

F
A
C
E
B
O
O
K
L
I
V
E

CHALLENGES IN MANAGING IAD IN THE NURSING HOME SETTING

**TUESDAY
29 JUNE
7.30 - 8.30**

FACEBOOK LIVE



**JULIE
MULLINGS**



SPONSORED
BY:



Medicareplus
INTERNATIONAL
Est. 2008

AIM OF SESSION

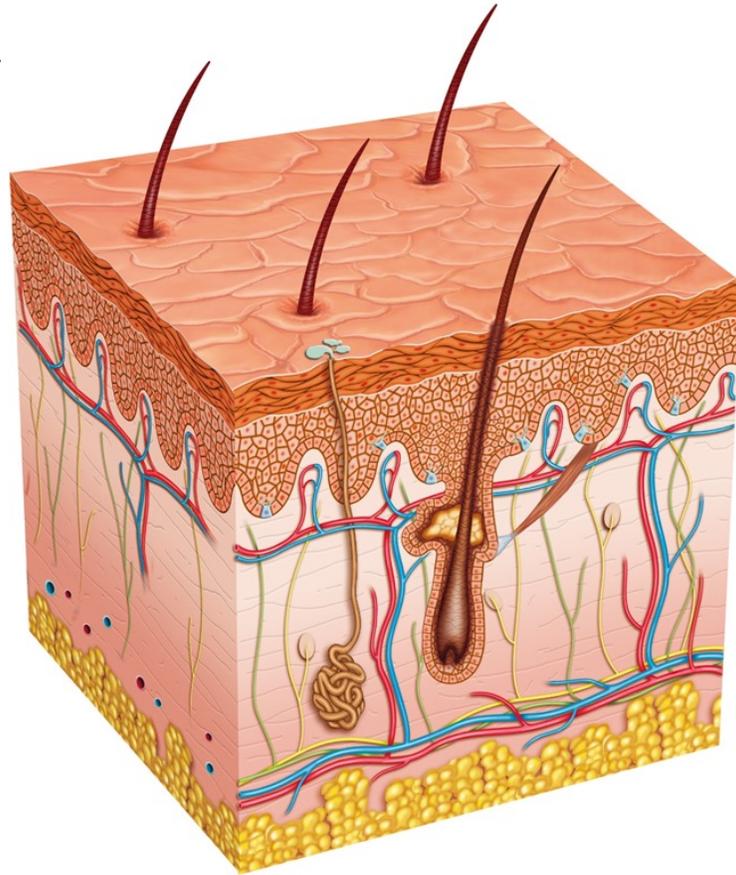
To discuss the clinical presentation of incontinence-associated dermatitis (IAD) and the impact of managing and treating the condition in a nursing home setting.

OBJECTIVES

- Revisit the importance of caring for the skin
- Understand the causes of IAD
- Describe the potential implications of IAD and the effect on the patient's skin
- Summarise how a structured approach can effectively manage problems associated with IAD

IMPORTANCE OF MAINTAINING SKIN INTEGRITY

Source of image: Shutterstock
(2003-2020) (Jpeg). Available at
<https://www.shutterstock.com>

