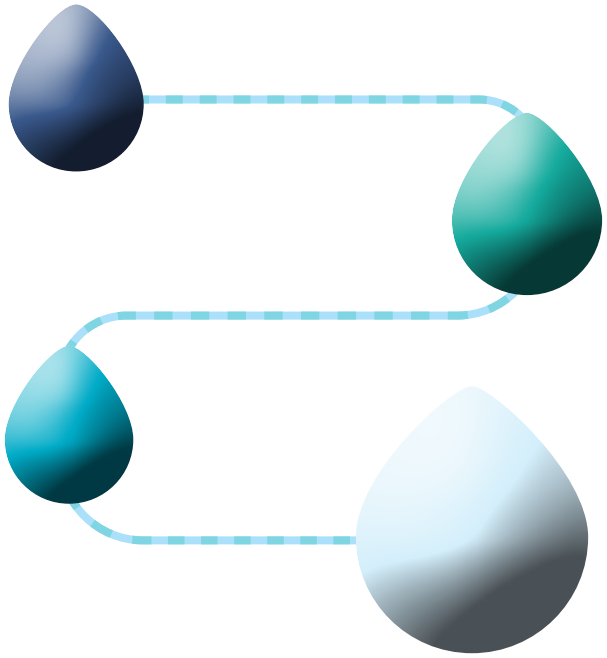
WOUNDS UK

Best Practice Statement

Continence and skin integrity in adults

2025



What is incontinence?

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Practical advice for practitioners

BEST PRACTICE STATEMENT: CONTINENCE AND SKIN INTEGRITY IN ADULTS

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FOREWORD

In June 2025, a multidisciplinary panel of experts met virtually to explore the intricate relationship between adult continence care and skin integrity. Central to the discussion was the need to challenge prevailing stigma around continence and highlight the positive impact that effective management can have on maintaining healthy skin.

Although continence care and skin integrity are frequently linked to nursing, it is crucial to recognise that this is a shared responsibility and is relevant to many healthcare professional groups, including physiotherapists, occupational therapists, healthcare assistants, and pharmacists (Association for Continence Professionals, 2023). Specialists involved in continence care may also include urologists, gynaecologists, gastroenterologists and colorectal surgeons. Continence and skin integrity encompasses multiple care settings, from hospital and community care to care homes and domiciliary environments, where individuals are supported by carers in their own residences.

This Wounds UK document explores the impact of skin damage associated with continence issues on an adult's mental health and overall quality of life. It draws attention to the interplay between physical care, psychological wellbeing, and broader sustainability considerations, and addresses the following key areas:

- Overview of incontinence
- Causes and understanding of moisture-associated skin damage and incontinence-associated dermatitis
- Timely and accurate assessment of incontinence and skin health
- Effective strategies for continence management
- Conducting comprehensive skin assessments
- Preventing and managing incontinence associated dermatitis
- The Three Pillars of Sustainability: Environmental, Social, and Economic Perspectives

All guidance is based on best available current literature, local/national initiatives and expert opinion.

Karen Ousey, Chair

WHAT IS INCONTINENCE?

Incontinence is a clinical symptom rather than a standalone disease or diagnosis and may arise from a diverse array of underlying causes. It represents one element within a broader spectrum of bladder and bowel dysfunction. Urinary and faecal incontinence are defined as "the complaint of any involuntary leakage of urine or faeces" (Abrams et al, 2002; Veronese et al, 2018).

Urinary and/or faecal incontinence is a major contributor to moisture-associated skin damage (MASD) caused by prolonged exposure to various sources of moisture, such as urine, stool, sweat, wound exudate, mucus, or saliva (Young, 2017). Incontinence-Associated Dermatitis (IAD) is a specific type of MASD caused by prolonged exposure of the skin to urine and faeces. This contact irritates the skin, disrupting its protective barrier, increasing its pH, and fostering microbial growth. The resulting inflammation, maceration, and erosion of the skin (Gray et al, 2007; Peart, 2023) leads to IAD, a painful condition that requires proper management to prevent further breakdown and secondary infections.

Ultimately, MASD serves as an umbrella term for skin conditions resulting from extended moisture exposure. IAD is one of the four recognised types of MASD, along with peristomal dermatitis, intertriginous dermatitis and peri-wound maceration (Fletcher et al, 2020; **Figure 1**).

There is a specific challenge related to stomal output. When a patient has a long-term stoma, the moisture involved still results from bodily fluids such as urine or faeces; however, this would be classified as peristomal skin damage rather than IAD, as IAD typically refers to the involuntary loss of urine or faeces via the urethra, anus, or a fistula.

Understanding urinary incontinence

Urinary incontinence (UI) impacts millions worldwide and is often underestimated in terms of its effects on personal and social wellbeing (Dooley et al, 2008). Urinary incontinence tends to occur more often in women, and pregnancy is a major factor in its development. During pregnancy, hormonal changes and the growing uterus can put extra strain on the pelvic floor muscles, which may weaken and lead to urine leakage (Aoki et al, 2017). The process of vaginal childbirth can further contribute to the issue by causing stress or injury to the muscles, nerves and tissues involved in supporting bladder control (Milsom and Gyhagen, 2025).

Based on epidemiological studies, several major risk factors can be identified in the pre-pregnancy and antenatal period for urinary incontinence (UI) and pelvic floor damage. These are summarised in the UR-CHOICE risk calculator (Wilson et al, 2014; Milsom and Gyhagen, 2025):

U Urinary incontinence before pregnancy
R Race/ethnicity
C Childbearing started at what age?
H Height (mother's height)
O Overweight (maternal weight/BMI)
I Inheritance (family history)

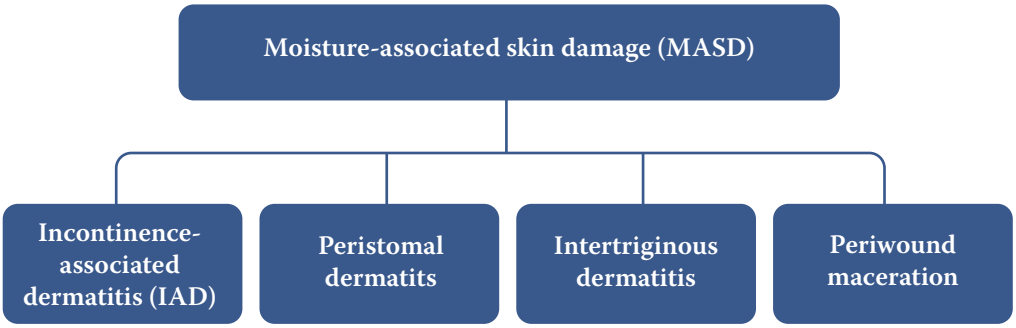

Figure 1. Types of MASD

C Children (number of children desired)
E Estimated fetal weight

These factors can help clinicians identify women at greater risk of developing pelvic floor dysfunction, enabling earlier intervention and counselling before or during pregnancy.

