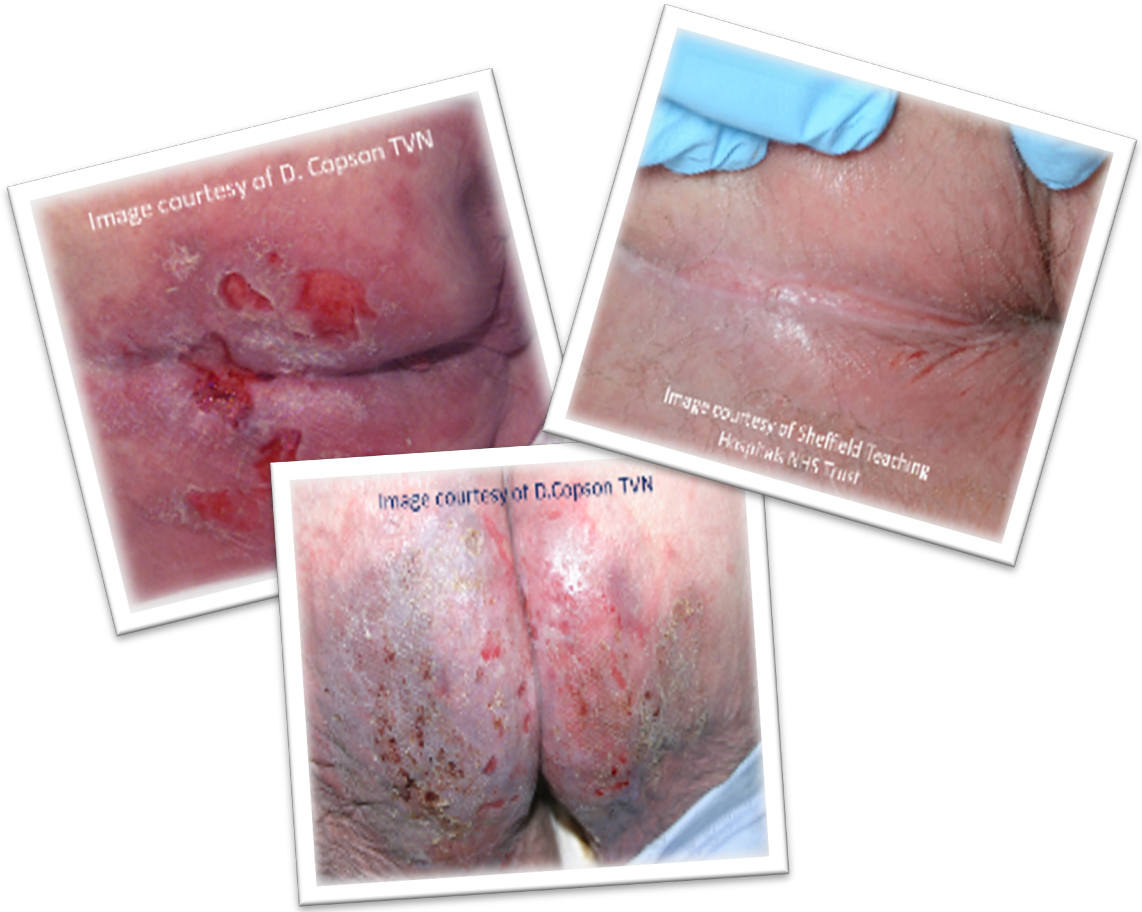
IAD is an inflammatory skin condition that occurs when the skin is exposed to urine or stool and leads to secondary infection, pain or skin lesions.

- The areas affected are:
- Perineum
- Labial folds
- Groin
- Buttocks
- Upper thighs.



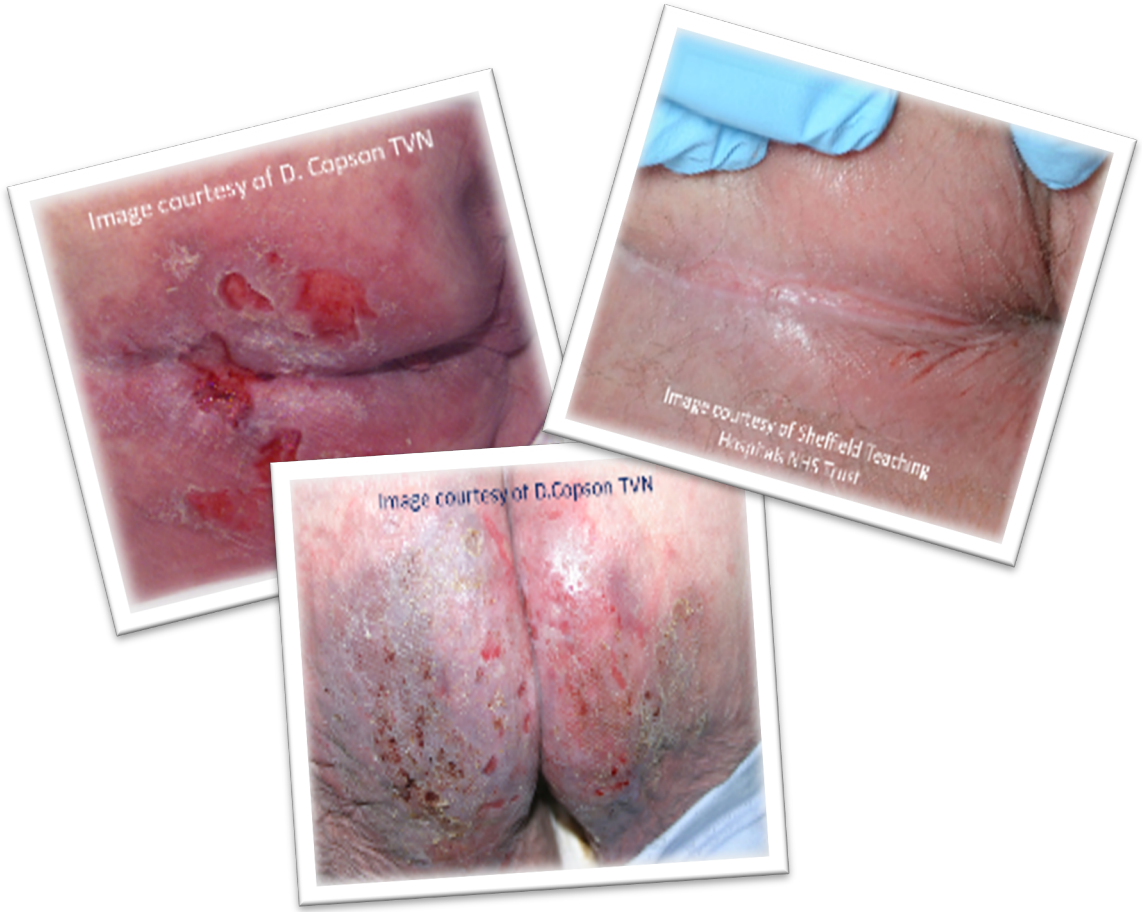
CLINICAL CHARACTERISTICS OF IAD?

- Wide spread diffuse blotchy erythema
- Indistinct margins
- Maceration
- Patches of denudement or partial thickness erosions
- Damage may be linear in skin folds.

