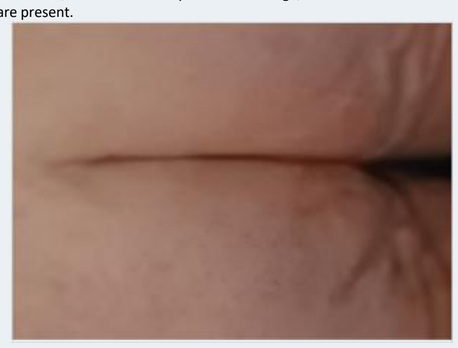
Incontinence-Associated Dermatitis: Recognition & Care Pathway

A practical guide to recognising IAD and matching care to the skin response. Category definitions follow the GLOBIAD framework.

ACIPC
Australasian College for Infection Prevention and Control

ASSESSMENT			MANAGEMENT		
CATEGORY	**CRITICAL CRITERION (DEFINING FEATURE)**	**ADDITIONAL CRITERIA (SUPPORTING FEATURES)**	**CARE RESPONSE**	**CLEANSE**	**PROTECT / RESTORE**
At Risk This row sits before the GLOBIAD scale. Intact skin, with no visible erythema or damage, but risk factors for IAD are present. 	Skin remains intact, with no visible redness or skin damage. IAD risk assessment must extend beyond continence status alone: consider prolonged exposure to urine and/or faeces, including when hygiene or protection is difficult.	Risk factors may include: • Reduced mobility or cognitive function • Difficulty with personal hygiene or reaching skin folds • Urinary or faecal incontinence, including diarrhoea • Body shape or skin folds that retain moisture • Previous IAD	Assess skin exposed to urine and/or faeces and assess pressure injury risk as routine assessment. Address causes of exposure and barriers to hygiene, continence care or skin protection. Document baseline findings and individual care needs.	Use a gentle, soap-free, pH-balanced, no-rinse cleanser or continence wipe. Clean promptly after faecal soiling, ideally within 10-15 minutes, and at every continence product change for urinary incontinence. Pat dry gently; do not rub.	Apply a suitable skin barrier to skin exposed, or likely to be exposed, to urine and/or faeces. If the epidermis is intact, consider a suitable leave-on skin care product to support barrier function. Follow product instructions for amount and reapplication.
Category 1A Visible erythema (redness) on intact skin, WITHOUT clinical signs of infection. 	Visible erythema with an intact skin surface and no clinical signs of infection. The affected area may be diffuse, blotchy or poorly defined.	Clinical features may include: • Blotchy or discoloured patches • Glossy or shiny-looking skin • Softened, waterlogged (macerated) skin • Warmth, firmness or swelling • Burning, stinging, itching or pain On darker skin, colour change may appear darker, paler or purplish.	Re-assess the skin, discomfort, continence and hygiene needs, and pressure injury risk. Document the category and findings. Review the care plan and reassess response; escalate if the skin deteriorates or fails to improve.	Use a gentle, soap-free, pH-balanced, no-rinse cleanser or continence wipe. Clean promptly after faecal soiling, ideally within 10-15 minutes, and at every continence product change for urinary incontinence. Pat dry gently; do not rub.	Apply an appropriate barrier to affected and exposed skin, following product instructions. Where the epidermis remains intact, a suitable leave-on skin care product may support the skin barrier.
Category 1B Persistent erythema (redness) on intact skin, WITH clinical signs suggestive of infection. 	Persistent erythema with clinical signs suggestive of infection. Assess for fungal or bacterial involvement and consider alternative diagnoses.	Clinical features may include: • Flaky white patches suggesting fungal infection or satellite pustules suggesting Candida albicans • Localised warmth or swelling • Glossy or shiny skin and maceration • Increasing tenderness, burning, itching or pain • Worsening or spreading skin changes Clinical assessment is required; a swab result alone does not establish infection.	Arrange clinical assessment. Where indicated, obtain appropriate microbiological samples to guide targeted antifungal or antibiotic treatment; where feasible, sample before antifungal therapy. Re-assess the skin, discomfort, continence and hygiene needs, and pressure injury risk. Escalate for spreading or systemic signs, deterioration or diagnostic uncertainty.	Use a gentle, soap-free, pH-balanced, no-rinse cleanser or continence wipe. Clean promptly after faecal soiling, ideally within 10-15 minutes, and at every continence product change for urinary incontinence. Pat dry gently; do not rub. Use appropriate swabbing, collection and storage techniques when clinically indicated.	Do not use antimicrobials routinely or prophylactically. Use targeted treatment when clinically indicated. Where infection is confirmed, apply topical antimicrobial as prescribed. Maintain suitable skin protection on non-affected areas, checking compatibility with prescribed treatment and following product instructions.
Category 2A Skin loss present, WITHOUT clinical signs of infection. 	Skin loss may appear as eroded, denuded or excoriated skin, sometimes with maceration. Damage may be diffuse rather than confined to one spot.	Clinical features may include: • Persistent redness or discolouration around skin loss. On darker skin, look for paler, darker, or purplish patches • Blotchy or discoloured patches from a previous healed area • Glossy or shiny-looking skin • Softened, waterlogged skin • Unbroken blisters or areas of denudement • Firmness, swelling or tenderness • Burning, stinging, itching or pain	Reassess the extent of skin loss, pain, ongoing exposure and pressure injury risk. Address continence and hygiene needs. Seek clinical or wound-care review for extensive, worsening or non-healing lesions. Sample if infection is suspected. Document the category and findings. Review the care plan and reassess response; escalate if the skin deteriorates or fails to improve.	Use a gentle, soap-free, pH-balanced, no-rinse cleanser or continence wipe. Clean promptly after faecal soiling, ideally within 10-15 minutes, and at every continence product change for urinary incontinence. Pat dry gently; do not rub. Consider appropriate microbiological sampling only when clinically indicated, for example if infection is suspected.	For breached or damaged epidermis, consider an appropriate advanced elastomeric skin protectant (over all affected areas) according to product instructions and clinical guidance. Use dressings only when clinically indicated and select them to minimise further skin trauma.
Category 2B Skin loss present, WITH clinical signs suggestive of infection. 	Skin loss plus clinical signs suggestive of infection. Assess for fungal or bacterial involvement and consider other causes of skin damage.	Clinical features may include: • Discolouration, exudate or localised changes around the lesion • Flaky white patches suggesting fungal infection or satellite pustules suggesting Candida. Yellow/brown/grey dead tissue (slough) in the wound bed, a green tinge in the wound bed may suggest Pseudomonas aeruginosa, heavy pus-like (purulent) drainage, and a glossy-looking wound bed may also suggest infection. • Increasing warmth, swelling, sensations of tenderness, itching or pain • Worsening or spreading skin changes • Systemic symptoms require urgent clinical assessment	Arrange prompt clinical assessment. When indicated, use appropriate microbiological sampling to guide targeted antifungal or antibiotic treatment. Seek medical/wound-care review for spreading or systemic signs, severe pain, deterioration or failure to improve. Address continence and hygiene needs. Document the category and findings. Review the care plan and reassess response; escalate if the skin deteriorates or fails to improve.	Use a gentle, soap-free, pH-balanced, no-rinse cleanser or continence wipe. Clean promptly after faecal soiling, ideally within 10-15 minutes, and at every continence product change for urinary incontinence. Pat dry gently; do not rub. Remove ongoing exposure to urine and/or faeces. Obtain samples when clinically indicated and preferably before targeted treatment where feasible.	Do not use antimicrobials routinely or prophylactically. Use targeted treatment when clinically indicated. Where infection is confirmed, apply topical antimicrobial as prescribed. For breached or damaged epidermis, consider an appropriate advanced elastomeric skin protectant (over all affected areas) according to product instructions and clinical guidance. Use dressings only when clinically indicated and select them to minimise further skin trauma. Maintain suitable skin protection on non-affected areas, checking compatibility with prescribed treatment and following product instructions.