A substantial proportion of postmenopausal women experience UI, with prevalence estimates ranging from 25% to over 50% in this population, highlighting the need for heightened awareness and improved understanding of the condition (Allafi et al, 2024). Oestrogen plays a key role in preserving the structural integrity and function of urogenital tissues, such as the urinary bladder, urethra, and pelvic floor muscles (Waetjen et al, 2009). The development of incontinence during this life stage is often multifactorial, influenced not only by hormonal changes but also by additional contributors, including weight gain, lifestyle modifications, and comorbidities such as diabetes and urinary tract infections (UTIs) (Russo et al, 2021).

Common reasons for male incontinence include medication, for example, diuretic medications can increase the risk of men's bladder leakage, urinary tract infections, temporarily weakened muscles due to prostate surgery leading to bladder weakness in men, changes in prostate size (a swollen prostate can obstruct urine from passing), being overweight puts extra pressure on abdominal and pelvic muscles, which makes it harder to avoid urine leakage and diabetes or neurodegenerative diseases (e.g. Alzheimer's).

It has traditionally been challenging to understand how common incontinence truly is. Many older people do not voluntarily raise continence issues, often feeling embarrassment or believing incontinence to be a normal part of ageing (Vethanayagam et al, 2017). Though not ideal, individuals may choose to manage the condition privately using incontinence pads or period pads, which are widely available. As a result, available data reflects only reported cases and may not accurately represent the full scope of both bladder and bowel incontinence.

According to ICD-10 coded data for England in 2024/25, there were 303,645 inpatient spells associated with incontinence diagnoses (codes R32 or R15), and 399,364 spells linked to pressure ulcer (PU) diagnoses (code L89). Of these, 50,383 spells included both incontinence and PU codes. Consequently, spells involving both conditions accounted for 12.6% of all PU-related spells and 16.6% of all incontinence-related spells demonstrating the importance of understanding prevention and management of incontinence and maintenance of skin integrity.

Other estimates state at least one person out of four could be affected by UI during their life (Pizzol et al, 2020), whereas estimates from Cobley et al (2023) range from 5% to 69% in community-dwelling women, with most studies reporting a prevalence in the range of 25%–45%. In the UK, urinary incontinence affects roughly 40% of women and 10% of men (Bladder Health UK, 2024). UI due to chronic causes can be divided into six main types. The International Continence Society (ICS, 2017) present the following:

1. Urinary incontinence
Stress (urinary) incontinence
Complaint of involuntary loss of urine on effort or physical exertion e.g. sporting activities), or on sneezing or coughing
Urgency (urinary) incontinence
Complaint of involuntary loss of urine associated with urgency

Postural (urinary) incontinence
Complaint of involuntary loss of urine associated with change of body position, for example, rising from a seated or lying position

Mixed (urinary) incontinence
Complaint of involuntary loss of urine associated with urgency and also with effort or physical exertion or on sneezing or coughing

Continuous (urinary) incontinence
Complaint of continuous involuntary loss of urine

Insensible (urinary) incontinence
Complaint of urinary incontinence where the individual is unaware of how it occurred

Box 1. Increased risk of urinary incontinence is observed in the following populations: (NHS, 2023)

- People who are increasing in age, although incontinence is not an inevitable part of ageing
- People who have a family history of the condition
- People who have lower urinary tract symptoms
- People who are obese
- People who are female (during pregnancy and following a vaginal birth; see UR-CHOICE risks for this population to be specific).

2. Incontinence associated with chronic retention of urine
Complaint of involuntary loss of urine which occurs in conditions where the bladder does not empty completely as indicated by a significantly high residual urine volume and/or a non-painful bladder which remains palpable after the individual has passed urine. (Note: The ICS no longer recommends the term overflow incontinence). A significant residual urine volume denotes a minimum volume of 300 ml, although this figure has not been well established

3. Nocturnal enuresis
Complaint of involuntary loss of urine which occurs during sleep

4. Coital incontinence (for women only)
Complaint of involuntary loss of urine with coitus

5. Functional incontinence
Complaint of involuntary loss of urine that results from an inability to reach the toilet due to cognitive, functional or mobility impairments in the presence of an intact lower urinary tract system

6. Multifactorial incontinence
Complaint of involuntary loss of urine related to multiple interacting risk factors, including factors both within and outside the lower urinary tract such as comorbidity, medication, age-related physiological changes and environmental factors.

Understanding faecal incontinence
Faecal incontinence, defined as the involuntary passage of solid or liquid stool, has an estimated global prevalence of up to 7% among community-dwelling adults and is associated with substantial impairment in quality of life (Bharucha et al, 2022). Despite its impact, disclosure is frequently hindered by feelings of embarrassment or stigma. Faecal incontinence is classified by symptom type (urge, passive, or mixed), aetiological origin (anorectal dysfunction, bowel pathology, or both), and severity, which reflects the frequency, volume, consistency, and mechanism (urge versus passive) of stool leakage life (Bharucha et al, 2022).

Combined faecal and urinary incontinence affects about 10% of women and 5–6% of men in the general population (Condon et al, 2019). This prevalence increases in nursing home residents to nearly 50% for both men and women.

Pathophysiology of urinary incontinence

The physiological ability to maintain continence is a behaviour that can be learnt from the age of 18 months once the spinal nerves are fully myelinated (Clifford et al, 2000). As such, any individual older than this approximate age who has a problem with leaking has a degree of incontinence. This is known as the involuntary, unintentional loss of urine from the bladder (Keane and O'Sullivan, 2000). It can range from a sudden, complete loss of bladder control to more frequent or small leaks, depending on the type and underlying cause.