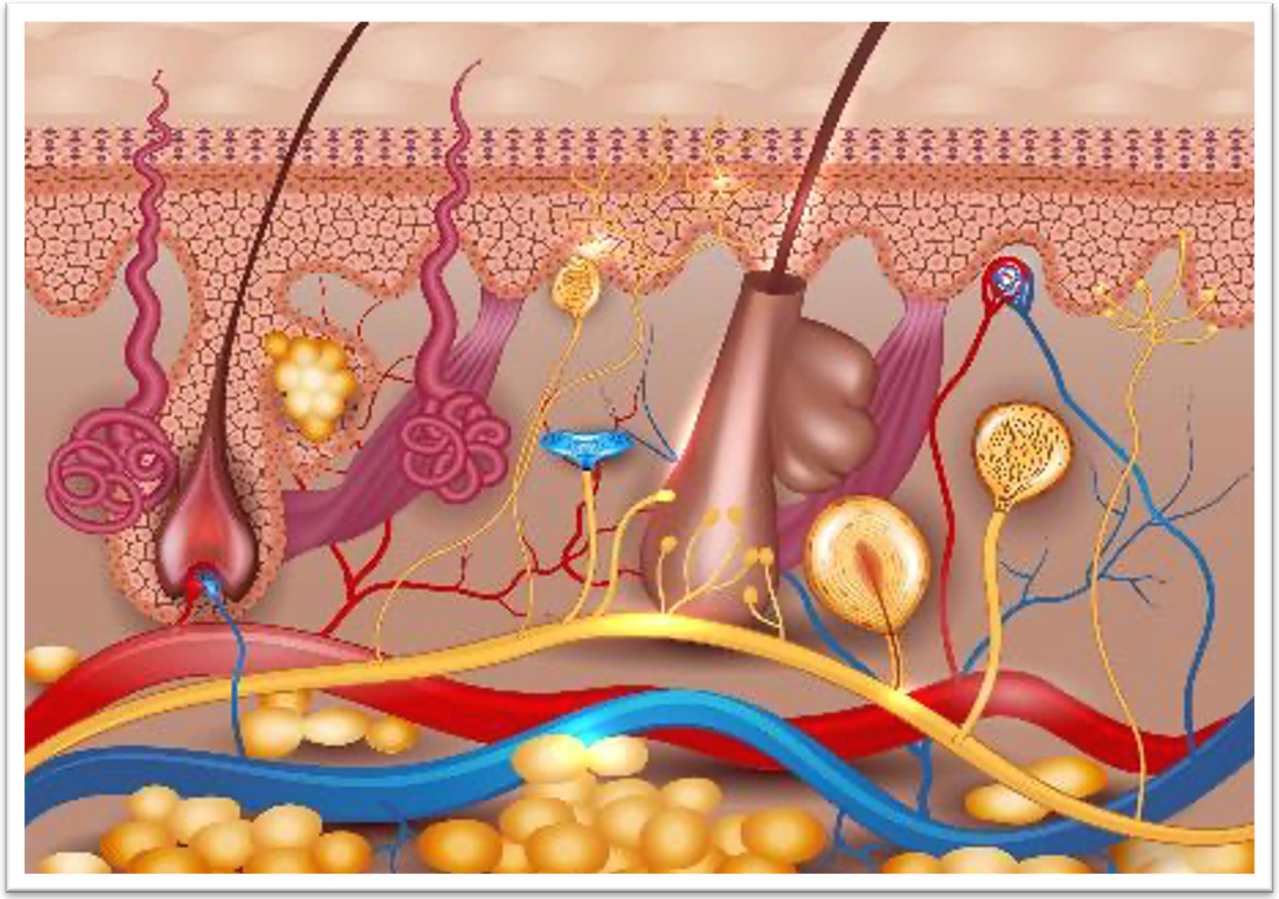


CLINICAL CHARACTERISTICS OF IAD?

- Leakage of serous exudate or possible bleeding
- May be over a bony prominence, in skin folds, anal cleft
- Or as peri-anal irritation with irregular shaped edges.



CLINICAL CHARACTERISTICS OF IAD?

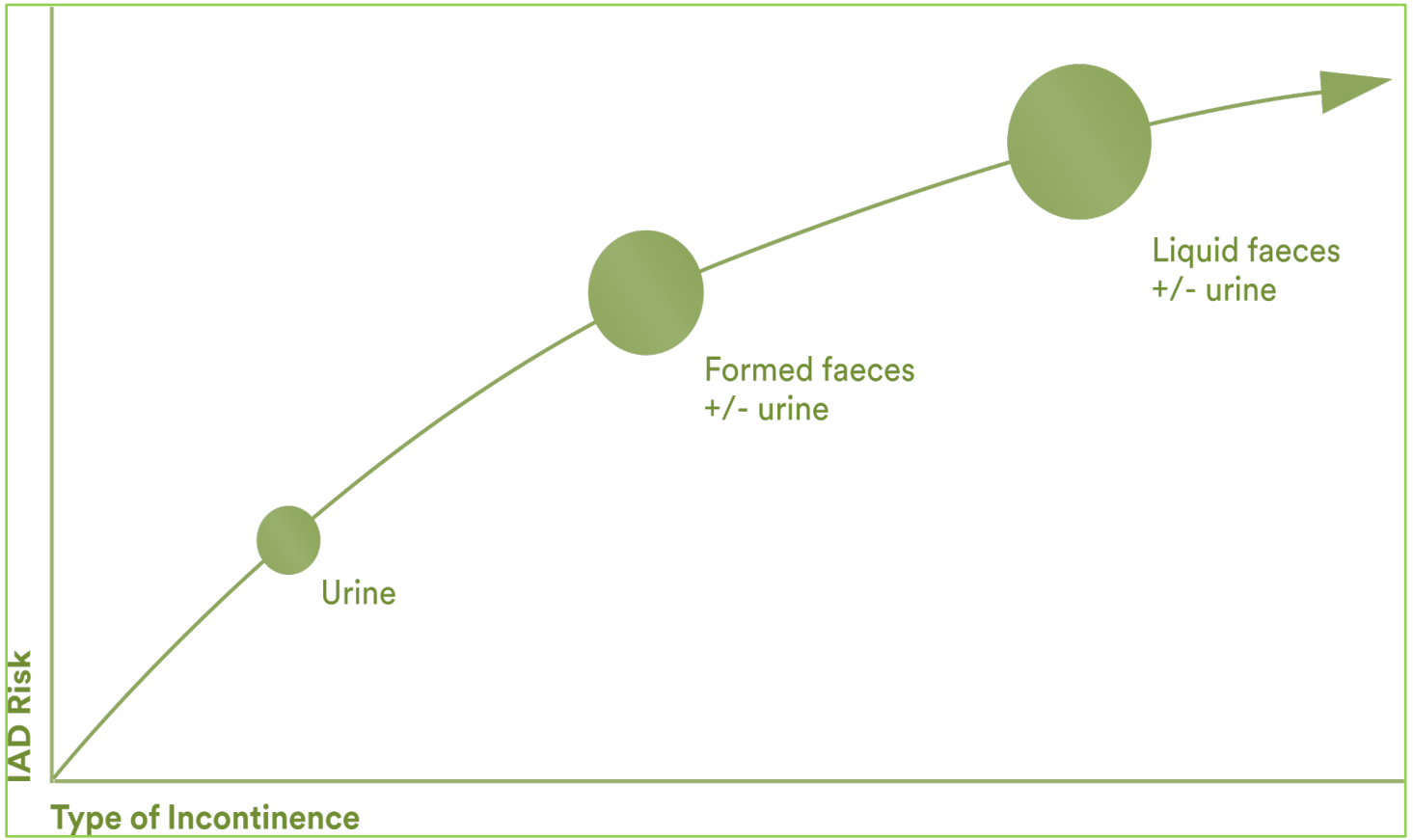


IAD can cause considerable pain (often burning in nature) and suffering for the individual, especially following each episode of incontinence.

Source of image: https:/www.shutterstock.com

WHO IS AT RISK OF IAD?

- All patients or residents with incontinence
- Patients with double incontinence are the most vulnerable – loose stools/ diarrhoea.

