

Management

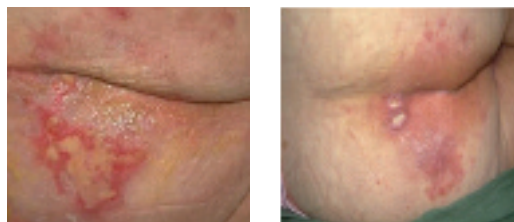
Moisture Lesion	Pressure Ulcer	Combination
<ul style="list-style-type: none"> Wash gently with a low pH soap or a skin cleanser Dry thoroughly by patting the skin Utilise barrier protection Use silicone medical adhesive remover if required Provide patient information 	<p>Think SKINS:</p> <p>Skin inspection</p> <p>Keep moving</p> <p>Incontinence</p> <p>Nutrition (food, hydration)</p> <p>Surface (bed, chair)</p>	<ul style="list-style-type: none"> Bring the two management plans together Focus on pressure and moisture management

Reporting

Moisture Lesion	Pressure Ulcer	Combination
<ul style="list-style-type: none"> Not to be reported as a Serious Incident Does not require a Root Cause Analysis Refer for Specialist Tissue Viability /Continenence Team if advice is required 	<ul style="list-style-type: none"> Report all category 2 pressure ulcers as an Incident, and all category 3 and 4 pressure ulcers as a Serious Incident on the Trust reporting system (<i>Ulysees</i>) The use of a monofilament debridement pad to assist with categorisation Refer all category 3 and 4 pressure ulcers to Tissue Viability 	<ul style="list-style-type: none"> Report all combination wounds as pressure ulcers

Combination

- A moisture lesion and a pressure ulcer may exist in the same area
- Where incontinence associated dermatitis/moisture lesions are accompanied by pressure, this must be reported as a pressure ulcer
- The two areas of moisture and pressure need to be addressed as part of their care plan



Contact details for the Tissue Viability Department

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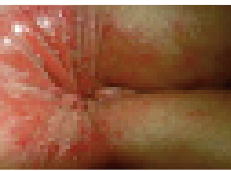


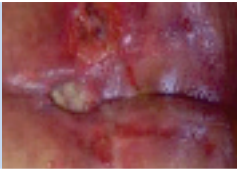
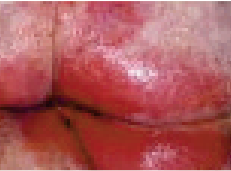


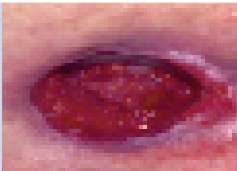



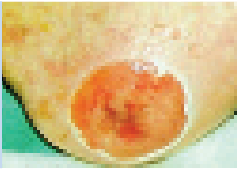


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Staff Guide to the Classification, Assessment and Management of

Moisture Lesions and Pressure Ulcers

Incontinence Associated Dermatitis (IAD) (Moisture Lesions)	Tick box if present	Signs and Symptoms	Tick box if present	Pressure Ulcer		
	<ul style="list-style-type: none"> Moisture must be present (e.g. shiny, wet skin caused by urinary incontinence or diarrhoea) 	<input type="checkbox"/>	< Cause >	<input type="checkbox"/>	<ul style="list-style-type: none"> Pressure and/or shear friction/moisture present 	
	<ul style="list-style-type: none"> Natal cleft/Inner gluteal/buttocks/any skin fold IAD may occur over a bony prominence. (If this appears to be the case, exclude pressure shear and friction prior to diagnosis) 	<input type="checkbox"/>	< Location >	<input type="checkbox"/>	<ul style="list-style-type: none"> Over a bony prominence or aligned with causative pressure 	
	<ul style="list-style-type: none"> Mirror image and linear in shape (splits in skin) Diffuse, in several superficial spots 	<input type="checkbox"/>	< Shape >	<input type="checkbox"/>	<ul style="list-style-type: none"> Takes the appearance of the causative pressure Limited to one spot or specific area 	
	<ul style="list-style-type: none"> Superficial 	<input type="checkbox"/>	< Depth >	<input type="checkbox"/>	<ul style="list-style-type: none"> Superficial or deep 	
	<ul style="list-style-type: none"> No necrosis 	<input type="checkbox"/>	< Necrosis >	<input type="checkbox"/>	<ul style="list-style-type: none"> A black necrotic scab on a bony prominence 	
	<ul style="list-style-type: none"> Diffuse or irregular edges 	<input type="checkbox"/>	< Edges >	<input type="checkbox"/>	<ul style="list-style-type: none"> Distinct edges 	
	<ul style="list-style-type: none"> Non uniform redness Blanchable or non-blanchable erythema Pink or white surrounding skin due to maceration 	<input type="checkbox"/>	< Colour >	<input type="checkbox"/>	<ul style="list-style-type: none"> Uniform redness If redness is non-blanchable, this indicates damage to the capillaries 	

Moisture damage will improve rapidly (e.g. 48-72 hrs). Pressure Ulcers will improve more slowly (e.g. usually longer than 7 days). If the area occurs over a bony prominence it is more likely to be a Pressure Ulcer.