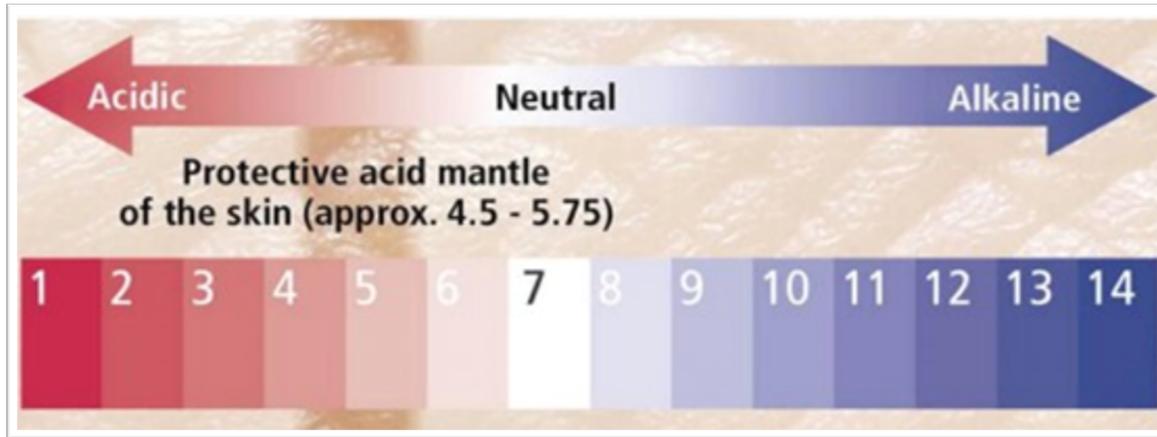


Epidermis

Dermis

Subcutaneous layer

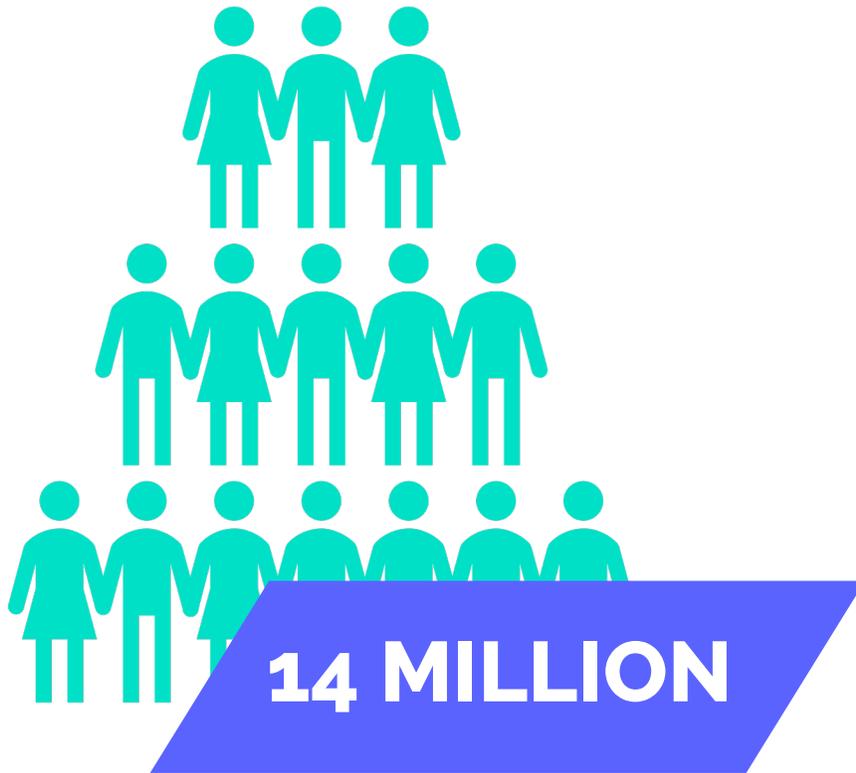
IMPORTANCE OF MAINTAINING SKIN INTEGRITY



The pH of healthy skin is between 4 and 6, providing an acidic environment that supports the resident, commensal bacteria on the surface of the skin.¹

In overhydration, the pH of the skin increases, resulting in an alkaline environment that is conducive to bacterial proliferation and infection.²

INCONTINENCE



An estimated 14 million adults experience incontinence in England alone, and this population is at a very high risk of developing IAD.⁴

INCONTINENCE

- IAD is the most common and widely recognised form of moisture-associated skin dermatitis (MASD), due to prolonged or chronic exposure of urine and/or stool, particularly liquid stool on the skin⁷
- It can appear in the peri-anal area, scrotum, groin, buttocks, gluteal cleft, and even extend down to the inner and posterior thighs³
- Up to **41% of care home residents** and **43% of all incontinent patients in acute care have IAD**^{6,7}

RISK ASSESSMENT OF VULNERABLE PATIENTS



- Identification of incontinence issues
- Start continence assessment
- Consider medicine review
- Continence equipment
- Consider referral to the bowel and bladder service
- Consider current toileting regimen or need for aids

MANAGEMENT OF SKIN INTEGRITY OF VULNERABLE PATIENTS

Fundamental aspects of IAD prevention and management should be based on:

- ✓ **Skin cleansing to remove contaminants and microorganisms**
- ✓ **Application of a skin moisturiser and an impermeable barrier that provides total skin protection³**

