

Table 1. Product use in incontinence-associated dermatitis

Category	Description	Recommended products
Prevent and protect	No redness and skin intact	• CliniShield Advance 360° Foam & Spray Skin Cleanser • CliniShield Advance Protective Barrier Cream
Category 1 (mild)	Red and skin intact	• CliniShield Advance 360° Foam & Spray Skin Cleanser • CliniShield Advance Protective Barrier Cream
Category 2 (moderate)	Red with skin breakdown	• CliniShield Advance 360° Foam & Spray Skin Cleanser • CliniShield Advance Barrier Film Spray/Wipes
Category 2 (severe)	Red with skin breakdown	• CliniShield Advance 360° Foam & Spray Skin Cleanser • CliniShield Advance Barrier Film Spray

- Minimises irritation with a gentle, non-stinging, pH-balanced formulation
- Avoids the risk of friction damage from the harsh scrubbing between applications, with a friction-free, non-rinse action.

The skin cleanser features a dual-action nozzle, with a foam mode for heavy incontinence care and a spray mode for lighter cleansing. It is particularly suited to patients exposed to ongoing moisture or at risk of epidermal deterioration.

Protect



CliniShield Advance barrier products provide immediate, targeted and long-lasting clinical protection against damage from urine, faeces and moisture.

CliniShield Advance Protective Barrier Cream is a cost-effective solution for intact or injured skin. It offers long-lasting, waterproof protection for up to 24 hours over large areas, while



actively moisturising to restore hydration. Additionally, its formula will not block incontinence-pad absorbency.

CliniShield Advance Barrier Film (spray or wipes) is intended for skin at risk of IAD, forming a breathable, transparent layer that acts as a protective barrier against damage from bodily fluids and waste, as well as against skin stripping and adhesive-related skin damage.

Case studies

These case studies describe the impact of the CliniShield Advance skin cleanser and the wider range in providing effective barrier protection, maintaining skin integrity, improving comfort and supporting continence care (Boxes 5–7).

Conclusion

IAD is a significant clinical challenge requiring early identification and structured skin care regimens incorporating cleansing and barrier protection. Practical considerations such as ease of application are also important. The cleanse–protect–restore model is essential to maintaining skin integrity and improving patient outcomes (Beeckman et al, 2015; Ousey et al., 2025). **BJN**

Key points

- ✓ IAD is caused by prolonged exposure to moisture and irritants
- ✓ Faecal incontinence presents greater risk than urinary incontinence
- ✓ Prevention through structured skincare is essential
- ✓ A pH-balanced skin cleanser should be used after incontinence episodes
- ✓ Barrier creams and films protect against irritants and friction
- ✓ Product selection should reflect severity and skin condition

Box 5. Case study 1



A 78-year-old woman presented with urinary incontinence secondary to overactive bladder and persistent vulval and groin irritation of several months' duration. She was prescribed topical oestrogen cream for suspected vulval atrophy; after 6 weeks, she reported no improvement.

The GP then prescribed a skin cleanser. After 2 weeks the patient reported a 50% improvement in symptoms, but irritation persisted.

Due to this, she then tried CliniShield Advance 360° Foam & Spray Skin Cleanser. After 1 week, she reported a 90% reduction in vulval and groin irritation. She expressed high satisfaction and requested continued supply via her GP, who agreed, noting improved efficacy and lower cost.

Box 6. Case study 2



A 90-year-old man living at home with carer support presented with IAD. Previously managed with sheaths and leg bags, he had reverted to incontinence pads changed four or five times daily. The carer applied a barrier cream to the groin and sacral area after each episode; this maintained skin condition without affecting pad absorption but caused a slight erythema.

The carer tried CliniShield Advance Protective Barrier Cream.

After 1 week, the patient reported easier application, faster absorption and improved protection, with softer skin and no impact on pad absorption. The carer considered CliniShield Advance Protective Barrier Cream superior to the initial barrier cream and less expensive for the NHS, and requested continued supply via her GP pending prescription availability.

Box 7. Case study 3



An 83-year-old woman living in a care home had permanent urinary incontinence and intermittent faecal incontinence. She had been using incontinence pads, changed around five times daily, together with a barrier cream applied twice daily. Despite this, her skin remained red, and she developed a sacral pressure injury. Therefore, she was evaluated on CliniShield Advance Protective Barrier Cream instead of the previous barrier cream.

After 1 week, both patient and assistant practitioner reported improvements compared to her previous regimen:

- The cream was easier to apply and absorbed well into the skin
- The skin was softer and no longer red
- Continence pads were observed to be more absorbent
- Less product was required to achieve effective skin protection
- Patient and caregiver found the product 'much better' and 'easy to apply'

CliniShield Advance Protective Barrier Cream improved skin condition, ease of application and pad performance, with high patient and caregiver satisfaction. It was considerably less expensive on the UK Drug Tariff, and its reduced product use and recyclable packaging further supported its routine use.