The urinary system is a highly integrated organ network essential for maintaining physiological homeostasis through the regulation of fluid balance, electrolyte concentrations, and waste elimination. It comprises the kidneys, ureters, bladder, and urethra, which function collectively to filter blood, generate urine, and facilitate the excretion of metabolic by-products (Seifter et al, 2021). Each kidney contains approximately one million nephrons, which serve as the fundamental units of filtration and reabsorption necessary for sustaining internal equilibrium.

Dysfunction in any component of this system can result in substantial impairment and debilitating functional disorders. The urinary system remains in its storage phase for over 99% of the time, accommodating the continuous production of urine by the kidneys and thereby maintaining continence essential for normal daily functioning. Urinary incontinence arises when bladder pressure exceeds urethral closure pressure, disrupting this storage balance (Cobley et al, 2023). See **Box 1** for those with increased risk of urinary incontinence (NHS, 2023).

Box 2. Increased risk of faecal incontinence is observed in people (NICE, 2022)

- Who are frail and older
- Who are constipated
- With loose stools or diarrhoea from any cause
- With neurological or spinal disease/injury (for example, spina bifida, stroke, multiple sclerosis, spinal cord injury)
- With severe cognitive impairment
- With urinary incontinence
- With pelvic organ prolapse and/or rectal prolapse
- Who have had colonic resection or anal surgery
- Who have undergone pelvic radiotherapy
- With perianal soreness, itching, or pain
- With learning disabilities
- Taking certain medications (including but not limited to antibiotics, selective serotonin reuptake inhibitors, laxatives, digoxin, orlistat; potential overuse of laxatives; regular review of these medications is needed)
- With diabetes mellitus
- Who are obese
- Who are female (due to obstetric injury and increased rates of inflammatory bowel disease).

Pathophysiology of faecal incontinence

The bowel briefly comprises of the small and large intestines, rectum and anal canal. The anal sphincter complex, including the internal and external sphincters, alongside the puborectalis muscle, maintains continence through contraction and reflexive relaxation (Ahmed et al, 2023). Damage to the sphincter, neurological disorders (e.g. multiple sclerosis, spinal cord injury), structural abnormalities, abnormal stool consistency, general disability including the ageing process and altered rectal sensation can all lead to incontinence (Emmanuel, 2019; Magnuson et al, 2023; Young, 2025). See **Box 2** for those with increased risk of faecal incontinence (NICE, 2022).

Public perception of incontinence

It is important to recognise that discussions about incontinence with members of the public can vary widely, as individual perceptions differ, some may interpret incontinence as complete loss of bladder control (e.g. frequent flooding), while others may think of it as occasional leakage. This highlights the need to educate healthcare professionals on how to accurately assess the symptoms and communicate effectively with patients and carers, as clear and sensitive communication is essential.

APPROPRIATE AND TIMELY ASSESSMENT OF INCONTINENCE AND SKIN INTEGRITY

Box 3. Suitable and unsuitable trigger questions (Yates, 2025)

Unsuitable

- Are you incontinent?
- Do you ever have any problems with your bladder or bowels?
- Do you wet the bed?

Suitable

- How often do you go to the toilet during the day? What about at night?
- Do you ever feel like you need to rush to the toilet urgently?
- Have you ever had a small leak or accident?

A comprehensive skin assessment should be performed at initial presentation or upon admission, followed by daily skin inspections (Beeckman, 2020)

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Trigger questions should be used to identify at-risk patients

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To assess and record incontinence, healthcare professionals typically use a combination of methods including bladder diaries, bowel charts/diaries, physical examinations, and potentially urodynamic testing. Bladder diaries help track fluid intake, urination frequency and volume, and leakage episodes over a few days (NICE, 2015a); bowel charts/diaries are a pertinent part of assessing faecal incontinence. New technologies/innovations are being developed to assist with the recording of the data.

A physical examination may include a pelvic or prostate examination, and urine tests can check for infection or other abnormalities (Bladder and Bowel UK, 2023). Dipstick urinalysis should not be used in isolation to diagnose urinary tract infection (UTI), as it may yield false-positive or false-negative results and is linked to unnecessary antibiotic prescribing (Kristensen et al., 2025). An exception applies when mild to moderate symptoms are present in females under 65 years of age, where its use may be appropriate (NICE, 2015b; Public Health England, 2020). Urodynamic testing can also help to provide more detailed information about bladder function if necessary.

A comprehensive skin assessment should be performed at the initial presentation or upon admission to the care setting. This should be followed by daily skin inspections as part of routine care, with clear documentation (Wounds UK, 2018; Fletcher et al, 2020; Mitchell, 2022).

In cases of frequent urinary or faecal incontinence, the frequency of skin assessments should be increased accordingly to monitor for irritation caused by ammonia and faecal enzymes (Beeckman et al, 2015). Clinicians should conduct visual inspections of skin areas exposed to urine and/or faeces for signs of IAD (Gray et al, 2012; Abrams et al, 2017). Palpation should also be used to assess for warmth, which may indicate early pressure-related damage, inflammation (dermatitis), or localised infection (Flanagan, 2020). When assessing IAD in individuals with black and brown skin tones, it is crucial to recognise that erythema (redness) may appear as purple-black or black, rather than the typical red seen in light skin tones which historically been described in relation to IAD (Bermudez et al, 2023). This often more subtle appearance can make it challenging to identify early skin damage on black and brown skin. Additionally, blanching (the temporary whitening of skin when pressed) may be muted or absent in dark skin tones, further complicating the assessment (Dhoonmoon, 2023).

Assessment of specific populations

Findings by Bradbury et al (2024) highlight systemic barriers in addressing continence needs among people living with dementia. Many healthcare professionals reported avoiding continence-related conversations due to limited dementia-specific continence knowledge. Once physical causes were excluded, continence issues were frequently viewed as outside their clinical remit, leading to reduced prioritisation and missed opportunities for proactive support. Additional challenges included constrained consultation time and limited access to specialist services equipped to provide tailored continence care.

To ensure continence is assessed appropriately and in a timely manner, the use of trigger questions is recommended, especially those that encourage more detailed responses rather than simple 'yes' or 'no' answers, see **Box 3**. These questions can help the assessor identify potential continence issues. Anyone who responds positively to a trigger question should then be referred for a full continence assessment. See **Box 4** for other aspects of assessment to consider.

