Incontinence Related Dermatitis or Moisture Lesion

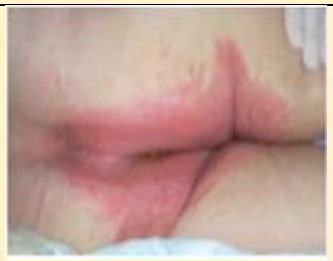
Tallaght University Hospital

Skin damage due to problems with moisture can present in a number of different ways. This tool aims to help you identify the cause to aid in the decision making for treatments. Moisture can be present in the skin due to incontinence (urinary and faecal), perspiration, wound exudate or other body fluids.

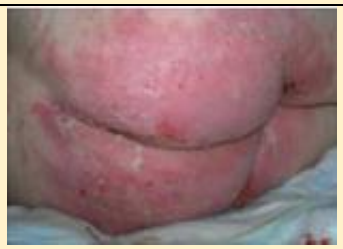
Lesions caused by moisture alone should not be classified as pressure ulcers

Incontinence Related Dermatitis (IRD)

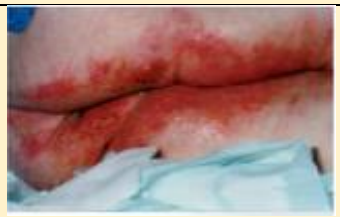
Mild
Erythema (redness) of skin only. No broken areas present.



Moderate
Erythema (redness) with less than 50% of broken skin. Oozing and/ bleeding may be present.



Severe
Erythema (redness) with more than 50% of broken skin. Oozing and/bleeding may be present.



Treatment: Avoid Pressure

Prevention/Mild IRD:
Cleanse skin with Tena Wash. Apply skin barrier cream

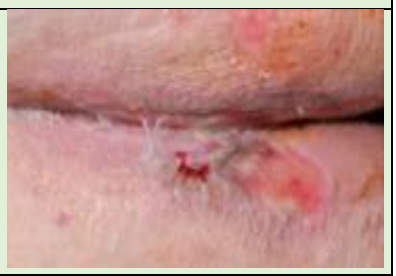
Moderate-Severe IRD:
Cleanse skin with Tena Wash. Apply Calilon barrier preparation, pea size twice a day. If no improvement refer to local guidelines or seek specialist advice.

NB:
Observe for signs of skin infection, e.g. candidiasis and treat accordingly. If infection is present do not use barrier cream as this will reduce effectiveness of treatment.

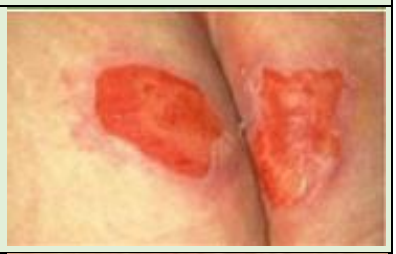
Moisture Lesions:

Skin damage due to exposure of urine, faeces or other body fluids

Location
Located in peri-anal, gluteal cleft, groin or buttock area. Not usually over a bony prominence.

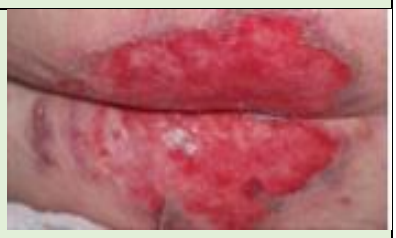


Shape
Diffuse often multiple lesions. May be 'copy', 'mirror' or 'kissing' lesion on adjacent buttock or anal cleft. Linear.

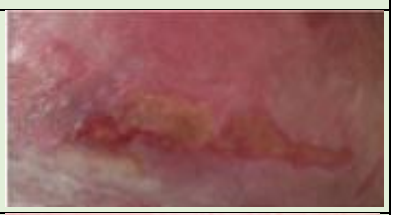


Edges
Diffuse irregular edges.

Necrosis
No necrosis or slough.
May develop slough if infection present.