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Prevention, assessment and management of incontinence-associated dermatitis: a guide



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Incontinence-associated dermatitis (IAD) is a form of moisture-associated skin damage caused by prolonged exposure to urine and/or faeces. It is associated with pain, skin breakdown and reduced quality of life. This guide outlines the causes, prevention, assessment and management of IAD, and explores the role of structured skin care regimens, including skin cleansers, barrier creams and barrier films, such as the CliniShield Advance range.

Incontinence-associated dermatitis (IAD) is a common yet frequently under-recognised complication of urinary and faecal incontinence. IAD is classified as a form of moisture-associated skin damage (MASD) (Box 1). Despite its prevalence, IAD is often underdiagnosed or misidentified, particularly in acute and long-term care settings where it may be confused with pressure damage.

IAD most commonly affects the perineal, perigenital, buttock and upper thigh regions, reflecting areas exposed to urine and/or faeces. The condition is associated with pain, discomfort, increased risk of secondary infection and a decline in skin integrity, which may contribute to further complications such as pressure ulcer development (Beeckman, 2015; Voegeli and Hillery, 2021).

Incontinence-associated dermatitis Causes

Prolonged skin exposure to moisture disrupts the normal barrier function of the stratum corneum. Overhydration causes maceration, increasing skin permeability and susceptibility to irritants and microorganisms (Dissemond et al, 2021; Voegeli and Hillery, 2021).

Urine contributes to skin damage primarily through alkalinisation of the skin surface. When urea is broken down by bacteria, ammonia is produced, raising skin pH and impairing the acid mantle that normally protects against microbial colonisation (Gray et al, 2012; Beeckman et al, 2015).

Faecal incontinence presents an even greater risk due to the presence of proteolytic and lipolytic enzymes, which directly degrade skin proteins and lipids. This enzymatic activity accelerates epidermal breakdown and increases susceptibility to inflammation and infection (Box 2) (Beeckman et al, 2015; Beele et al, 2018).

Additional contributing factors include:

- Friction and shear, particularly during cleansing or repositioning
- Occlusion from absorbent products, which traps moisture against the skin
- Immobility, leading to continuous exposure to irritants

Box 1. Moisture damage

Incontinence-associated dermatitis is one of several conditions classified under moisture-associated skin damage (MASD), which also includes:

- Periwound dermatitis, caused by exposure to wound exudate
- Peristomal dermatitis, resulting from leakage of stoma effluent
- Intertriginous dermatitis, resulting from skin friction, heat and trapped moisture.

Although the sources of moisture differ, these conditions share a common underlying mechanism: prolonged exposure to moisture leading to disruption of the skin barrier (Dissemond et al, 2021).

'IAD affects up to 41% of incontinent residents in long-term care'

- Altered skin resilience, particularly in older adults or those with comorbidities (Beeckman et al, 2016).

These factors often act synergistically, resulting in rapid deterioration of skin integrity if not addressed promptly. Damage from IAD progresses from disruption of the stratum corneum to deeper epidermal injury and possible infection (Dissemond et al, 2021; Voegeli and Hillery, 2021).

Prevalence

IAD is widely reported across healthcare settings, although prevalence varies depending on patient population and care environment. Studies suggest that IAD affects approximately 33% of hospitalised incontinent patients and around 41% of incontinent residents in long-term care settings, with rates across all settings ranging from 5.6% to 50% depending on the population studied. Rates are consistently higher in individuals with faecal or dual incontinence (Beeckman et al, 2015; Banharak et al, 2021; Voegeli and Hillery, 2021). A widely cited study in a community setting found that over half (52.5%) of people living with faecal incontinence experienced IAD (Rohwer et al, 2013).

Despite this, IAD is frequently under-recognised and under-reported, partly due to inconsistencies in assessment and documentation. Misclassification as pressure ulcers remains a significant issue, which can lead to inappropriate management

strategies and skewed incidence data (Kottner and Dissemond, 2025).

Clinical signs

The clinical presentation of IAD can vary depending on severity, duration of exposure and individual patient factors, as well as whether it is caused by faecal or urinary incontinence (Box 3). However, common signs include:

- Diffuse erythema, often with poorly defined edges
- Maceration, resulting in soft, overhydrated skin
- Pain, burning or itching, which may be reported by the patient
- Superficial skin erosion or denudation
- Irregular or patchy areas of skin damage (Gray et al, 2012; Beeckman et al, 2015).

In contrast to pressure ulcers, IAD typically presents as widespread, superficial inflammation over areas exposed to moisture, rather than localised damage over bony prominences.

In more severe cases, secondary infection may occur, particularly with *Candida* species, presenting as satellite lesions, increased erythema or moist, weeping skin.