Soap and water still remains a traditional cleansing method, however, it is considered to be sub-optimal care.⁹

TRADITIONAL SOAPS... IMPLICATIONS



Source of image: Shutterstock (2003-2020).
Available at <https://www.shutterstock.com>

- Are alkaline and can disturb the 'acid mantle'
- Increased pH damages the skin barrier
- Frequent washing decreases natural sebum and bacterial flora
- Sebum has acidic properties
- Perfumed soaps may cause irritation and dryness

ALTERNATIVES TO TRADITIONAL SOAPS



Source of image: Shutterstock
(2003-2020). Available at
<https://www.shutterstock.com>

- Consider an emollient as a soap substitute
- Use a non-scented pH-balanced soap
- Avoid cleansers with alcohol and preservatives
- Use disposable wipes: soft, gentle wipes not baby wipes
- Pat skin dry, don't rub



CHARACTERISTICS OF IAD

- Widespread blotchy erythema
- Diffuse or irregular edges
- Shiny wet skin
- Superficial
- No necrosis
- Damage may be linear in skin folds
- Leakage of serous exudate or possible bleeding



CHARACTERISTICS OF IAD

IAD occurs in skin folds, anal cleft or as peri-anal irritation with irregular-shaped edges. It can extend over a bony prominence and become a combination pressure ulcer and IAD.