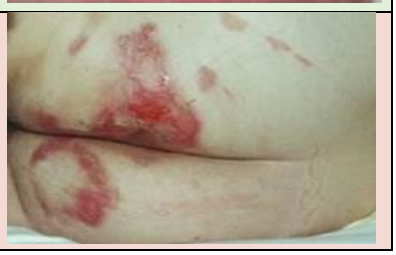


Depth
Superficial partial thickness skin loss. Can enlarge or deepen if infection present.



Colour
Colour of redness may not be uniform. May have pink or white surrounding skin (maceration). Peri-anal redness may be present.

Combination Lesions:
These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage but awareness of other causes and treatments is needed. (See Pressure Ulcer Grading Tool).

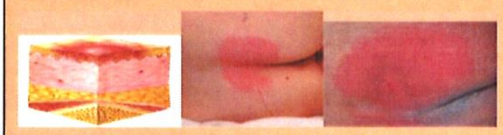


Adapted from www.tissueviabilityscotland.org Developed August 2017, updated April 2020

Appendix 2. HSE 2018 Pressure Ulcer Category/Staging System Recommendation

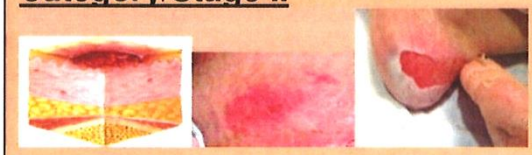
Definition: ***"A pressure ulcer is a localised injury to the skin and / or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance has yet to be elucidated"***

Category / Stage I



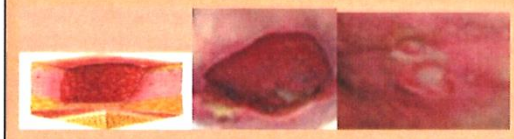
Category/ Stage I: Intact skin with non – blanchable redness of a localised area usually over a bony prominence. Discolouration of the skin, warmth, odema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. The area may be painful, firm, soft, warmer or cooler as compared to adjacent skin. (EPUAP 2009)

Category/Stage II



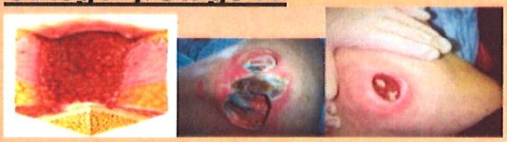
Category / Stage II: Partial thickness skin loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough. May present as an intact or open/ ruptured serum filled blister filled with serous or sero- sanginous fluid. Presents as a shiny or dry shallow ulcer without slough or bruising. (EPUAP 2009).

Category/Stage III

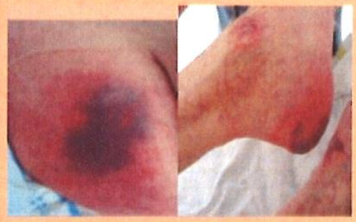


Category / Stage III: Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. The stage may include undermining or tunnelling (EPUAP 2009).

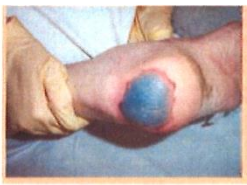
Category/Stage IV



Category / Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunnelling. Exposed bone / muscle is visible or directly palpable (EPUAP 2009).



In individuals with non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear, this skin change may be an indication of emerging, more severe pressure ulceration i.e. an emerging **Category/Stage III or IV Pressure Ulcer.** Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the patients' health record. These observations should be recorded in tandem with information pertaining to the patient history of prolonged, unrelieved pressure/shear.
It is estimated that it could take **3-10 days** from the initial insult causing the damage, to become a **Category/Stage III or IV Pressure Ulcer** (Black et al, 2015).



Stable eschar (dry adherent, intact without erythema or fluctuance) on the heel serves as the body's biological cover and should not be removed. It should be documented as at least Category / Stage III until proven otherwise.