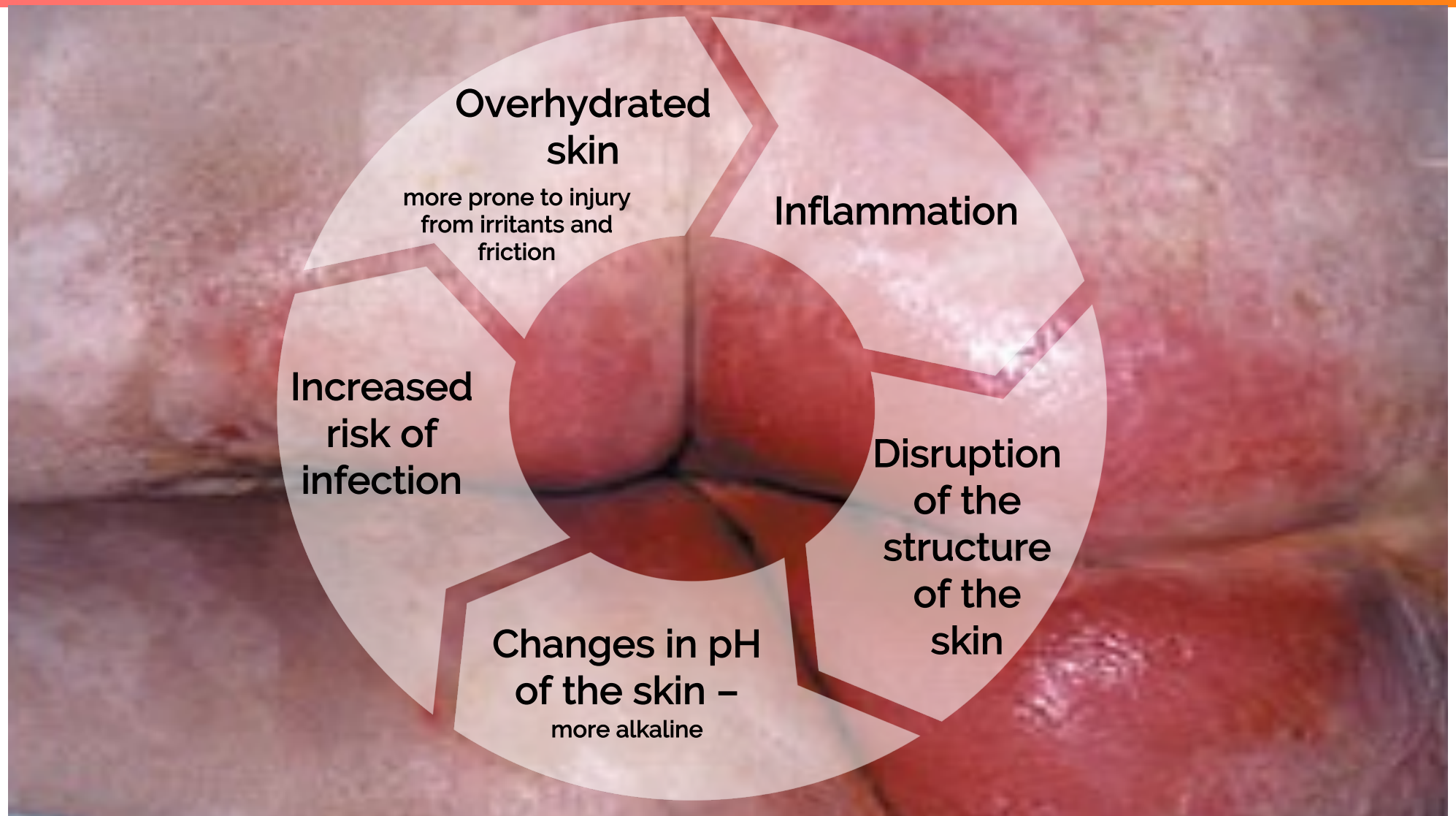


WHO IS AT RISK OF IAD?

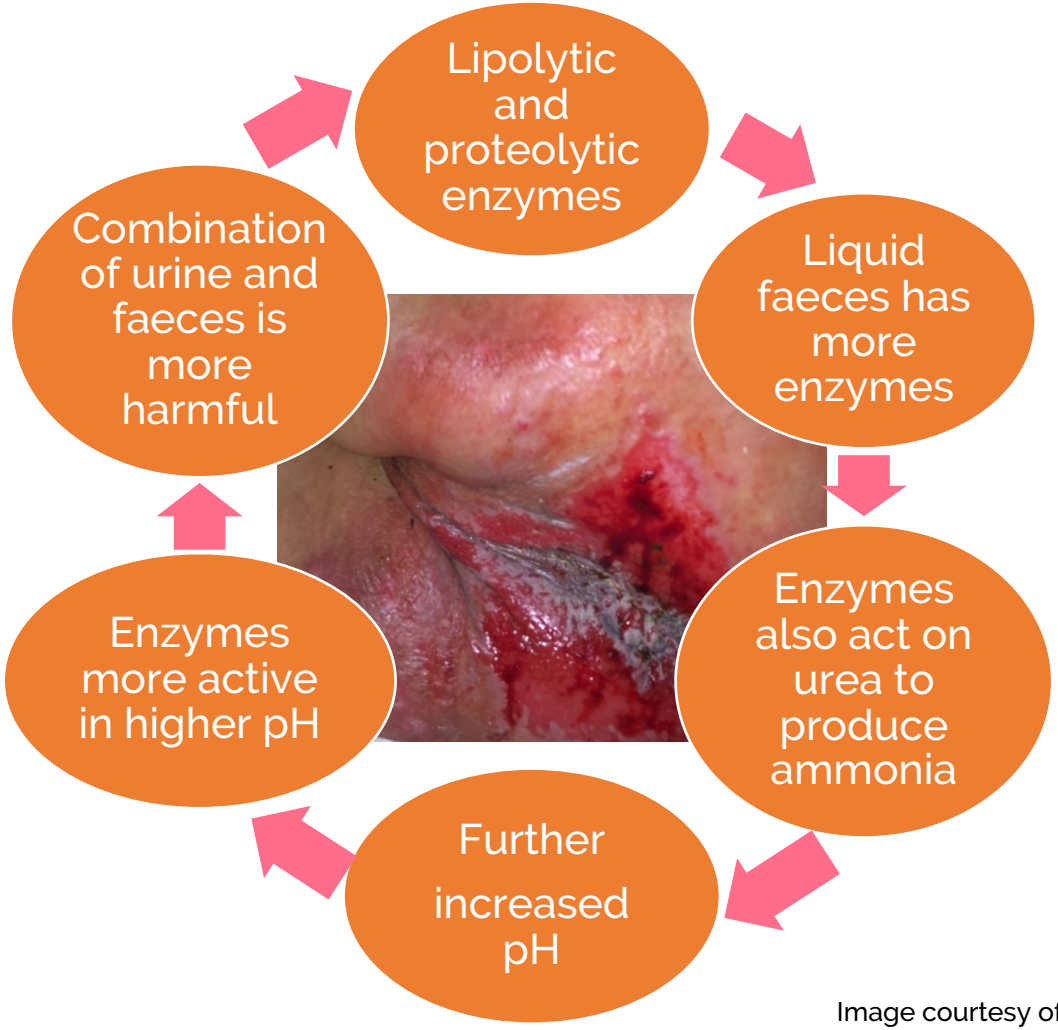
Up to **41%** of nursing home residents have IAD (Nix and Haugen, 2010).

43% of all incontinent patients in acute care have IAD (Gray and Bartos, 2013).

EFFECT OF URINE AND FAECES ON THE SKIN



INCONTINENCE ASSOCIATED DERMATITIS: FAECES

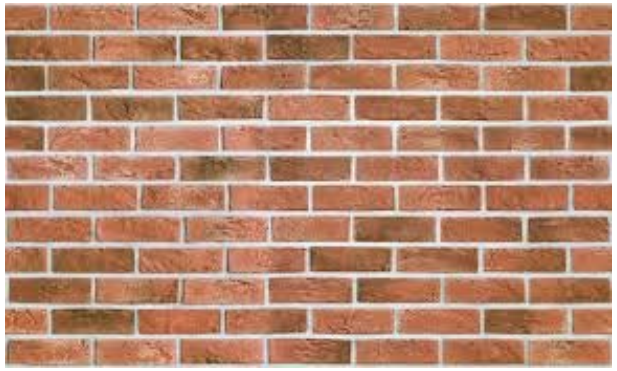


(Beeckman et al, 2015)

Image courtesy of M. Hughes TVN

HYDRATION

- Dry skin is more susceptible to infection and ulceration
- Dry areas should be rehydrated to:
  - Maintain the natural skin barrier
  - Reduce erythema
  - Reduce roughness and soften any skin cracks
  - Ease itching.



Normal skin/dry skin

HYDRATION

- Moisturise with an emollient – emollients increase the amount of water held in the skin
- Emollients should be considered as part of a skin care regime to ensure skin is hydrated and supple – do not use on skin exposed to excessive moisture.

WHAT IS A PRESSURE ULCER?

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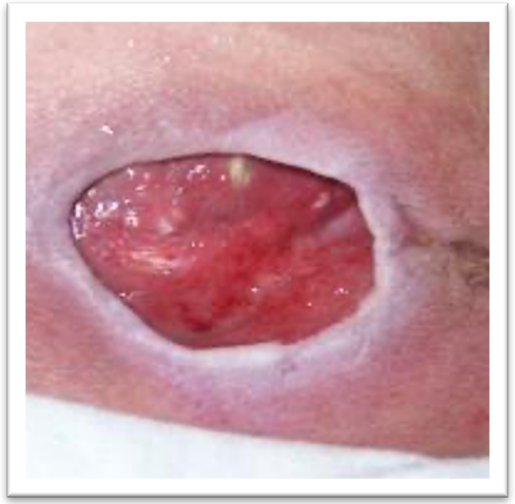
WHAT IS A PRESSURE ULCER?

