Comparing Efforts on 3 Continents to Improve Clinical Practice for the Prevention and Treatment of Incontinence-Associated Dermatitis

Advancements in IAD Prevention

The best methods for prevention of IAD in high-risk patients include the following[10].

- Identify and treat the cause of incontinence.
- Frequently assess skin integrity and color.
- Cleanse skin gently with slightly acidic products (similar to the 5.5 pH of normal skin).
- Use emollients and skin agents to soften the skin.
- Place high-risk patients in the semi-prone position for 30 minutes 2 or 3 times a day to expose the skin to air.
- Apply a protectant to the skin.
- Use underpad that pull moisture away from the skin.

The Institute for Healthcare Improvement (IHI) recommends that on an in-system one can incorporate cleansing solutions with emollients and skin protectants be available at each patient’s bedside for the prevention of IAD. Adding bedside stations has demonstrated to significantly improve incontinence care compliance, thus reducing the incidence of IAD[10].

Research in North America

- Evaluation of the prevalence of incontinence-associated skin disease (IADS) in the acute care setting[2007]:
  - The overall prevalence of incontinence and IAD in the acute care setting[2007] was 17.6% (10% of patients counted in prevalence).
  - Skin injury was observed in 42.3% of patients, with the most common types being erythema, excoriation, and maceration.
  - A higher rate of skin injury was observed in patients with hypoglycemia and poor nutritional status.

- Development of a new IAD classification and intervention tool (IAD Intervention Tool (IIT)) in 2008[1]:
  - The IIT is designed to identify high-risk individuals in the presence of at least 1 of these conditions: skin damage or injury, and compromised or absent barriers of the skin.

- In May 2009, the expert panel conducted a scoping review of the treatment and the prevention of IAD.

Research in South America

- Restructuring of an IAD Prevention Protocol at a patient care facility in São Paulo, Brazil in 2007 and implementation in April 2008:
  - A study performed at Children’s Hospital Department monitored the patients’ charts.
  - The protocol was restructured: IAD incidence and prevalence and staff adherence to the protocol were monitored after the restructuring. The restructured protocol resulted in a significant reduction of skin injuries. These results were published at the Dermatology Nurses’ Association Annual Conference in March 2009.

Aspects of restructuring:
- Staff education: Pertinent nursing staff education: 1-hour lecture for nurses before implementation, regarding concepts, etiology, pathophysiology, prevention, and treatment of IAD

- Follow-up in the field: The IAD group is a support group in early IAD recognition and differentiation from other causes for better patient outcomes.

- Support and follow-up by the IAD group for nurses and for difficult cases: includes family educators.

- Revisit of the IAD tool: diagnosed in every patient and including the emergency rooms, help reduce deaths.

- Change and updating of the descriptive protocol to an algorithmic protocol (IAD-AP) to learn and follow.

- Hour medical care given for the patients and the IAD protocol is then supported as a nursing clinical protocol: Nurses manage beds, Foley catheters, prevention, and treatment unless ask the Field of other professionals.

- 1-hour educational lecture for hospital administrators (as, according incident)

- Introduction of skin care nurse to high-risk patients.

- Bioclear barrier cream (already introduced to the Brazilian market) in 2007. This product is being incorporated into the hospital skin care regimen.

- A campaign to make public skin cream available to the Brazilian market is under way.

Implications for Future Research

- Caregivers worldwide should be educated regarding evidence-based strategies for the identification, prevention, and treatment of IAD.

- IAD assessment tools and treatment guidelines should be standardized in all health care institutes to improve clarity of research results and clinical applicability.

- The IADT should be acceptable at the patient’s bedside to ensure prompt assessment and treatment of IAD. Currently, 2 translations of the IADT are available.

- A randomized controlled trial with a large patient cohort should be conducted to determine the clinical and economic impacts of IAD.

References

When you add quality ingredients you get a first class jambalaya!!

The world is one big global village! If we combine our efforts we will come out with a higher quality of care for people vulnerable to or experiencing IAD!