Box 4. Other aspects of assessment to consider

- Be aware of what's considered normal: typically, urinating 6–7 times per day is within normal limits. More than this may warrant further investigation
- Encourage patients to complete a bladder diary after taking their history to track frequency of urination, fluid intake and volume voided
- Consider doing a urine analysis, though note that results are not always reliable, especially in older populations.

Scan the QR to view the Continence Product Advisor website, designed to give users, carers and healthcare professionals detailed, essential information about products for bladder, bowel, and toileting problems.

If no assessment tools are available within your trust, the International Consultation on Incontinence Questionnaires (ICIQ) may be used as an alternative. These validated questionnaires, accessible at https://iciq.net, are internationally available and cover all types of incontinence.

Early assessment by an appropriately trained professional allows a patient-centred and cost-effective care pathway to be followed. Following assessment, the use of containment products, medication and the level of intervention can be triaged and escalated (NHS England, 2018).

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WHO IS RESPONSIBLE FOR THE MANAGEMENT OF CONTINENCE?

Continence management is the responsibility of all healthcare professionals working with affected individuals

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MYTH

Incontinence-associated dermatitis (IAD) is the same as MASD.

TRUTH

MASD is the umbrella term of four different types of MASD. IAD is a type of MASD caused by the prolonged exposure to urine and/or faeces in adults and adolescents.

It is important to ensure thorough removal of bodily fluids when cleansing (i.e. urine/faeces). The skin should be gently cleansed using a low- irritating cleanser within a structured skin care programme.

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Continence management is the responsibility of all healthcare disciplines including nurses, physiotherapists, occupational therapists, healthcare assistants, and pharmacists (Association for Continence Professionals, 2023). It may also include urologists, gynaecologists, gastroenterologists and colorectal surgeons.

Continence care would benefit from an interdisciplinary approach, rather than a multidisciplinary one, to ensure more integrated and collaborative practice. While a multidisciplinary model involves professionals working in parallel within their own areas of expertise, the interdisciplinary model promotes a more integrated and collaborative framework in which team members actively share knowledge, jointly plan care, and align interventions. This approach leverages the diverse expertise of healthcare professionals to deliver comprehensive assessment and management of urinary and faecal incontinence through coordinated and holistic care.

To raise awareness and emphasise the importance of continence management, it is essential to reduce stigma, promote education, and advocate for improved care. This can be achieved through initiatives such as public awareness campaigns including World Continence Week, support groups, and educational materials.

Another important factor to consider is the role of healthcare professionals in ensuring that patients have appropriate access to toileting facilities or equipment to help them maintain continence (e.g. urinary bottles). In a hospital setting, for example, individuals with functional limitations, such as restricted mobility, communication difficulties, or visual impairments, are particularly vulnerable; resource and staff shortages can be a significant issue for this group of patients. Clinical areas should conduct thorough risk assessments to prevent functional incontinence. However, as part of the management strategy, the use of incontinence pads are known to be considered to protect vulnerable skin if the initial prevention efforts are unsuccessful.

Nevertheless, relying heavily on incontinence pads can contribute to a loss of independence, potential skin damage, and even the development of incontinence. This raises a critical question: are some patients becoming incontinent because of the overuse or inappropriate use of pads in a particular care setting? In hospital settings, nursing models should incorporate elimination care, encompassing the assessment, support and management of urinary and bowel elimination, as a key aspect of patient assessment. Nurses should respond promptly to requests for commodes, urinals, or bedpans, while also considering environmental factors such as the accessibility and proximity of toilet facilities (Reis da Silva, 2024).

Effective cleansing of the skin and appropriate skin care products

Effective skin cleansing plays a vital role in preventing IAD, with the individual's comfort and overall experience being especially important when skin is compromised or at risk of damage. While the desire for cleanliness is common, the pain associated with cleansing broken skin can be significant (Woodward et al, 2025), pain and itching are the biggest factors associated with IAD (Ousey et al, 2017). Therefore, gentle and appropriate cleansing methods are essential to balance hygiene with the need to minimise discomfort and prevent further irritation.

Cleansing should be performed using clean, soft cloths or incontinence wipes, especially in delicate areas such as the perineum, to reduce the risk of trauma. Gentle wiping pressure should be used only when absolutely necessary (Konya et al, 2024). Harsh rubbing or massaging with abrasive materials can damage skin and underlying cells, cause inflammation, and is more likely to harm than

provide any benefits such as increased blood flow (McNichol et al, 2018). In patients with larger body sizes, attention must be given to thoroughly clean all folds and creases to ensure complete removal of bodily fluids.

Cleansing intimate areas often carries social stigma, making it essential to approach such care with sensitivity, respect, and a commitment to preserving dignity. For individuals with cognitive impairment, personal care can trigger agitation or distress, adding complexity to continence management.

Box 5 outlines practical tips for cleansing intimate areas effectively and respectfully.

A Cochrane review (Graham et al, 2025) found limited evidence to suggest that any one cleanser is clinically more effective than another. However, observational research shows that many individuals continue to use familiar products, such as shower gels, even when these may not be the most appropriate choices (Woodward et al, 2025). This is important because harsh surfactants like Sodium Lauryl Sulfate (SLS) and Sodium Laureth Sulfate (SLES), which are common in soaps and shower gels, can strip away protective oils and contribute to skin dryness (Shah et al, 2025).

Traditional soap and water should not be used to cleanse areas susceptible to IAD, instead a pH-balanced skin cleanser should be used (Graham et al, 2025). Other ingredients to avoid include synthetic fragrances, parabens, and phthalates, as they may trigger allergic reactions, cause sensitivity, or disrupt hormonal balance (Rádis-Baptista, 2023) (See **Box 6** for more recommended practices on cleansing intimate areas).

Instead, the use of no-rinse or pH-neutral skin cleansers is advised to minimise irritation and dryness and reduce the likelihood of compromised skin integrity (McNichol et al, 2018). Evidence from a systematic review concluded that low-irritating cleansers, when used within a structured skincare regimen, help maintain skin integrity (Fastner et al, 2023) whilst a recent Cochrane review suggested a skin cleanser and a leave- on product may prevent IAD (Graham et al, 2025).

After cleansing, the next step is to protect the skin. The aim is to restore and maintain the skin's barrier function, reduce exposure to irritants and help manage any inflammation (Carville and Ousey, 2025). Healthcare professionals should advocate for the use of barrier products to protect the skin from exposure to moisture and irritants, although there is little evidence that any one product is more effective than any other (Graham et al, 2025). However, use of a barrier product may not be necessary if the cleanser or wipe used has additional barrier properties.