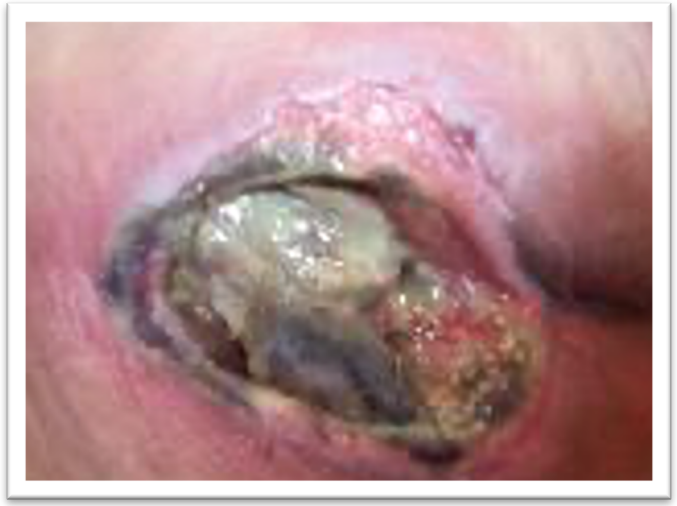
Pressure ulcer guidance identifies that a pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence.

The four main factors in causing pressure ulcers are:



- Pressure
- Shear
- Friction
- Moisture.

(NHS England, 2019)



WHAT IS A PRESSURE ULCER?

Pressure ulcers can affect anyone at any point in their life cycle. Pressure ulcers have many implications to both individuals and the NHS:

- Pain
- Longer stays in hospital
- Increased risk of infection
- Cost.

(NHS Improvement, 2018)

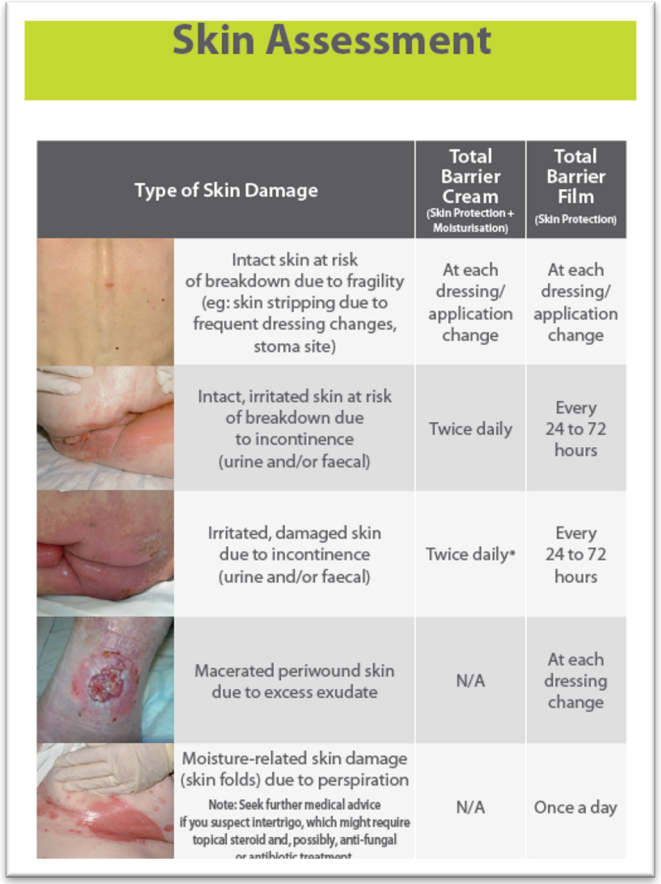
SSKIN: PRESSURE ULCER PREVENTION

Surface:

- Mattress
- Cushion
- Bed and heel protectors.

Skin Inspection:

- Complete a full skin assessment
- Complete an individual care plan
- Complete clinical incident form for all Grade 2 and above pressure ulcers.



Skin Assessment

Type of Skin Damage		Total Barrier Cream (Skin Protection + Moisturisation)	Total Barrier Film (Skin Protection)
	Intact skin at risk of breakdown due to fragility (eg: skin stripping due to frequent dressing changes, stoma site)	At each dressing/ application change	At each dressing/ application change
	Intact, irritated skin at risk of breakdown due to incontinence (urine and/or faecal)	Twice daily	Every 24 to 72 hours
	Irritated, damaged skin due to incontinence (urine and/or faecal)	Twice daily*	Every 24 to 72 hours
	Macerated periwound skin due to excess exudate	N/A	At each dressing change
	Moisture-related skin damage (skin folds) due to perspiration Note: Seek further medical advice if you suspect intertrigo, which might require topical steroid and, possibly, anti-fungal or antibiotic treatment	N/A	Once a day

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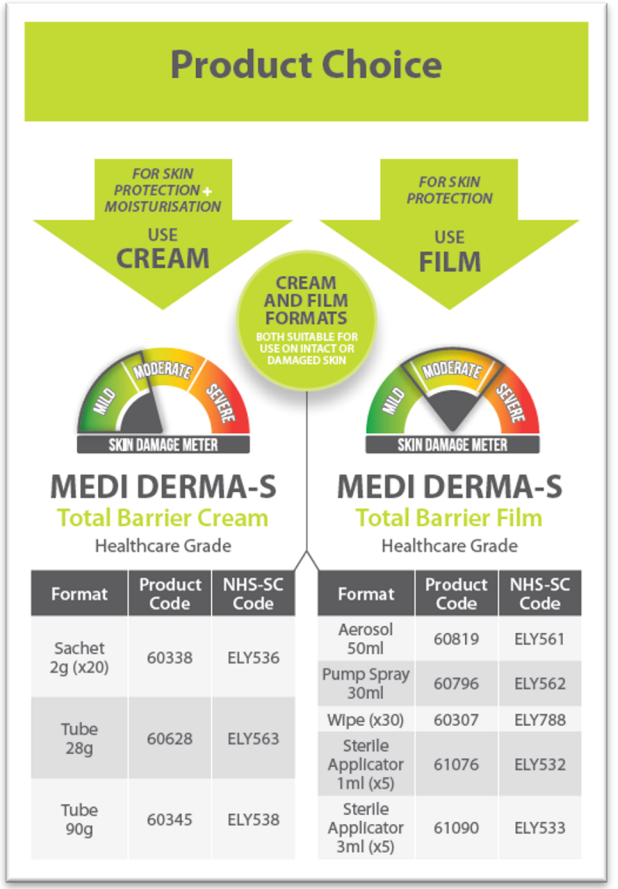
SSKIN: PRESSURE ULCER PREVENTION

Keep moving:

- Give repositioning advice
- Frequency of repositioning
- Consider offloading heels.

Incontinence:

- Assess skin for moisture damage
- Consider referral to continence team
- Formulary skin barrier products to help reduce risk of deterioration
- Report all moisture damage.



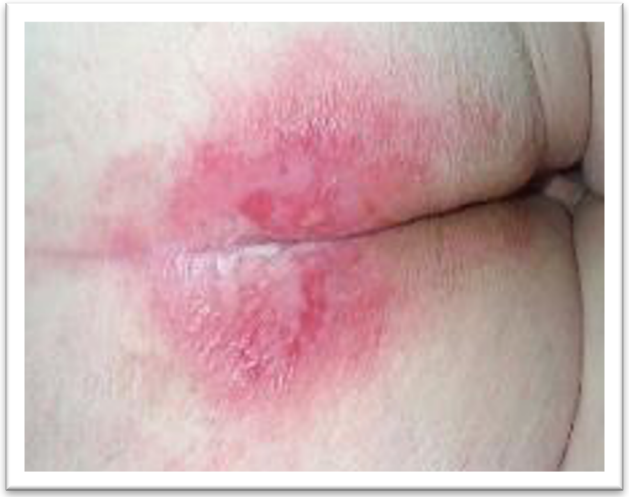
SSKIN: PRESSURE ULCER PREVENTION

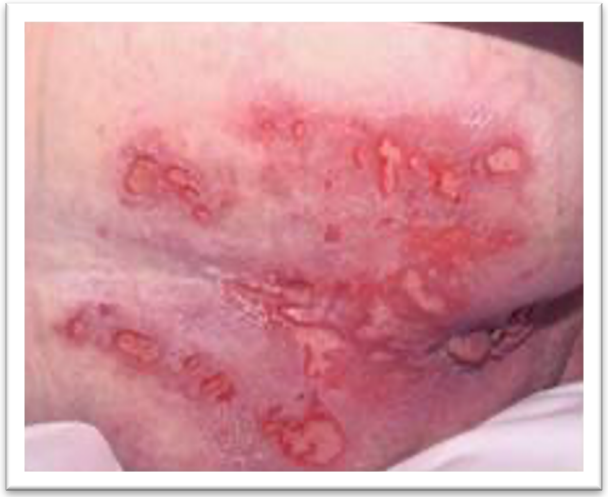
Nutrition:

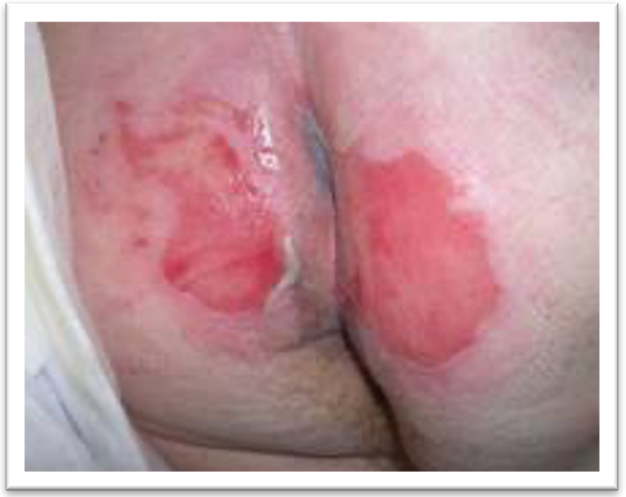
- Complete nutritional risk assessment – Malnutrition Universal Screening Tool (MUST)
- Complete an individual care plan
- Offer dietary advice
- Commence fluid balance or food chart.