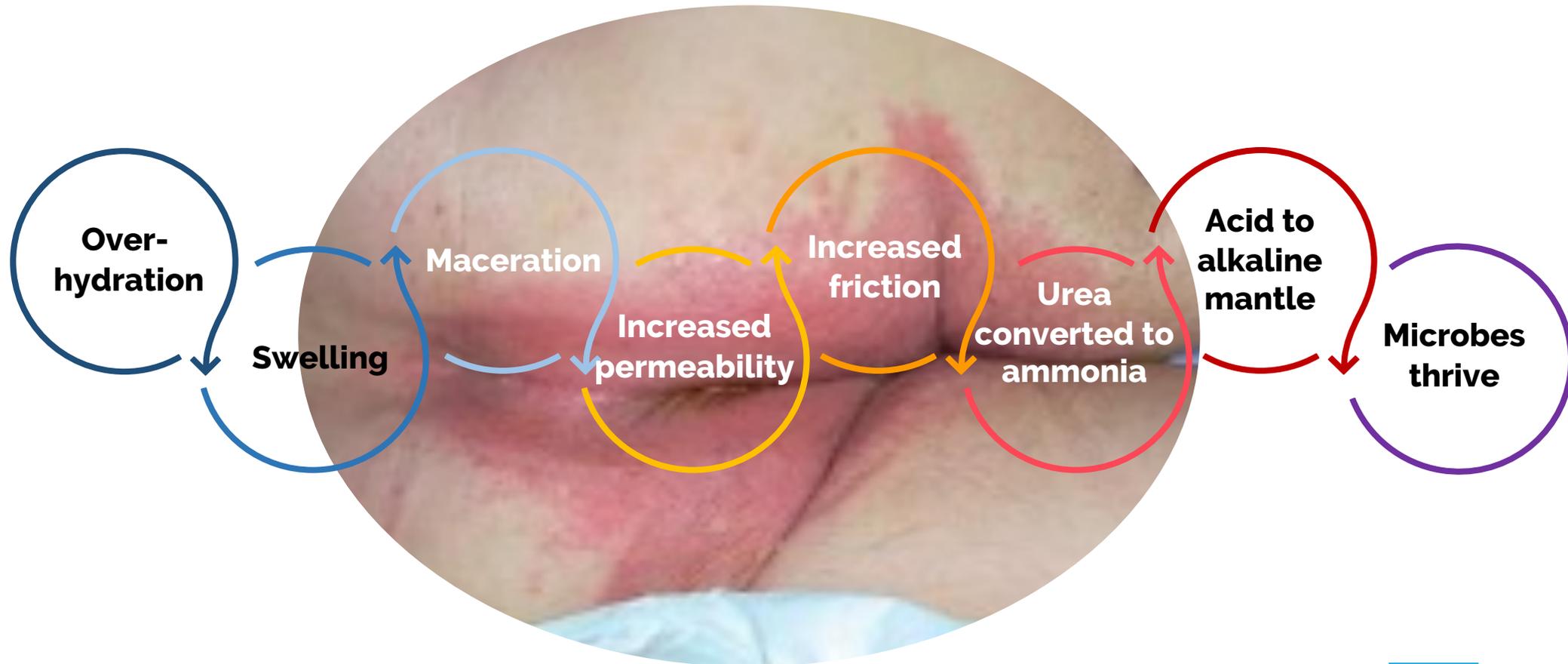


INCONTINENCE-ASSOCIATED DERMATITIS

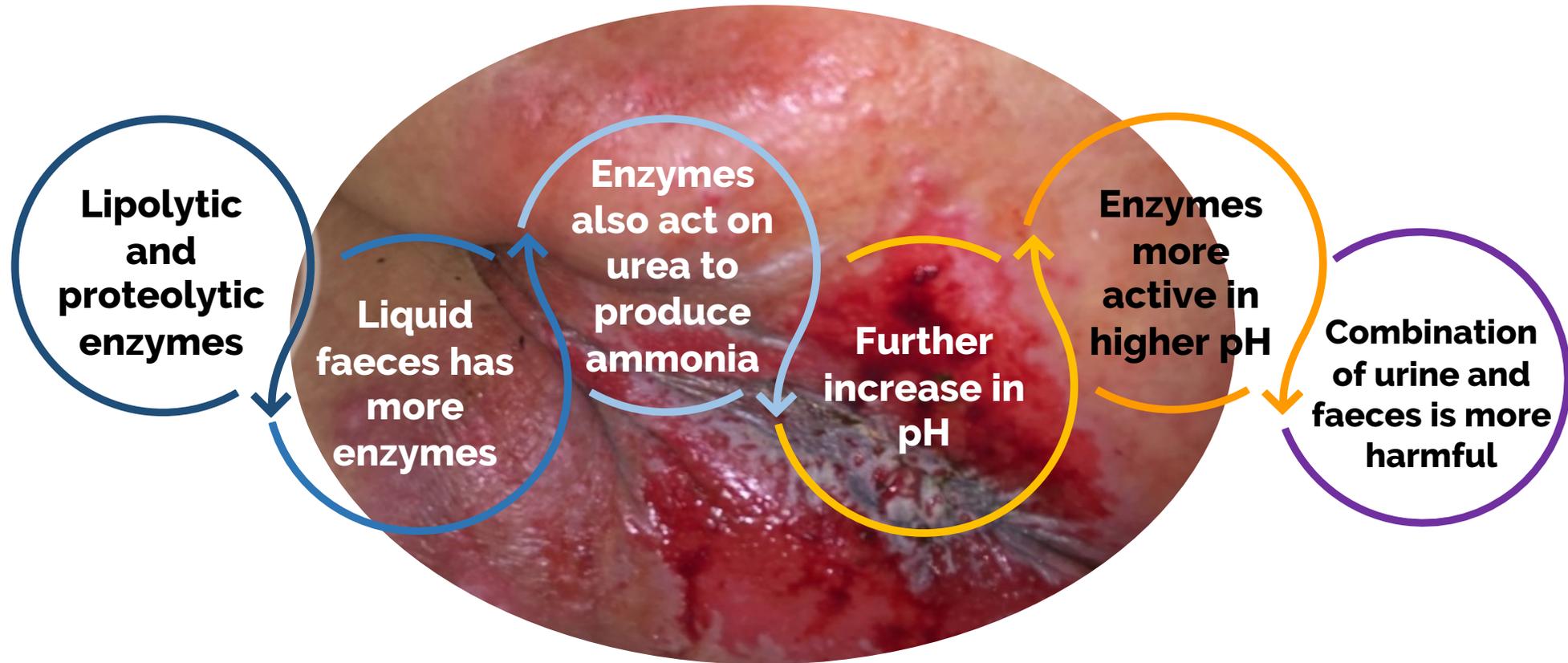
- IAD occurs following prolonged contact of urine or faeces with the skin
- Damage caused by IAD is more susceptible to friction, shearing, and at a much greater risk of pressure damage