Barrier products for managing and preventing incontinence dermatitis and skin breakdown can be classified into three broad categories (Fletcher et al, 2020):

1. Generic skin protectors: Generic skin protectors include those containing zinc oxide and paraffin. These products repel moisture from the skin surface
2. Barriers: Some products are specifically formulated to protect the skin of individuals with incontinence, offering a barrier without added antibacterial or antifungal agents. They can be applied in various forms, including sprays, wipes, creams and applicators
3. Antibacterial and antifungal products: Some barrier products contain antibacterial or antifungal agents and may be used preventatively in patients at higher risk of infection, such as those with lymphoedema and skin folds. These products do not treat active infections, which must be managed and resolved before barrier protection is applied. It is important to note that fungal infections should be treated with an appropriate antifungal agent, not an antibacterial product.

The barrier product used is typically the one prescribed by the GP or provided by the healthcare organisation. While carers may sometimes use over-the-counter items (e.g. petroleum jelly, zinc oxide, or wipes), this is not to be recommended. For optimal effectiveness and safety, the product used should be as recommended on the local formulary.

Barrier products should only be applied to the skin and not be applied directly to incontinence pads, as they can impair the pad's ability to absorb urine effectively.

Box 5: Tips on communicating and preparing for intimate cleansing (Bohbot et al, 2025)

- Explain what you are doing and how/why
- Expose only the required amount of the body to maintain dignity
- Consider if a chaperone is required

MYTH

Incontinence wipes are the same as baby wipes.

TRUTH

Incontinence wipes are not the same as baby wipes. They are specially designed to meet the needs of adult skin, typically offering larger dimensions, stronger materials, and formulations that help minimise skin irritation while addressing bacteria commonly linked to incontinence.

A barrier product should be applied to prevent skin damage in patients at risk of IAD

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Box 6: Practical tips on cleansing

- Avoid harsh soaps; prefer mild, pH-balanced cleansers (syndets)
- Wash once daily, front to back, ideally after bowel movements. This practice helps prevent the spread of bacteria from the anal area to the urethra and bladder, where it can lead to infection.
- Limit exposure to plain water; excessive washing dries the skin
- Do not use douches, antiseptics or antibacterial cleansers
- Choose hypoallergenic products free from fragrances and dyes
- Use small amounts of cleanser and rinse thoroughly
- Be careful with shaving or waxing to reduce irritation
- Opt for cleansers with moisturisers or soothing ingredients
- Adapt hygiene practices to age and life stage

This may lead to slower urine absorption, increased risk of skin damage, and potential leakage. Barrier creams should be used sparingly for similar reasons, as excessive use can affect the effectiveness of absorbent products.

Talcum powder should be avoided altogether, as it can interfere with pad performance and contribute to skin irritation. Additionally, talcum powder carries health risks. It may be contaminated with asbestos, a known carcinogen linked to lung cancer and mesothelioma when inhaled. Even asbestos-free talc can cause respiratory irritation, breathing difficulties, and lung damage. Furthermore, perineal use of talc has been identified as a possible cause of ovarian cancer (Taher et al, 2019).

When managing incontinence, it is crucial to consider the broader impact of treatment options on the surrounding skin. While incontinence management products are necessary, they can lead to skin damage including maceration if they trap moisture and prevent adequate airflow, creating a humid environment which can weaken the skin's protective barrier. Thick layers of zinc oxide-containing products, for example, can create a physical barrier that is difficult to remove, trapping moisture and irritants against the skin, which can lead to issues like skin breakdown or dermatitis. To prevent this, it is crucial to cleanse the skin gently but thoroughly to remove the product, especially in areas prone to moisture, such as the surrounding skin exposed to urine and faeces.

It is important to acknowledge that evidence guiding the selection of absorbent products remains limited (Murphy et al, 2023). Product selection should be guided by an individualised assessment, with containment pads regarded as only one possible option. Reliance on pads can be reduced through targeted interventions such as pelvic floor training, bladder retraining and toileting programmes, which not only cut costs but also lower the risk of incontinence-associated dermatitis (Yates, 2021b; Imamura et al, 2010; Demaagd and Davenport, 2012; All Wales Continence Forum, 2022). Selection must also account for skin integrity, as inappropriate use of alternatives such as penile sheaths may cause discomfort, friction damage or erosion (Pomfret, 2006; Bycroft et al, 2003).

Table 1 presents the most commonly used product for absorbing and containing both light and moderate/ heavy leakage (Continence Product Advisor, 2017).

Prevalence of IAD

A total of 14 million adults in the UK have urinary incontinence and 6.5 million have bowel problems, but the incidence of IAD in the UK has not been established. Prevalence of IAD may be up to 51% of people with incontinence living at home and 30% in nursing and residential care (Woodward et al, 2020). Recent studies in German nursing care homes estimate the point prevalence of IAD at 20.1% and IAD incidence of 23–26% within 6 months; in the USA, the incidence of IAD was found to be 5.5% over 14 days among nursing home residents, and as high as 30% over 1 month in Belgian nursing homes (Woodward et al, 2024).

It is important to understand that, when coding, IAD is not the same as MASD, but rather a specific form of it. The ICD-10 code EK02.22 is for irritant contact dermatitis due to incontinence (also known as IAD), which is a skin reaction caused by prolonged and repeated contact with urine and/or faeces in adults and adolescents (WHO, 2025).

Pathophysiology of IAD

When urine and faeces come into contact with the skin surface as a result of incontinence, overhydration and destruction of the stratum corneum and keratinocytes occurs. Bacteria on the skin produce urease, an enzyme, that converts urea into ammonia and damages the skin directly (Owen et al, 2024a). The ammonia raises the pH of the skin compromising stratum corneum cohesion and the permeability of the skins protective barrier. Inflammatory cytokines are released and lead to inflammation of the epidermis and dermis (Koudounas et al, 2021). (See Box 8 for clinical signs and symptoms of IAD). Risk factors for IAD can be found in Box 7.