IAD AND PRESSURE ULCERS

IAD is a recognised risk factor for pressure ulceration and the two conditions can coexist in an individual. However, there is still confusion between superficial pressure ulcers and IAD.





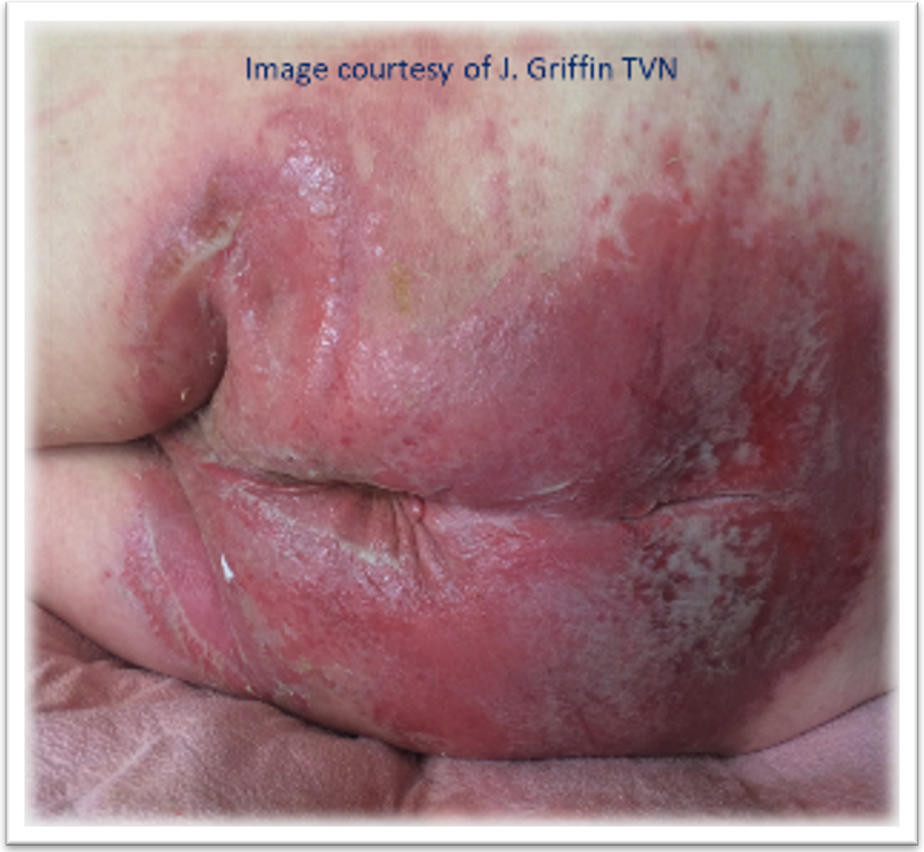


DIFFERENTIATION: PRESSURE ULCERS AND IAD

Why is it important to differentiate between pressure ulcers and IAD?:

- Prevention and treatment strategies differ
- The cause of the problem can be established and removed (for example, a moisture lesion will not heal if purely treated with pressure relief and vice versa)
- Actual number of pressure ulcers reported may be inflated.

IAD AND PRESSURE ULCERS

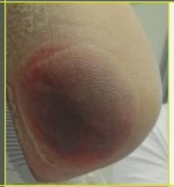
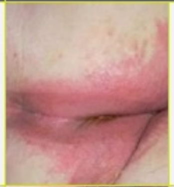
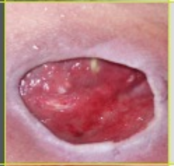
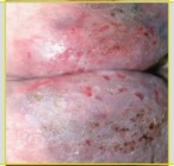
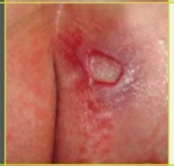
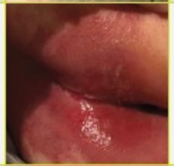
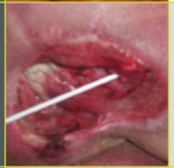
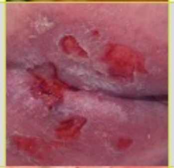
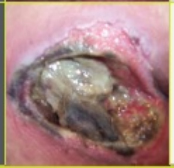
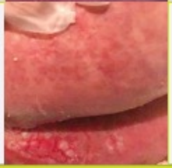


Skin damage that is established to be as a result of incontinence **should not** be recorded as a pressure ulcer, but should be referred to as **MASD** to distinguish it, and documented separately

(NHS Improvement, 2018).

DIFFERENTIATION: PRESSURE ULCERS AND IAD

Differentiation Guide

Cause	Pressure Ulcer Established cause - Pressure and/or shear		Incontinence-Associated Dermatitis (IAD) Established cause - Continuous exposure to urine and/or faeces	
Location		Most likely over a bony prominence		Can occur over a bony prominence if moisture present - exclude pressure and shear. A linear (straight) lesion limited to the anal cleft is likely to be Moisture-Associated Skin Damage. Peri-anal redness/irritation is most likely Moisture-Associated Skin Damage due to faeces.
Shape/Edges		Regular shape with a more defined wound edge		Diffusely scattered, irregularly shaped. If a 'kissing' lesion is observed across two adjacent surfaces, at least one is likely due to moisture.
Colour		Non-blanching redness or blue/purple discolouration is likely due to pressure damage. Red granulation, soft/black necrotic or sloughy tissue in the wound bed indicates a pressure ulcer.		If redness or discolouration is uneven, moisture damage is the likely cause. Pink or white surrounding skin indicates maceration
Depth		Can vary in depth from unbroken non-blanching erythema to full thickness tissue loss extending to tendon or bone		Superficial – Partial thickness skin loss, but may enlarge when infection is present
Necrosis		Presence of necrosis (black scab or softening blue, brown, grey or yellow tissue) indicates a pressure ulcer		Moisture-Associated Skin Damage does not contain necrotic tissue. Where there is <u>necrotic tissue</u> within the IAD, this will be due to a <u>combination</u> of both pressure and moisture damage and should be reported as a pressure ulcer.[4]

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REVISED RECOMMENDATIONS

Pressure ulcers: revised definition and measurement summary and recommendations - June 2018	
Moisture-associated skin damage (MASD) should be counted and reported in addition to pressure ulcers.	Where skin damage is caused by a combination of MASD and pressure, it will be reported based on the category of pressure damage.
Rationale: to capture skin damage that is currently reported inconsistently. To help identify the clinical problem with individual trusts and quality improvement action that needs to be taken.	Rationale: this will clarify the requirement to report pressure ulcers where MASD is also present.
Impact: likely impact is higher reported numbers of incidents; new category needed for local monitoring systems.	Impact: low impact on reported numbers.

