Management

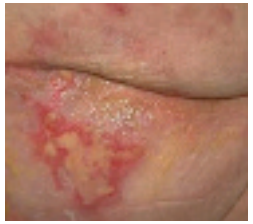
Moisture Lesion	Pressure Ulcer	Combination
• Wash gently with a low pH soap or a skin cleanser • Dry thoroughly by patting the skin • Utilise barrier protection • Provide patient information	Think **SSKINS**: **S**urface *(bed, chair)* **S**kin inspection **K**eep moving **I**ncontinence **N**utrition *(food, hydration)*	• Bring the two management plans together • Focus on pressure and moisture management

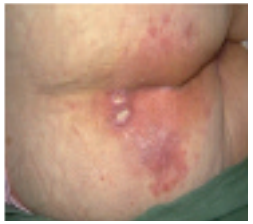
Reporting

Moisture Lesion	Pressure Ulcer	Combination
• Not to be reported as a Serious Incident • Does not require a Root Cause Analysis • Refer for Specialist Tissue Viability /Continence Team if advice is required	• Report all 2,3 and 4 pressure ulcers on the Trusts reporting system - *Datix*. • Use **Debrisoft®*** to assist with categorisation • Consider referral of category 3 and 4 to Tissue Viability for advice.	• 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





This *'Moisture Lesion or Pressure Ulcer?'* tool is the work of the Worcester Tissue Viability teams, presented by Jackie Stephen-Haynes at EWMA 2015, London.

For further information on how you and your colleagues can use this tool, please contact:

Tissue Viability Link

***For more information on Debrisoft® please call:**
Sharon Taylor: 07896 279 961
email: sharontaylor@activahealthcare.co.uk
or visit: www.debrisoft.co.uk

Reference:
Stephen-Haynes, J. Callaghan, R. Simm, S. Evans, M. (2015) 'Development and Implementation of a Tool to Assess and Differentiate Moisture Lesions and Pressure Ulcers.' EWMA Journal, Vol 15 (2), p37-38

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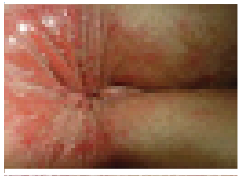
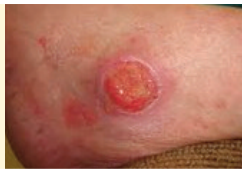
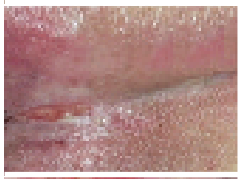
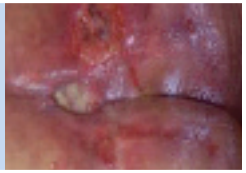
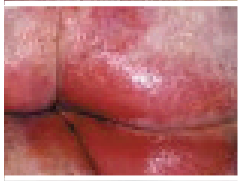
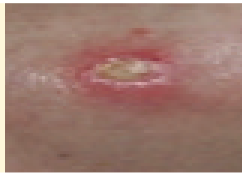
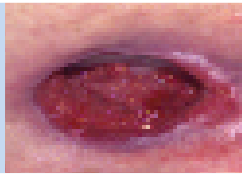
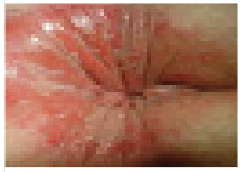
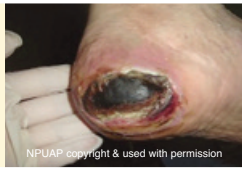
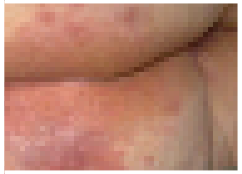
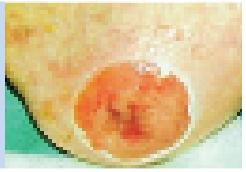
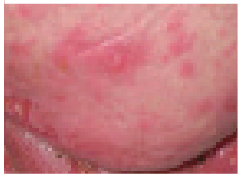
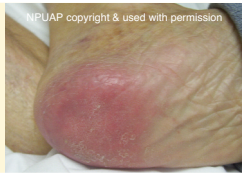
East Lancashire Hospitals NHS
NHS Trust

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	
	• Moisture must be present (e.g. shiny, wet skin caused by urinary incontinence or diarrhoea)	☐	< Cause >	☐	• Pressure present	
	• 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)	☐	< Location >	☐	• Over a bony prominence or aligned with causative pressure	
	• Mirror image and linear in shape (splits in skin) • Diffuse, in several superficial spots	☐	< Shape >	☐	• Takes the appearance of the causative pressure • Limited to one spot or specific area	
	• Superficial	☐	< Depth >	☐	• Superficial or deep	
	• No necrosis	☐	< Necrosis >	☐	• A black necrotic scab on a bony prominence	
	• Diffuse or irregular edges	☐	< Edges >	☐	• Distinct edges	
	• Non uniform redness • Blanchable or non-blanchable erythema • Pink or white surrounding skin due to maceration	☐	< Colour >	☐	• Uniform redness • If redness is non-blanchable, this indicates damage to the capillaries	

Remember:

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.