Holistic impacts

The impact of IAD extends beyond physical skin damage. The associated pain, discomfort and embarrassment can impact both dignity and quality of life (Voegeli and Hillery, 2021).

Box 2. Cascade of moisture-associated skin damage

moisture ► maceration ► pH change ► enzymatic activity

Box 3. Comparing faecal and urinary incontinence

Although both urinary and faecal incontinence contribute to IAD, their effects on the skin differ significantly (Beeckman et al, 2015; Beele et al, 2018).



Urinary incontinence primarily causes maceration and pH imbalance, weakening the skin barrier over time.



Faecal incontinence exposes skin to digestive enzymes, which break down epidermal structures and accelerate tissue damage.

Patients who are doubly incontinent are at particularly high risk due to the combined effects of moisture, pH change and enzymatic activity (Beeckman et al, 2016). This group often requires more intensive preventative and protective strategies.

IAD may also contribute to:

- Reduced mobility due to discomfort
- Sleep disturbance
- Social withdrawal or reduced engagement in care.

From a healthcare perspective, IAD increases care complexity and workload, requiring more frequent skin assessment, cleansing and product application. It is also associated with increased risk of infection and prolonged hospitalisation, contributing to higher healthcare costs (Beeckman, 2015).

Prevention and management

Risk factors

There are several factors that can identify someone as at increased risk of IAD (Beeckman et al, 2016; Deprez et al, 2023; Ousey et al, 2025):

- Incontinence
- Immobility
- Advanced age
- Cognitive impairment
- Diarrhoea
- Poor nutrition.

IAD can worsen due to a combination of factors, including infrequent cleansing, friction during care, maceration from occlusive pads or use of products at the wrong pH.

Assessment and categorisation

People at risk of or with IAD should be assessed on admission, during care and after incontinence episodes (Beeckman et al, 2015). If IAD is present, its severity should be matched to one of the following classifications (Beeckman et al, 2015; Kottner and Dissemond, 2025):

- Mild: erythema with intact skin
- Moderate: partial skin loss
- Severe: extensive breakdown, with infection risk.

People with IAD should also receive a bladder and bowel (re)assessment to determine the nature and severity of the underlying incontinence, as well as whether it can be more effectively managed.

Referral

As standard practice, identification of IAD should be followed by consideration of referral to local community nursing or bladder-and-bowel care teams, depending on local pathways. The relevant team will then be responsible for diagnosis and treatment of urinary and faecal incontinence, including review of continence management. For example, they may find that IAD is often linked to inadequate absorbency of continence products, and skin issues resolve with the right products.

Management

Effective management of IAD requires structured nursing care, in alignment with best-practice guidance (Doughty et al, 2012; Fletcher et al, 2020; Dissemmond et al, 2021; International Continence Society, 2024; Ousey et al, 2025). This may follow the cleanse-protect-restore model (Box 4):

- 1. Cleanse skin promptly after episodes of incontinence with a pH-balanced skin cleanser
- 2. Protect skin by applying barrier cream or film
- 3. Restore and maintain skin integrity through ongoing care, including control of moisture and minimisation of friction and trauma.

Bed-bound patients also require frequent repositioning and skin inspection (Fletcher et al, 2020; Voegeli and Hillery, 2021).

Understanding IAD within the broader framework of MASD enables a holistic and evidence-based approach to skin care across a range of scenarios (Fletcher et al., 2020; Dissemmond et al., 2021), with consistent principles of:

- Moisture management
- Skin protection
- Reduction of friction and trauma.

Structured skin care regimens should incorporate products designed to cleanse and protect fragile skin exposed to ongoing moisture, incontinence, friction, shear and medical adhesive-related trauma. Such

regimens have been shown to maintain skin integrity, prevent further deterioration and reduce the incidence of skin injury across multiple patient groups, while also improving consistency of care delivery (Tickle and Callaghan, 2020).

CliniShield Advance

The CliniShield Advance range of products is designed to effectively cleanse and protect against IAD (Table 1 and Figure 1). The CliniShield Advance range is cost-effective and supports efficient care delivery with easy application, rapid drying and lasting protection. The skin-friendly formulations are non-sting, non-sticky free of alcohol, fragrance, parabens, phthalates and natural rubber latex. The range includes a skin cleanser; a protective barrier cream in a 28g or 90g tube; and a barrier film in a spray or wipes.

Cleanse



The CliniShield Advance 360° Foam & Spray Skin Cleanser is used to cleanse intact or injured skin following episodes of incontinence, helping protect against IAD. Its innovative upside-down delivery system — the first of its kind — makes it ideal for cleansing difficult-to-reach areas. Its thorough cleansing action should have the following results:

- Effectively breaks down urine and faeces, even when stubbornly dried to the skin
- Moisturises the skin to avoid dryness and support skincare regimens

Box 4. Cleanse-protect-restore management model

 1. Cleanse

 2. Protect

 3. Restore