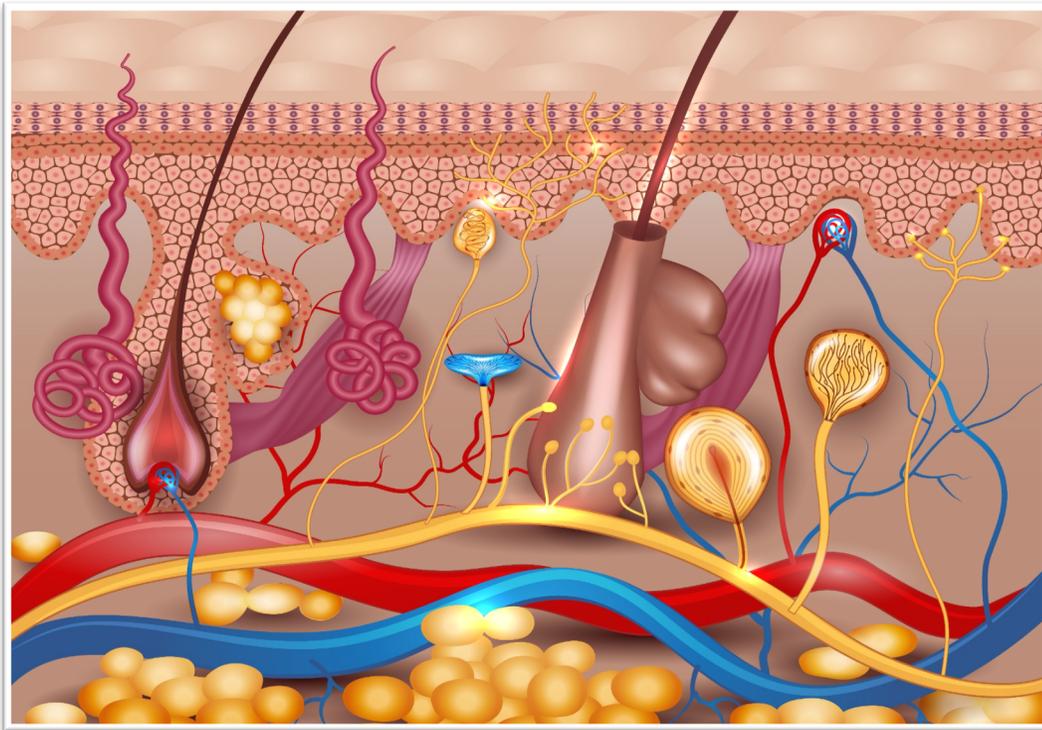
INCONTINENCE-ASSOCIATED DERMATITIS — URINE⁸



INCONTINENCE-ASSOCIATED DERMATITIS — FAECES⁸



CLINICAL CHARACTERISTICS OF IAD



Source of image: Shutterstock (2003-2020) (Jpeg). Available at <https://www.shutterstock.com>

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

This is due to nerve endings at the dermal-epidermal junction becoming exposed when the skin is broken.

CASE STUDY ONE

History

Patient is a 74-year-old female, with a history of dementia, hypertension, left-sided cerebral vascular disease, poor nutrition and weight loss. She is unable to independently mobilise or perform activities of daily living (ADL), and is incontinent of urine and faeces.



CASE STUDY ONE *CONTINUED*

Current treatment

Daily bed bath using soap and water. Following episodes of incontinence baby wipes are being used to clean, and an antiseptic healing cream applied to red and excoriated groins and bottom. Containment products are being used and a washable bed pad.

Tissue viability treatment plan

Wash with aqueous cream and apply a barrier film. Referral to bladder and bowel team and dietician.

CASE STUDY TWO

History

Patient is an 80-year-old female, with a history of diabetes and peripheral vascular disease, and is obese. She is bedbound and incontinent of urine and faeces.



CASE STUDY TWO *CONTINUED*

Current treatment

Daily bed bath using soap and water and following episodes of incontinence. Foam dressings being applied to multiple superficial broken areas to both buttocks. Containment products are being used and patient is nursed on a dynamic mattress.

Tissue viability treatment plan

Wash with aqueous cream and apply a barrier film. No dressings to be applied to the area. Referral to bladder and bowel team, dietician and diabetes specialist nurse.

