Targeting Incontinence-Associated Dermatitis – A Leading Risk Factor for Pressure Ulcers
US hospitals no longer paid for pressure ulcers – fecal incontinence increases pressure ulcer risk by 22X

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Introduction
Incontinence-associated dermatitis (IAD) is characterized by skin inflammation resulting from exposure to urine and/or feces as a result of incontinence. IAD manifests as skin redness with or without blistering, erosion, or loss of the skin barrier function and is a painful condition that begins with a simple maceration but can progress to severe inflammation with continued exposure.1

The 5 Million Lives Campaign, sponsored by the Institute for Healthcare Improvement (IHI), seeks to reduce patient harm. One of the goals of this campaign for 2007 and 2008 is to reduce the incidence of pressure ulcers. The IHI has issued recommendations for appropriate incontinence care, which include keeping patients dry, cleansing the skin with a mild cleansing agent to minimize irritation and dryness, and applying a topical moisture barrier to protect the skin against further exposure to urine and/or feces.2 The IHI recommends using pre-moistened, disposable barrier cloths to cleanse, moisturize, deodorize, and protect the patients’ skin after each incontinence episode.3

Soap and water, which are commonly used for cleanup after an incontinence episode, are inadequate for the care and prevention of IAD because they strip the skin of natural oils and most soaps have an alkaline pH which puts skin at risk for secondary infection with fungi and bacteria.4

Purpose
Bliss et al5 have described a skin care regimen that involves the use of a cleanser and that provides a moisture barrier. This regimen reduced the rate of IAD in nursing home patients and reduces the costs associated with incontinence care.6 However, this regimen is only useful if the health care staff are able to accurately identify IAD.

We developed a visual tool that helps to identify IAD, assess the severity of IAD, and determine the appropriate intervention for the treatment of IAD.7

Methods
Inpatient surveys were conducted, excluding obstetric and most psychiatric patients; geriatric psychiatry patients were included. The results were published, and peer-reviewed efforts ensued to create a visual tool to assist with the identification, classification, and appropriate treatment of IAD.8

In 2005, 198 of 761 inpatients were identified as incontinent; 54% of these patients had a skin injury in the area exposed to urine and/or feces. In 2006, 120 of 688 inpatients were incontinent; 42.5% of these patients had a skin injury in the area exposed to urine and/or feces. After the publication of the above IAD incidence results, a visual tool was developed that involved:

1) conducting a systematic literature review of the various definitions and stages of IAD;
2) reviewing the evidence and comparing IAD tools;
3) assembling appropriate pictures, definitions, and interventions dependent on the stage of IAD;
4) using a peer-reviewed process, developed by industry experts, concerning the appropriateness of the tool; and
5) incorporating peer-reviewed commentary as appropriate to enhance the validity of the tool.

Results
The initial findings indicated that IAD is very common. In response to this finding and because many health professionals lack the knowledge to accurately differentiate between pressure injury and IAD, a visual tool was developed that provides a simple and accurate means of identifying, classifying, and treating IAD. The tool recommends the use of an all-in-one barrier to prevent IAD. This recommendation is based on IHI guidelines and on the proven effectiveness of such a barrier.9

Discussion
The tool includes suggestions for evidence-based prevention regimens in nursing home residents with incontinence: economics of skin damage prevention.10

A major problem associated with IAD is mistaking it for pressure injury, which results in the wrong care plan being initiated. It is important to define IAD and distinguish it from pressure ulcers for reporting purposes and so that the correct decisions are made concerning patient care.

The effective prevention and treatment of IAD differs from that of pressure ulcers, and the accurate identification of IAD can result in cost savings through a more focused problem-specific approach and more accurate reports of prevalence and incidence.

Conclusion
IAD is very common in incontinent patients and is a painful and disabling condition. It is important to differentiate between IAD and pressure injury because the protocols for prevention and treatment of the two conditions are different.

The failure to accurately differentiate between IAD and pressure ulcers may adversely affect patient outcomes and result in reporting errors.

The tool includes suggestions for evidence-based prevention and care, including the use of all-in-one barrier cloths that clean, moisturize, and protect the skin against IAD which may result from ongoing exposure to urine and/or feces.

A peer-reviewed visual tool was developed to make it easy for healthcare staff to identify, stage, and treat IAD.

The visual tool presents interventions for each level of severity of IAD using definitions developed from the literature.

If your facility desires to utilize this tool, please send an email to IADIT@medbiopub.com to obtain copyright permission and give your input as the tool is revised to become clinically relevant.

References
4. Institute for Healthcare Improvement. Getting started kit: Reduce methicillin-resistant staphylococcus aureus (MRSA) infection how-to guide. ©2007 Institute for Healthcare Improvement. Available at: www.ihi.org/IHI/Programs/Campaign.
6. IHI. The IHI recommends using pre-moistened, disposable barrier cloths to cleanse, moisturize, deodorize, and protect the patients’ skin after each incontinence episode. For help identifying IAD, contact IAIHIT@medbiopub.com to obtain copyright permission and give your input as the tool is revised to become clinically relevant.