CLEANSE
Remove urine and faeces gently with an appropriate cleanser; dry thoroughly before applying skin protectant.

PROTECT
Apply a suitable barrier to reduce direct exposure to urine, faeces and friction; follow product directions.

RESTORE
If epidermis is intact, skin. consider skin care to support the skin barrier. If breached/damaged, select a protectant suitable for compromised

ASSESS ALL SKIN TONES
Redness may be less visible on darker skin. Compare with surrounding skin and assess temperature, swelling, firmness, tenderness, pain and itching.

DOCUMENT AND REVIEW
. Use GLOBIAD-M if available. If improvement is not evident after 1-2 days, reassess; typical resolution is within 1-2 weeks. Record location, category, symptoms, care and response

CHECK FOR PRESSURE INJURY
IAD and pressure injury can coexist. If the cause is uncertain, address moisture and pressure risks while arranging appropriate clinical assessment.

Telling IAD apart from a pressure injury

They can look similar and occur together. When uncertain, assess and manage both while arranging review.

FEATURE	INCONTINENCE-ASSOCIATED DERMATITIS (IAD)	PRESSURE INJURY
Cause	Prolonged exposure to urine and/or faeces, often with friction.	Sustained pressure and/or shear over tissue, reducing local blood flow.
Location	Perineal, perianal and adjacent skin; buttocks, groin, inner thighs and skin folds.	Over bony prominences or beneath/around a medical device.
Shape / edges	Often diffuse, irregular or poorly defined; may reflect areas of exposure.	Often localised; shape may correspond to the pressure point or device.
Depth	Usually superficial epidermal damage; may be diffuse or include skin loss.	Ranges from non-blanchable discolouration to deeper tissue damage.
Colour	May be red, blotchy, darker, paler or purplish depending on skin tone.	Non-blanchable colour change; appearance varies with skin tone and injury depth.
Symptoms	May cause burning, stinging, itching, tenderness or pain.	May be painful or tender; sensation can also be reduced or altered.
Overlap	IAD may increase skin vulnerability; both conditions can be present together.	Assess pressure risk even when IAD is present; document and manage both if indicated.

KEY POINTS

Prevent prolonged exposure to urine and/or faeces; cleanse gently, dry thoroughly, protect the skin and reassess response. Avoid routine or prophylactic topical antimicrobials. If skin changes deteriorate, do not improve, or the diagnosis is uncertain, escalate for clinical review.

This pathway supports clinical judgement and local procedures; it does not replace individual assessment, appropriate infection assessment or product instructions.

References: 1. Beeckman D, Barakat-Johnson M, Ahtiala M, Bernaerts K, Conway B, Dunk AM, et al. Incontinence-associated dermatitis: moving prevention forward. Best Practice Update 2026. London: Wounds International; 2026. Available from: https://woundsinternational.com/wp-content/uploads/2026/04/SOL26_BPS_IAD_WINT_WEB.pdf
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