Table 1. Absorbent products. Adapted from The Association for Continence Professionals, 2023

Category 1	Product - a warerproof-backed absorbent product that is help in place using separate, close-fitting (regular or specific designed) underwear	
Category 2	Unbacked product - an absorbent product without a waterproof backing used either inside another product or on its own, secured using separate, close-fitting, underwear which itself includes waterproofing in the product area	
Category 3	Male product - a waterproof-backed absorbent product for men that is designed to cover the penis and scrotum, and is held in place using separate, close-fitting (regular or specifically designed) underwear	
Category 4	Male Pouch - a waterproof-backed absorbent product for men, fashioned into a pocket into which the penis -and sometimes the scrotum, too - is placed	
Category 5	Pull-on product (Protective underwear) - a product in which the absorbent core, waterproof backing and the means to hold it in place are combined in a single design resembling regular underwear. Elastic linings around the waist and hips help give a close fit	
Category 6	Wrap-around product (All-in-one, Adult brief) - a one-piece product in which the absorbent core and means to hold it in place are combined in a single design, secured using adjustable adhesive tabds or a hook and loop fastening system at the sides	
Category 7	Belted product - a one-piece product in which the absorbent core, waterproof backing, and the means to hold it in place are combined in a single design, secured by means of an adjustable belt with adhesive tabs or a hook and loop fastening system	

Box 7. Risk factors for incontinence-associated dermatitis (IAD; Ousey et al, 2017; Kottner et al, 2025)

Types of incontinence

1. Faecal incontinence (diarrhoea/formed stool)
2. Double incontinence (faecal and urinary)
3. Urinary incontinence

What to look out for

- Frequent episodes of incontinence (especially faecal)
- Use of occlusive containment products
- Poor skin condition
- Compromised mobility
- Diminished cognitive awareness
- Poor personal hygiene
- Pyrexia
- Medication (antibiotics, immunosuppressants, vasopressors)
- Poor nutrition
- Critical illness
- Older incontinent adults*
- Older age
- Increased stool frequency
- Diarrhoea
- Friction/Shear issues
- Female sex
- Obesity
- Diabetes mellitus
- Vasopressor

**Very high risk*

Severity of IAD should be evaluated using the validated Ghent Global IAD Categorisation Tool (GLOBIAD).

Best Practice Statement

Box 8: IAD clinical signs and symptoms

Acute
- Erythema (purple discolouration in dark skin tones)
- Maceration
- Oedema
- Vesicles and blisters
- Erosion
- Pain especially on mobilisation and during incontinence care
- Pruritus (Kottner and Dissemond, 2025)

Chronic
- Skin thickening
- Scaling
- Post-inflammatory hyperpigmentation
- Lichenification

Secondary infection*
- Purulent exudate
- White scaling
- Satellite papules and pustules

* *Candida albicans* is most common

Faecal incontinence significantly increases the risk of developing IAD due to several interrelated physiological and environmental factors:
- Chemical irritation from faeces: Faeces contain digestive enzymes (including proteases and lipases) that can directly irritate and damage the skin. An increase in the skin pH increases the activity of these enzymes and breaks down proteins and fats, which can compromise the skin's protective barrier (Owen et al, 2024b)
- Higher risk with loose stools: Loose or liquid stools are particularly harmful because they spread more easily over the skin and contain higher concentrations of digestive enzymes. This increases both the area affected and the severity of IAD
- Increased risk of infection: Damaged skin from IAD is more prone to secondary infections, particularly fungal (e.g. Candida albicans) and bacterial (e.g. Staphylococcus aureus) infections. These can further delay healing and worsen symptoms.

For assessing skin affected by IAD, the validated Ghent Global IAD Categorisation Tool (GLOBIAD) is considered the most effective tool for evaluating severity [Figure 2]. Designed to standardise the assessment and documentation of IAD, GLOBIAD categorises IAD severity based on visual inspection of the affected skin areas (Beeckman et al, 2018).

The tool relies on 'redness' as a key indication of damage but acknowledges that a variety of tones of redness may be present (e.g. the skin may be lighter or darker than it was at baseline skin assessment, or purple rather than red, in patients with black and brown skin tones [Beeckman et al, 2018]). Ultimately, 'redness' is a descriptor of inflammation, and that inflammation can appear a range of colours dependent on skin tone.

The GLOBIAD M tool, an adaptation of the original GLOBIAD, has been developed to further enhance the assessment of IAD by enabling its use in digital and mobile platforms. This modern version allows for more consistent documentation and monitoring of IAD progression in both clinical and research settings, supporting clinicians in making timely and evidence-based decisions regarding skin care management.

Incontinence, particularly urinary incontinence, typically does not change drastically overnight unless there's a change in medication, significant change in the patient's condition or other significant intervention and, therefore, a detailed reassessment at every single visit may not be required. However, IAD should be assessed at every visit as it can develop quickly (e.g. a matter of hours), requiring prompt attention.

Anybody who is incontinent is at risk of IAD but individuals with double incontinence (both urinary and faecal) or those experiencing diarrhoea and liquid stools are at a higher risk due to the increased exposure to alkaline irritants and enzymes.

Skin for All is a useful resource: This organisation provides valuable examples of how various skin conditions appear on black and brown skin tones, which can support healthcare education and resources. Scan the QR code to access the resources