EXAMPLES OF IAD AND PRESSURE ULCERS

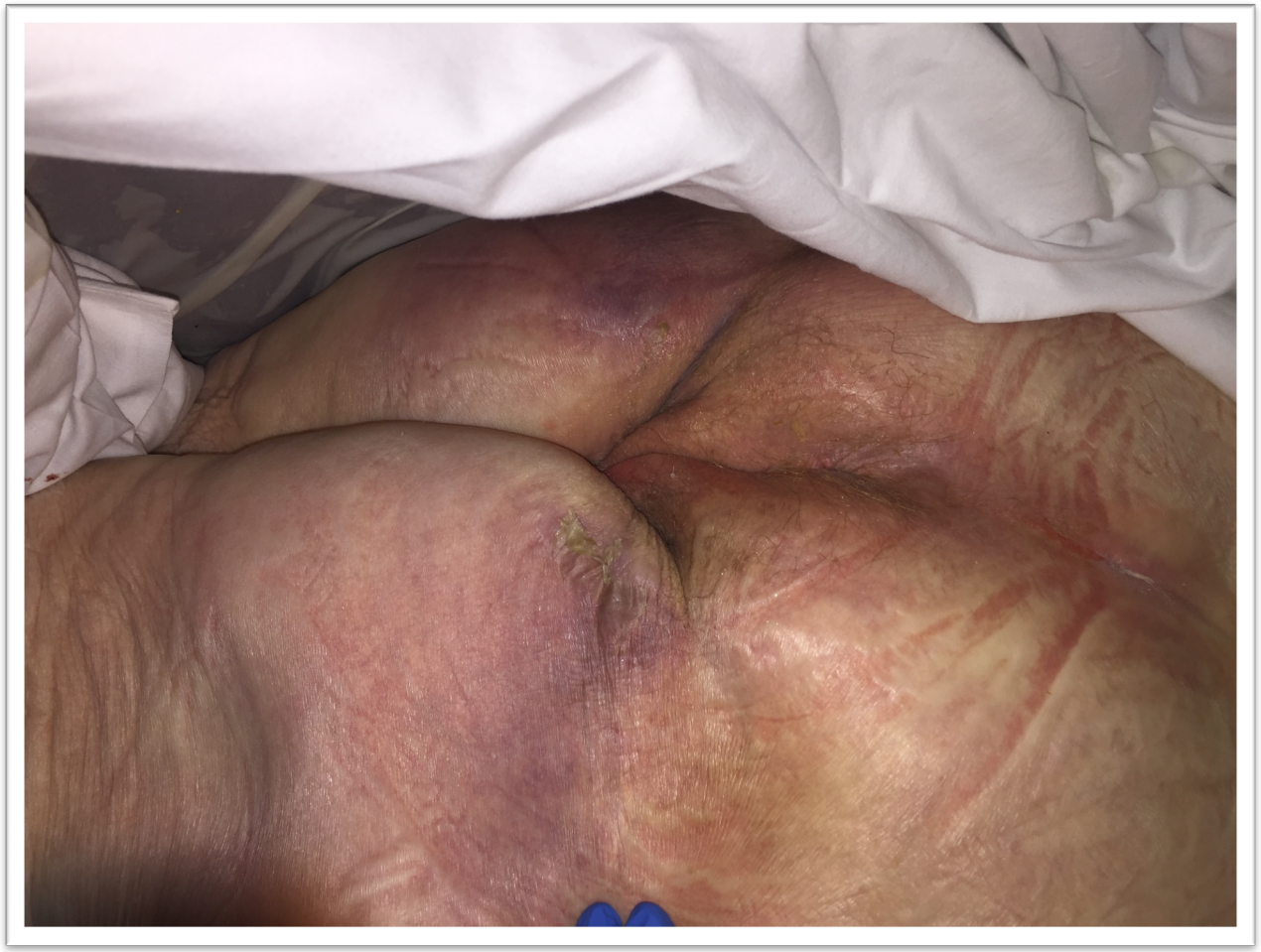


Image provided by Siobhan Mccoulough TVN

EXAMPLES OF IAD AND PRESSURE ULCERS

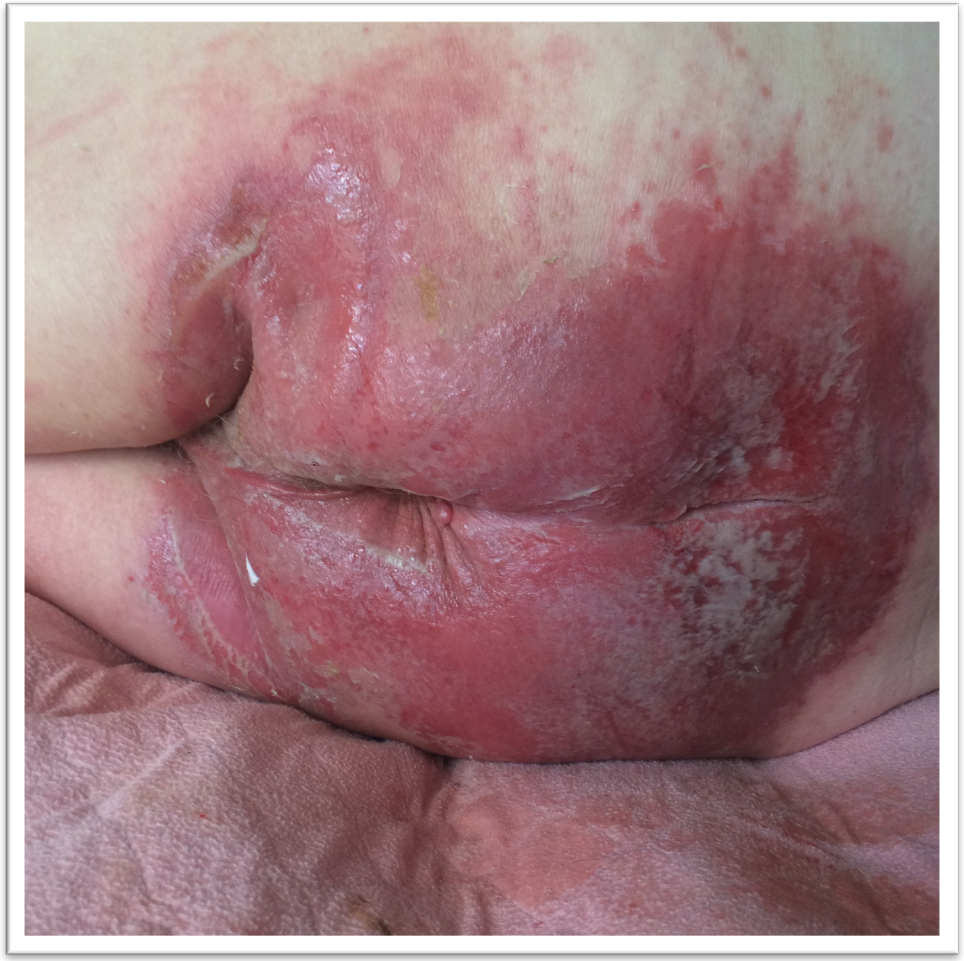
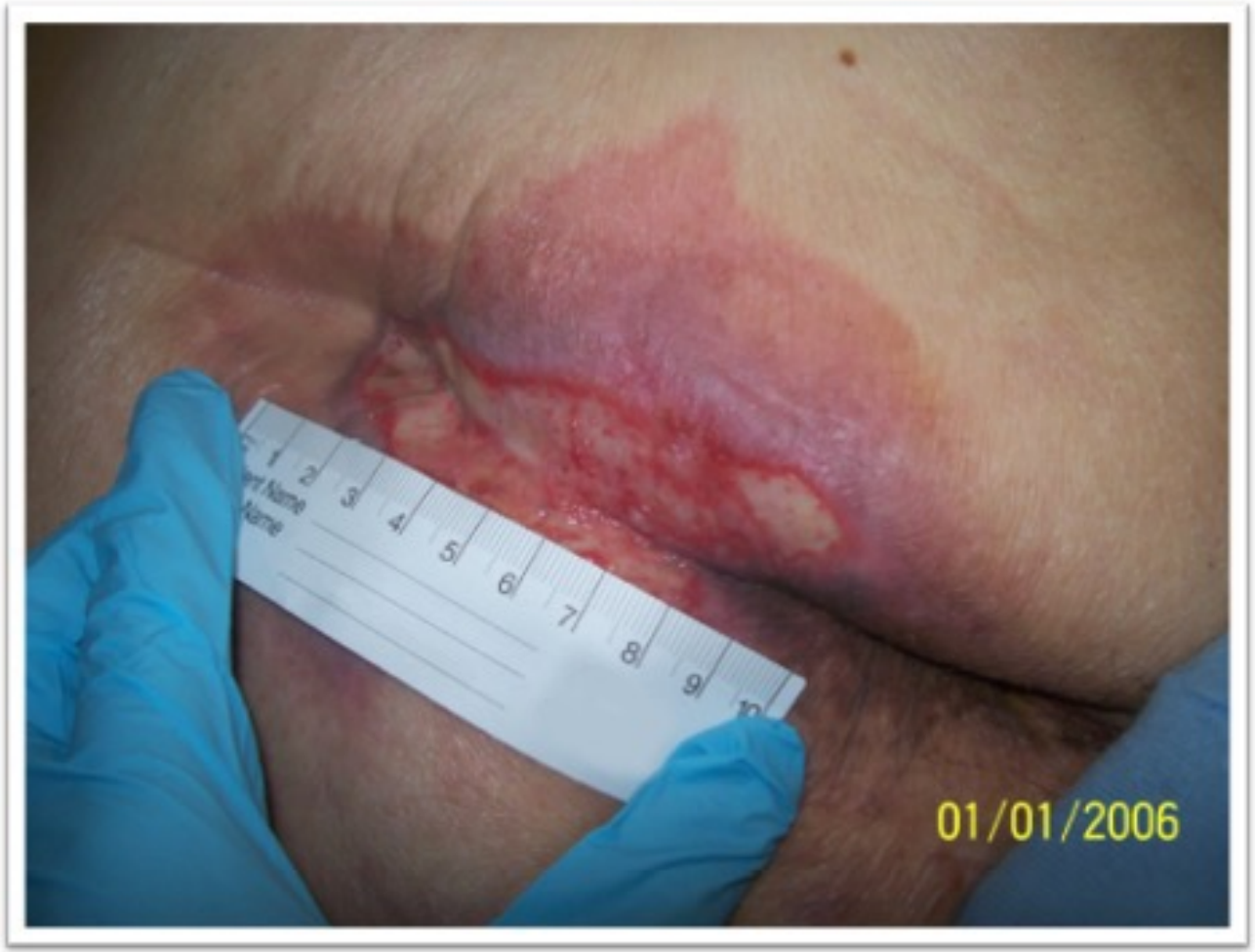