CASE STUDY THREE

History

Patient is an 87-year-old male, with a history of prostate cancer. He has restricted mobility and uses a frame and is incontinent of urine.



CASE STUDY THREE *CONTINUED*

Current treatment

Wash, shower or bath using soap and water and following episodes of incontinence. Emollient and antifungal ointment being applied to red and excoriated groins. Containment products are being used and the patient is nursed on a high specification foam mattress.

Tissue viability treatment plan

Wash with aqueous cream and apply a barrier cream. Emollient ointment and antifungal cream discontinued. Referral to bladder and bowel team, patient started on a sheath and urine bag.

CASE STUDY FOUR

History

Patient is a 75-year-old male, with a history of diverticular disease. He is independently mobile for short distances and is incontinent of urine and faeces.



CASE STUDY FOUR *CONTINUED*

Current treatment

Wash, shower or bath using soap and water and baby wipes following episodes of incontinence. Multiple broken areas to natal cleft and buttock being treated with a large sacral foam dressing. Containment products are being used and patient is not being nursed on any pressure-relieving or reducing equipment.

Tissue viability treatment plan

Wash with a foam and spray incontinence cleanser and skin protectant ointment. Large sacral foam dressing discontinued. Referral to colorectal surgeon, bladder and bowel team.

CASE STUDY FIVE

History

Patient is an 83-year-old female, with a history of rheumatoid arthritis. She is bedbound, declines to be repositioned, and has capacity to make her own decisions. She is incontinent of urine and faeces. IAD is severe and has extended over the sacral bone and she has developed a category 3 pressure ulcer.



CASE STUDY FIVE *CONTINUED*

Current treatment

Bed bath using soap and water and following episodes of incontinence. Multiple broken areas to buttock and category 3 pressure ulcer to sacrum being treated with a hydrofibre and multiple foam dressings. Containment products are being used and patient nursed on a dynamic mattress.

Tissue viability treatment plan

Wash with foam and spray incontinence cleanser and skin protectant ointment to buttocks and alginate gel to sacral category 3 pressure ulcer. Discontinued hydrofibre and multiple foams. Referral to bladder and bowel team.

TOTAL BARRIER PROTECTION (TBP)



TAKE HOME MESSAGES

- Holistic assessment
- Early recognition of risks
- Prevention
- Stop using soap and baby wipes
- Step up and down approach
- Referral and collaborative working
- Standardised care
- Care plans and algorithms

SIGN UP FOR YOUR FREE PRODUCT SAMPLE

Sign up to receive a free sample of Medi
Derma-S Total Barrier Film 1ml
Applicator at:

medicareplus.co.uk/sample



REFERENCES

1. Flanagan M (2013). *Wound healing and skin integrity: principles and practice*. London: John Wiley and Sons
2. Voegeli D (2016) Incontinence-associated dermatitis: new insights into an old problem. *Br J Nurs* 25(5): 256–62
3. Beeckman D, Campbell J, Campbell K, et al (2015) Incontinence associated dermatitis: moving prevention forward. Proceedings of the Global IAD Expert Panel. Available online: Wounds International. <http://tinyurl.com/hr28grk> (accessed April 2020)
4. Lumbers M (2019) How to manage incontinence-associated dermatitis in older adults. *Br J Community Nurs* 24(7): 332–7
5. Ousey K, O' Connor L (2017) Incontinence Associated Dermatitis Made Easy. *Wounds UK* 13(1)
6. Nix D, Haugen V (2010) Prevention and management of incontinence-associated dermatitis. *Drugs Aging* 27(6): 491–6
7. Gray M, Bartos S (2013) Incontinence-Associated Dermatitis in the Acute Care Setting: A Prospective Multi-Site Epidemiological Study. Presented at the Symposium on Advanced Wound Care. May 2013
8. Beeckman D, et al (2015). Incontinence Associated Dermatitis: moving prevention forward. *Wounds International*.
9. Beeckman D, Woodward S and Gray M (2011) Incontinence-associated dermatitis: step-by-step prevention and treatment. *Br J Community Nurs* 16(8): 382–9

F
A
C
E
B
O
O
K
L
I
V
E



DOWNLOAD CERTIFICATE

WWW.JCN-LIVE.CO.UK/CERTIFICATE