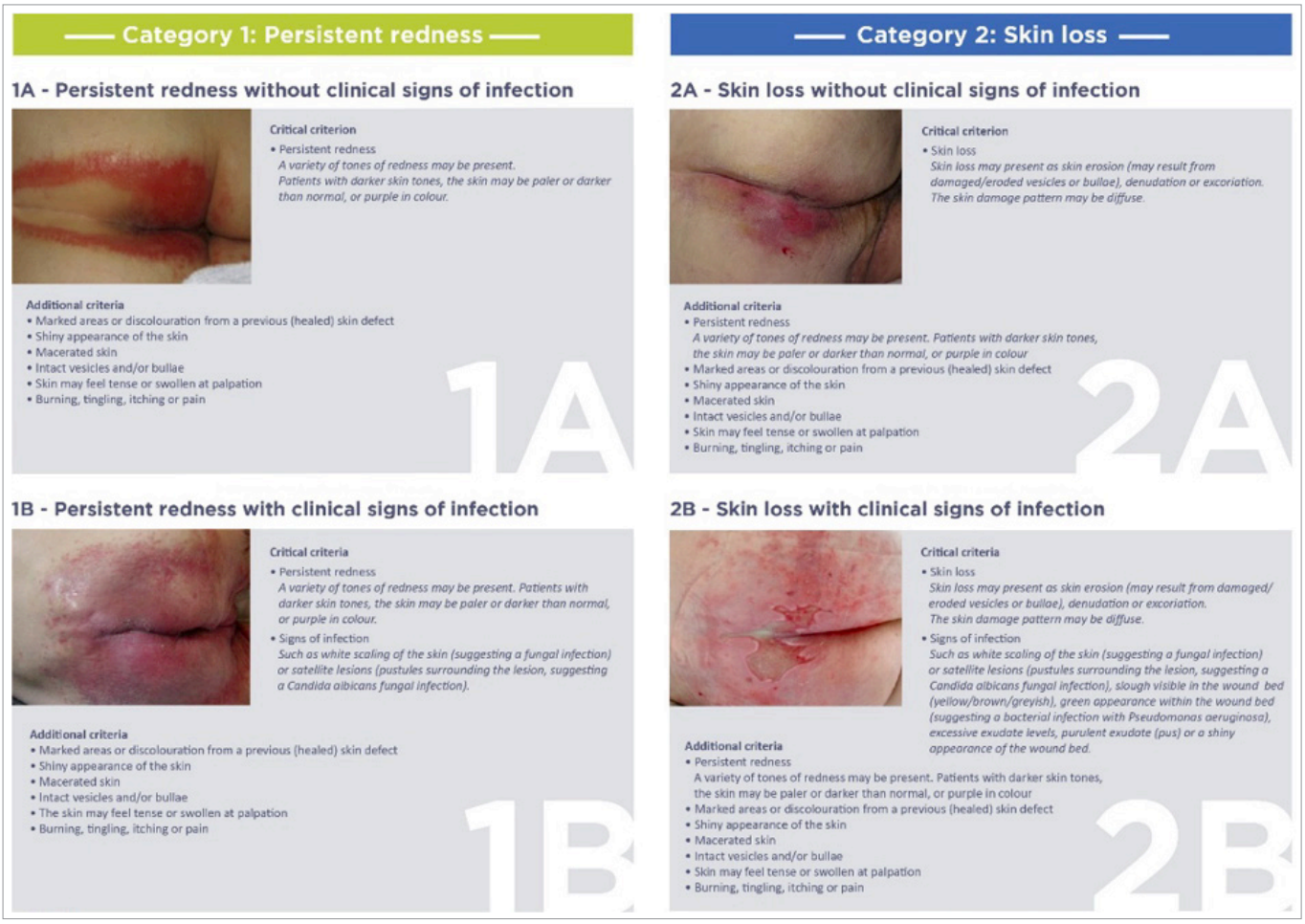

Figure 2. The validated Ghent Global IAD Categorisation Tool (GLOBIAD) (Van den Bussche et al, 2018).

Access the GLOBIAD M tool: The validated digital version of the Ghent Global IAD Categorisation Tool for standardised IAD assessment

WHICH AIDS SHOULD BE USED?

MYTH

Sanitary pads and maternity pads are suitable for managing incontinence issues.

TRUTH

Sanitary pads and maternity pads are unsuitable for managing incontinence because they are not designed to handle the rapid and sometimes large volumes of urine associated with bladder leaks or handling of faecal matter.

Continence pads have a one-way top layer that allows urine to move into the absorbent core, which contains superabsorbent polymer (SAP) and pulp for retention. SAP absorbs the urine, turning it into a gel and locking it away, preventing leakage and odours, and keeping the skin dry. Ultimately, continence pads are designed to handle the rapid and sometimes large gushes of urine associated with bladder leaks.

Prior to the widespread availability of commercially produced continence pads, period pads (menstrual pads) and maternity pads were often used for managing urinary incontinence, even though they are not designed for this purpose and are less effective than dedicated absorbent products.

Period pads are designed to absorb menstrual flow (a soaked sanitary pad only holds about 5 millilitres of blood), which is relatively slow and consistent; a standard maternity pad is designed to hold a minimum of 450 millilitres of fluid to manage significant postpartum bleeding, though the actual amount can vary by product and type. The amount an incontinence pad can hold in milliliters varies significantly by product, ranging from around 150 milliliters for a light-level pad to over 2,000 milliliters for high-absorbency overnight products. A fully soaked incontinence pad usually contains roughly its maximum absorbency (e.g. 150-2,000 millilitres depending on the product), which is far greater than the capacity of a standard menstrual pad.

It is important to note that procedure pads should not be used for continence care. They are not designed to absorb large volumes of urine, can contribute to skin irritation and damage from increased friction, and may allow leakage of urine or faeces onto the floor, creating a slip hazard. In addition, inadequate protection of the skin can lead to incontinence-associated dermatitis (IAD), increased risk of infection, and further skin breakdown. In individuals experiencing both menstruation and incontinence, fluid management becomes a key consideration for maintaining skin integrity. In these cases, the use of an absorbent product for incontinence is recommended due to its superior absorbency and moisture-wicking properties. However, frequent pad changes may be necessary, particularly in instances of heavy menstrual bleeding where clot formation can occur on the pad surface. Timely pad replacement helps prevent saturation, reduce the risk of skin damage, and support optimal hygiene.

When managing faecal incontinence, pad use can offer protection for clothing and furniture, particularly when stools are solid. However, faeces will remain on the surface of the pad's one-way top layer, leaving the skin exposed and unprotected. In cases of double incontinence, absorbent pads effectively absorb urine and help maintain skin integrity; however, once bowel movements occur, prompt pad changes are essential to minimise prolonged skin contact with faeces and reduce the risk of irritation or breakdown. For individuals experiencing very loose stools, pads may absorb the fluid component, but particulate matter tends to stay on the pad surface.

While pads can be a helpful part of managing faecal incontinence, they may not always offer sufficient protection for skin health. It is important to consider alternative or complementary interventions tailored to the individual's needs, stool consistency, and care environment. Clinicians should explore other absorbent products beyond standard pads (e.g. penile sheaths, absorbent boxer-style briefs and faecal management systems for diarrhoea) and seek input from specialist services for complex bladder or bowel concerns.

The 3 pillars of sustainability (environmental, social and economic)

Suboptimal continence care extends beyond financial implications. It profoundly affects individuals' wellbeing, emotional resilience, and

overall quality of life. The daily routines and mental health of caregivers are also significantly impacted, particularly when care is inconsistent or under-resourced. Misuse of absorbent products remains a widespread issue, often stemming from a lack of understanding surrounding product design and appropriate use, especially regarding absorbency levels and suitability for individual needs. Ensuring the correct product is selected requires targeted education for both professionals and caregivers.

