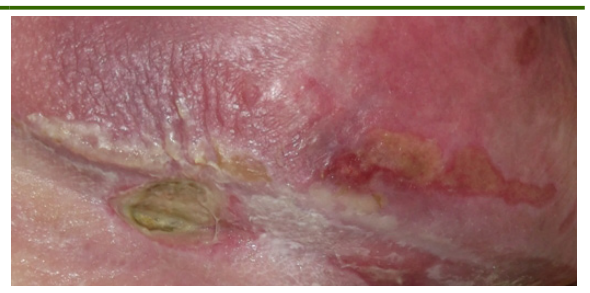
Scottish Excoriation & Moisture Related Skin Damage Tool

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 decision making for treatments.
Moisture may be present on the skin due to incontinence (urinary and faecal), perspiration, wound exudate or other body fluids e.g. locia, amniotic fluid.
Lesions caused by moisture alone should not be classified as pressure ulcers.

Combination Lesions:

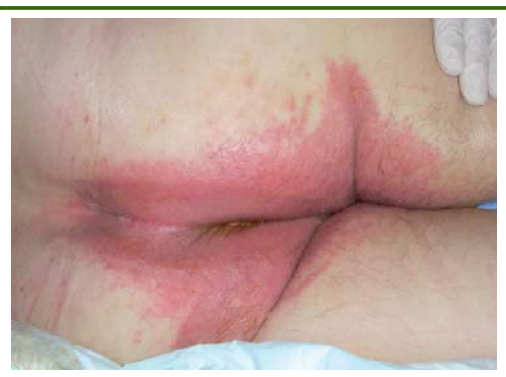
These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage but awareness of other causes and treatments is needed.
See Pressure Ulcer Grading Tool



Incontinence Related Dermatitis (IRD)

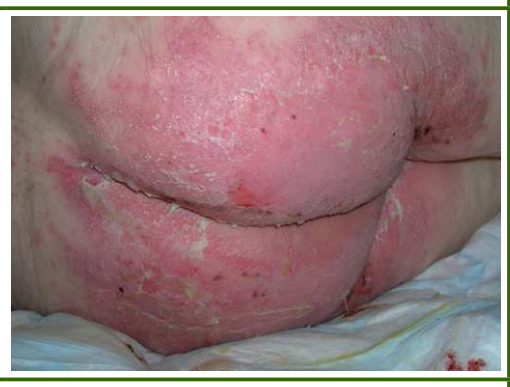
Mild

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



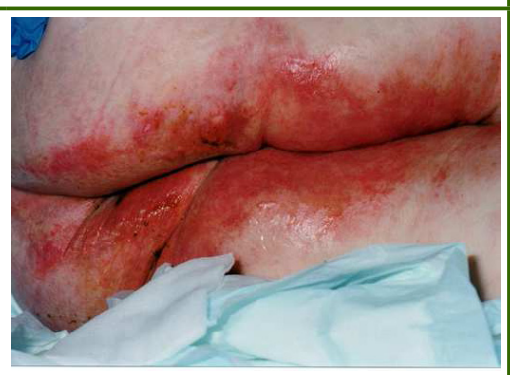
Moderate

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



Severe

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



Treatment:

Prevention/Mild IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply Moisturiser +/or skin protectant e.g. barrier cream/film which does not affect absorbency of continence products.

Moderate-Severe IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply liquid/spray skin protectant, OR barrier preparation, if no improvement refer to local guidelines or seek specialist advice.

NB:
Observe for signs of skin infection, e.g. candidiasis, and treat accordingly (do not use barrier films as this will reduce effectiveness of treatment)

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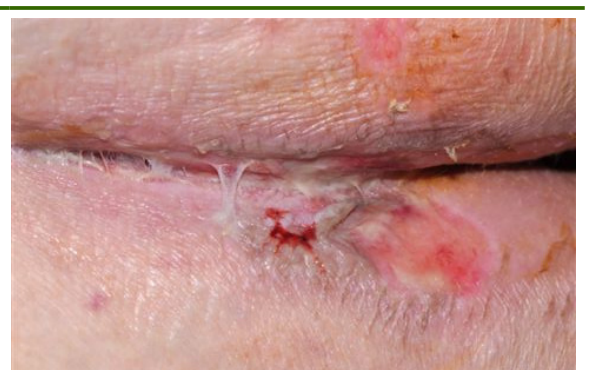
Moisture Lesions:

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

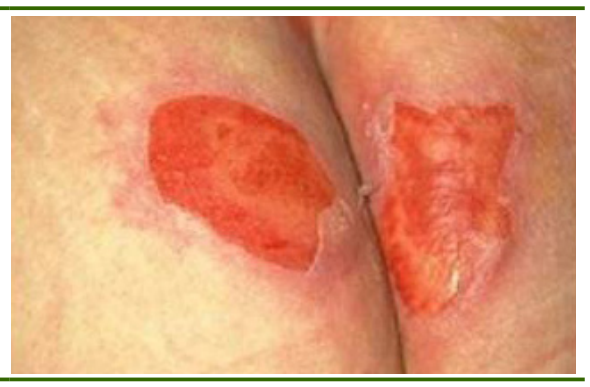
Location

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



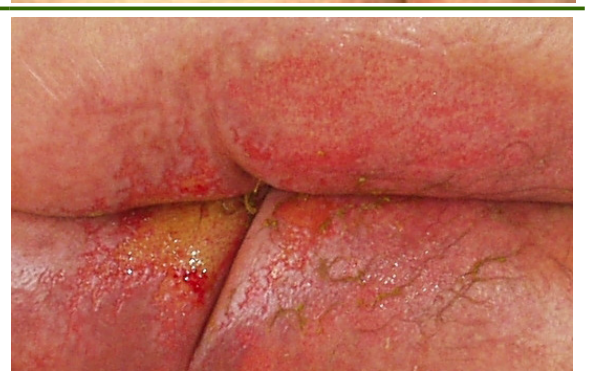
Shape

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



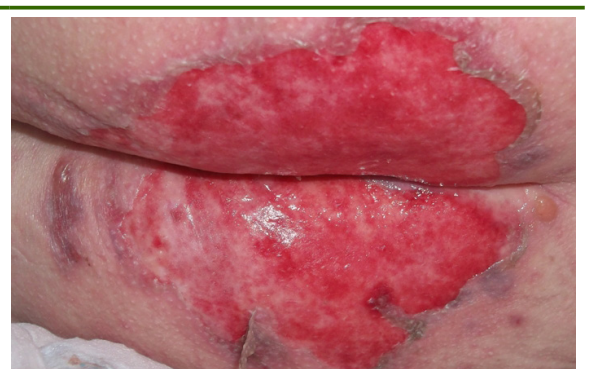
Edges

Diffuse irregular edges.



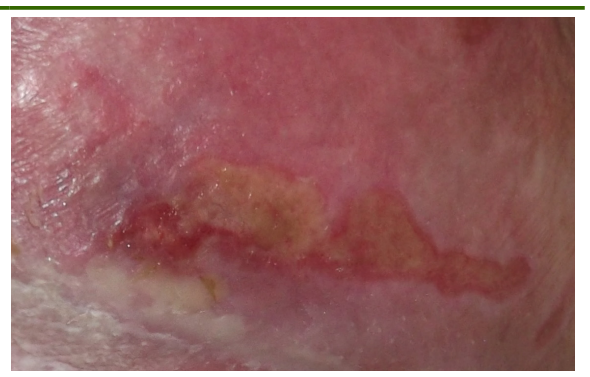
Necrosis

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.