**Incontinence-associated dermatitis 3: systems for reporting skin damage**

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| **How to use this article in your revalidation activities** | |
| Print the article and distribute it to all members of your journal club before your meeting. Use the author commentary and discussion points below to help get your discussions started.  Participation in journal clubs can be used for revalidation as **participatory CPD** and/or **reflective accounts.**  **Participatory CPD:** Record the time you spent reading the article and discussing it in your journal club, describe what you learnt from the article and your group discussions, explain how you will apply it to your practice, and how it links to the NMC Code; | **Reflective accounts:** think about what you learned from your discussions, how you can use your learning to improve your practice, and how this relates to the NMC Code. Add this information to the ‘notes’ section at the end of this document.  If you subscribe to *Nursing Times,* log the evidence in the ‘Other professional development’ or ‘Reflective accounts’ section of your NT Portfolio.  For more information on setting up and running a journal club go to **nursingtimes.net/ntjournalclub** |

**Clinical editor commentary**

Skin damage caused by pressure or moisture can be quick to occur but slow to heal. Prevention is of course the ideal, but where it does occur, early recognition, accurate diagnosis and appropriate management are essential to minimise patient harm.

Recognition that pressure ulcers not only caused significant patient harm, but also costs to health and social care services – and that the vast majority were avoidable, has led to a range of strategies to reduce their incidence. However, differentiating between pressure damage and moisture damage can be difficult, and the wider recognition of pressure damage has often led to moisture damage being misdiagnosed. To address the problem healthcare providers are now encouraged to report incidence of moisture-associated skin damage (MASD) locally, but this requires that staff are able to differentiate it from pressure damage.

Periwound and peristomal MASD are generally easier to differentiate from pressure damage than intertriginous dermatitis (ID) and incontinence-associated moisture damage (IAMD) because the pre-existing wound or stoma provide a valuable clue. While ID and IAMD are more challenging to diagnose, understanding their causes and risk factors and recognising the differences between them and pressure damage can make the task easier. However, the first requirement is for staff to be aware of MASD and the need to include it in pressure ulcer risk assessments to help prevent it, and to consider it when assessing skin damage when it does occur.

**Discussion points**

* Are staff in your service who assess patients’ pressure ulcer risk or conduct skin assessments sufficiently aware of MASD?
* Have staff received training on how to differentiate between pressure damage and MASD?
* Do you report incidences of MASD?
* How could your service increase the potential that patients with risk factors for MASD will be recognised and preventative steps will be taken?
* How could your service improve responses to MASD when it does occur?

**Revalidation evidence**

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**Your notes**