The widespread reliance on disposable absorbent products presents major environmental and logistical challenges. The volume of waste generated, coupled with limited sustainable disposal options, highlights the need for more environmentally conscious approaches and innovation in continence care.

Disposable absorbent products, particularly those with high plastic content, can take centuries to decompose, with estimates reaching up to 500 years (Incontinence UK, 2023). Most are disposed of via landfill or incineration, contributing significantly to waste accumulation and air pollution. This disposal process not only increases environmental burden but also releases harmful emissions, raising concerns about long-term ecological and public health effects (Bladder and Bowel UK, 2024).

Consideration must be given to the disposal of unused pads. Many food banks and hygiene charities accept donations of unused, hygienically packaged absorbent products, such as pads and adult absorbent wear/briefs, alongside other essential toiletries. Organisations such as The Pad Project UK actively redistribute these items to individuals living with incontinence in the community, helping to reduce waste and support those in need: https://byyoursidehomecare.co.uk/thepad-projectuk. In addition, many NHS Trusts have their own disposal processes or policies regarding the return of unused absorbent products, and these must always be followed in practice.

Advancing sustainability in continence care calls for a broader shift toward reusable products, such as washable pads and absorbent underwear. This transition not only reduces environmental impact but also encourages a more holistic, person-centred approach to care. Access to a variety of styles and absorbencies is essential for effective management, helping to minimise unnecessary leakage, reduce the need for frequent changes, and prevent product waste. Achieving this requires collective responsibility from manufacturers and policymakers to prescribers, researchers, healthcare professionals, and end users (Bladder and Bowel UK, 2024)

Certain brands are actively working on sustainable solutions for their pads, focusing on reducing waste and minimising their environmental impact. Some companies are committed to reducing their carbon footprint, optimising packaging, and promoting circular economy initiatives. This includes using renewable materials, reducing plastic, and exploring options for recycling and composting.

Interested in sustainability and a Greener NHS? Scan the QR code and join the Nursing and Midwifery Sustainability Network to discuss ideas and work together to improve the environmental impact of nursing

PRACTICAL ADVICE FOR PRACTITIONERS

For patients experiencing incontinence issues alongside compromised skin integrity, a comprehensive, multi-faceted approach is essential. This should include gentle skin cleansing, use of barrier products and selection of appropriate continence aids. Effective management also involves addressing underlying medical conditions and encouraging mobility to support overall skin health and recovery. Ross et al (2023) report that a 2-hourly schedule of asking the patient discreetly if they would like help to go to the toilet provides both social interaction and an improvement in continence.

There remains a tendency to focus on managing the symptoms of incontinence, particularly skin care, rather than addressing the underlying causes. Asking personal or sensitive questions about continence is often avoided, but this is a barrier that must be overcome to provide more effective, person-centred care.

Effective communication is crucial when discussing incontinence and skin integrity issues, due to the sensitive nature of these topics and their impact on a person's wellbeing. Bowel movements, for example, are a sensitive subject that many people consider taboo and rarely talk about openly. Many older people do not voluntarily raise continence issues, often feeling embarrassment or believing incontinence to be a normal part of ageing (Vethanayagam et al, 2017).

Remember, as with any clinical skill, the more you practice these conversations, the easier and more natural they become.

Changing the narrative is essential to breaking the taboo and encouraging open dialogue. Tailor your approach depending on the setting and patient, when working with older adults, as they may wake at night for reasons unrelated to bladder function (such as pain, anxiety, or medication side effects), which can make it harder to distinguish between nocturia and other causes of disturbed sleep. See **Box 9** for effective communication tips. Equally, skin integrity must be considered holistically: moisture-associated skin damage (MASD) should be recorded and reported alongside pressure ulcers. Inconsistent reporting obscures true prevalence and hinders quality improvement (NHS Improvement, 2018). To ensure accountability and progress, MASD should be systematically documented, analysed, and addressed with the same rigour as pressure ulcers. Embedding MASD within patient safety frameworks ensures visibility, accountability, and measurable improvement.

Education is key

It is essential that healthcare professionals and carers receive mandatory training in continence care, as it plays a vital role in delivering high-quality support and upholding the dignity and wellbeing of those in their care. This training should be made mandatory rather than optional to enhance care standards and reduce the risk of harm. The UK Continence Society have specified standards for competency linked to training support requirements: https://ukcs.uk.net/Policy_Documents.

Since the COVID-19 pandemic, many continence clinics have closed, and most services now operate within community settings. However, access is inconsistent and varies widely depending on location. As a result, corporate providers are increasingly stepping in to support the NHS, filling critical service gaps. Ultimately, education is key.

Many cases of incontinence can be improved or managed through simple lifestyle changes, from encouraging sensible fluid intake to promoting pelvic floor exercises. Tools such as the Squeezy NHS app can support users by providing guidance and helpful reminders to stay consistent with their pelvic floor exercise routines.

Box 9. Effective communication tips

- Use a non-judgemental, conversational tone
- Use simple language and avoid jargon/medical terminology
- Ensure privacy and that conversations cannot be overheard
- Allow plenty of time; it may take up to an hour to obtain a full history from the person being assessed.

CONCLUSION

Skin damage linked to incontinence can have a profound impact on both mental health and quality of life, yet these aspects are often underexplored in practice. True progress requires moving beyond viewing skin and continence care as separate issues. Dual, integrated assessments should become standard, ensuring that skin integrity and continence are considered together rather than in isolation. The reasons behind the current separation, whether due to knowledge gaps, time pressures or system limitations, must be questioned.

Trigger questions, too, should evolve to reflect this integration, bridging skin and continence assessments rather than keeping them apart. Models of integrated practice already exist, with roles spanning tissue viability, stoma, and continence care demonstrating the value of a joined-up approach. The next step is to embed such integration into routine care pathways, supported by education, system change, and leadership commitment.

If we continue to treat continence and skin as parallel but separate concerns, opportunities for prevention, improved outcomes, and enhanced quality of life will be lost. The challenge, and opportunity, is to ask: why are we not fully integrating them already, and what will it take to make this the norm?

Scan the QR to view brands of skin protection products

Scan the QR to view the Bladder and Bowel Forum that provides professional support to Royal College of Nursing members working in the field of Bladder and Bowel Care

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