Image provided by Jackie Griffin TVN

EXAMPLES OF IAD AND PRESSURE ULCERS



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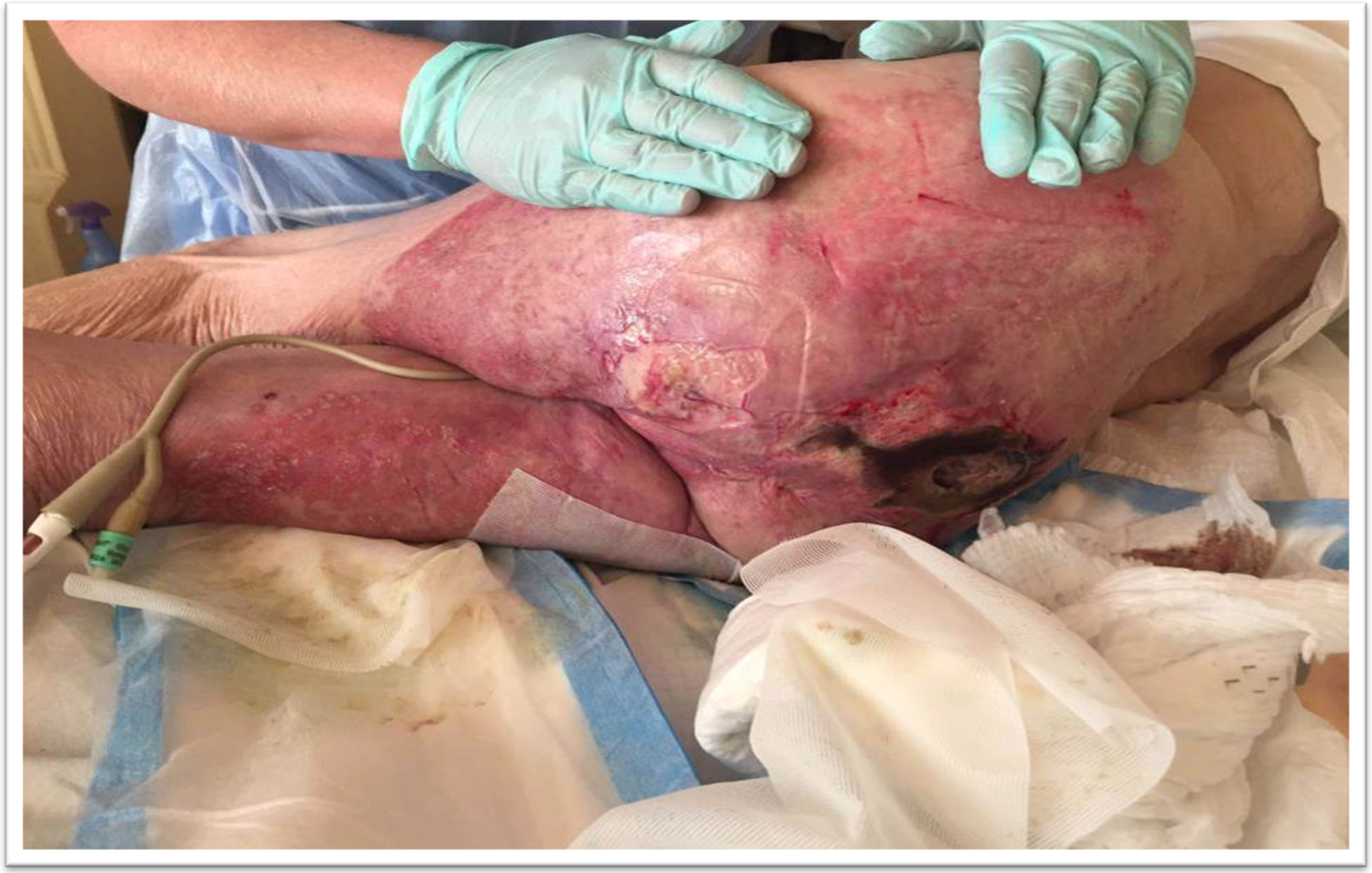


Image provided by Maria Hughes TVN

EXAMPLES OF IAD AND PRESSURE ULCERS

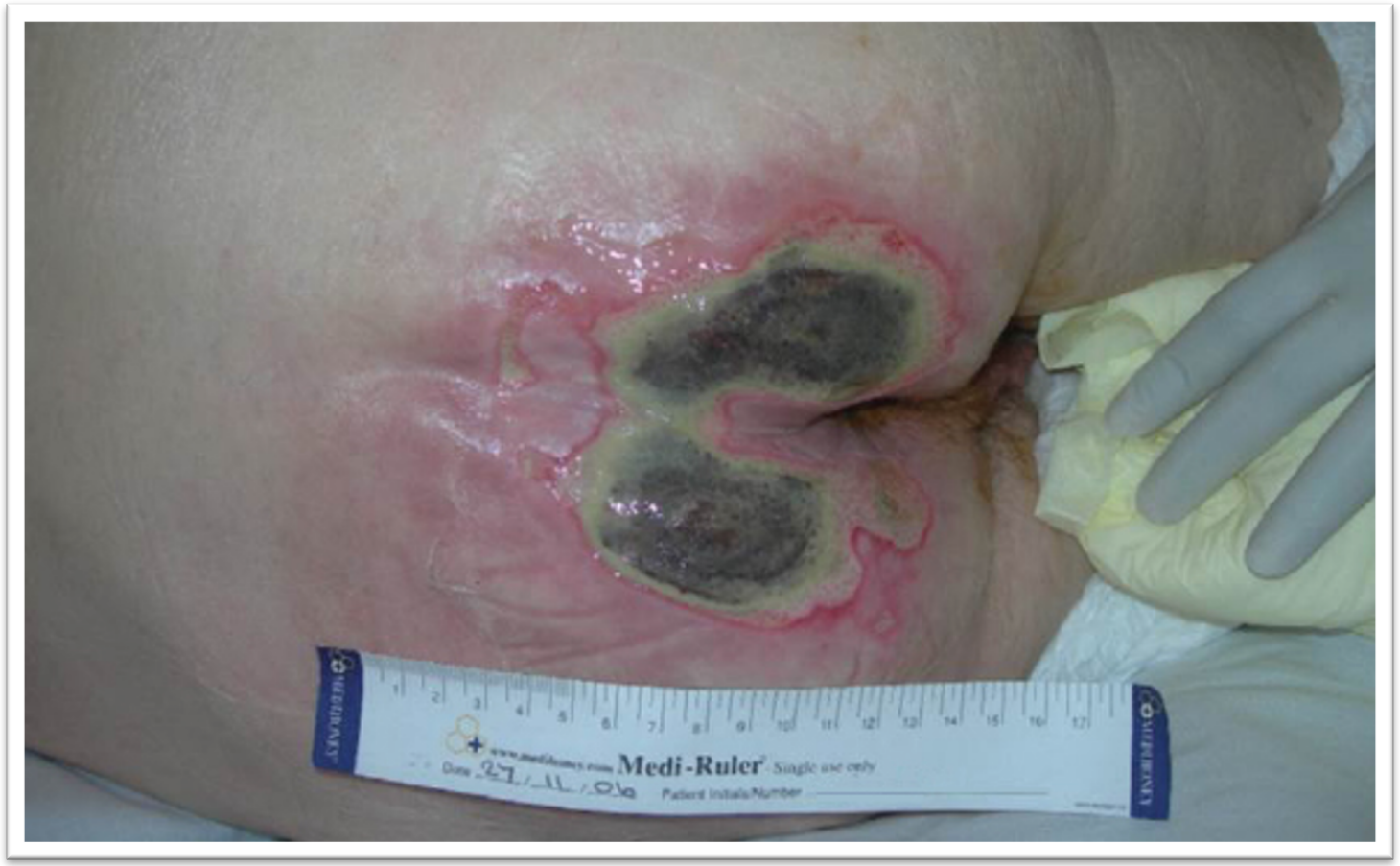


Image provided by Maria Hughes TVN

TOTAL BARRIER PROTECTION (TBP)

Step Up
If there is no significant improvement in the skin after 2-3 days

Step Down
If there is noticeable improvement in the skin after 2-3 days

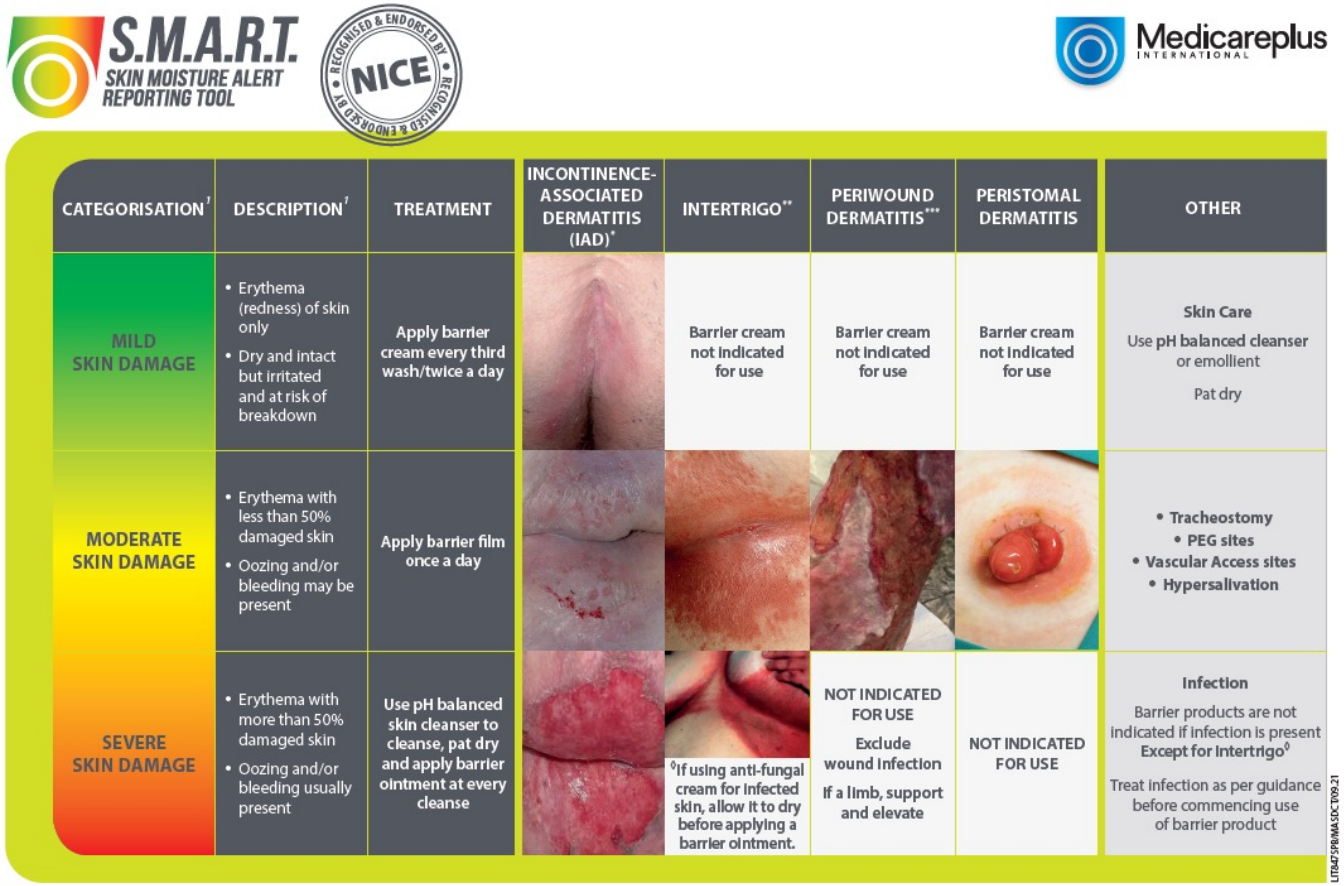
MEDI DERMA-S Total Barrier Cream

MEDI DERMA-S Total Barrier Film

MEDI DERMA-*PRO* Skin Protectant Ointment and Foam & Spray Incontinence Cleanser

*Barrier products should not be on repeat prescription

S.M.A.R.T.



Nursing Times Award nomination 2021

(Jones and Winterbottom, 2019; NICE, 2019)

NAPPY-ASSOCIATED DERMATITIS (NAD)

Nappy-Associated Dermatitis (NAD)

NHS
University Hospitals Plymouth
NHS Trust

- Nappy-Associated Dermatitis (NAD), also known as nappy rash, is caused by prolonged exposure of urine and faeces to the skin (Health Direct Australia, 2015).
- The pH of the skin alters and damages cells, causing dermatitis or irritation (Schmid-Wendtner and Korting, 2006).

Prevention & Treatment in Neonates & Paediatrics

Neonates Skin Barrier:

- Skin barrier properties depend on the thickness and integrity of the stratum corneum (Telofski et al, 2012)
- Full-term infants have a 30% thinner stratum corneum than adults and are less resilient (Stamatas et al, 2010; Blume-Peytavi et al, 2012)
- Premature infants, particularly those of very low birth weight, are at increased risk of skin damage and infection

Skin Condition	**Intact Skin** Intact skin at risk of skin damage	**Mild Skin Damage** Irritated skin at risk of breakdown	**Moderate Skin Damage** Moderate erythema and small areas of damaged skin (<50% of affected area)	**Severe Skin Damage** Intense erythema and large areas of damaged skin (>50% of affected area)
Cleansing	• Change frequently or soon after soiling • Cleanse with warm water and/or emollient and wet gauze • Pat dry (no rubbing) or allow to air dry			• Change frequently or soon after soiling • Cleanse with **MEDI DERMA-PRO** Foam and Spray Incontinence Cleanser (no rinsing required) • Pat dry (no rubbing) or allow to air dry
Skincare Regimen	Apply **MEDI DERMA-S** Total Barrier Cream • A pea-sized amount to a palm-sized area • To bottom, groin and genitalia • Apply twice daily **Do not use MEDI DERMA-S Total Barrier Cream for patients who need Phototherapy / UV light treatment.**		Apply **MEDI DERMA-S** Total Barrier Film • To bottom, groin and genitalia • Every 24-72 hours	Apply **MEDI DERMA-PRO** Skin Protectant Ointment • A thin layer • To bottom, groin and genitalia • After every nappy change
Nursing Recommendation	**Assessment** • Observe and document changes in skin integrity • Assess frequency and consistency of stools on a daily basis • Consider differential diagnosis and dermatological referral • Look for features that may indicate bacterial secondary infection • Anticipate increased NAD risk from antibiotics, immunosuppression treatment or neonatal abstinence syndrome (NAS) • Consider possible sensitivity to detergents, fabric softeners or external products that have contact with the skin	**Good Practice** • Encourage regular nappy-free time as much as possible • Use skin barrier products that do not interfere with the absorbency of nappies • Encourage use of disposable gel core nappies • Reassess skin-care regime every 48 hours • In case of skin deterioration, **contact a tissue viability nurse** • If thrush is present, administer antifungal treatment before applying barrier product	**Avoid** • Baby wipes of any kind for neonates • Perfumed soaps and moisturisers • Powders, such as talcum powder • Thickly applied creams that can block the absorbency of nappies	

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