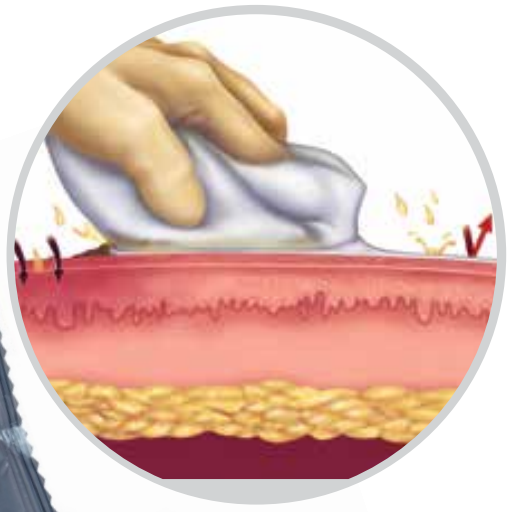
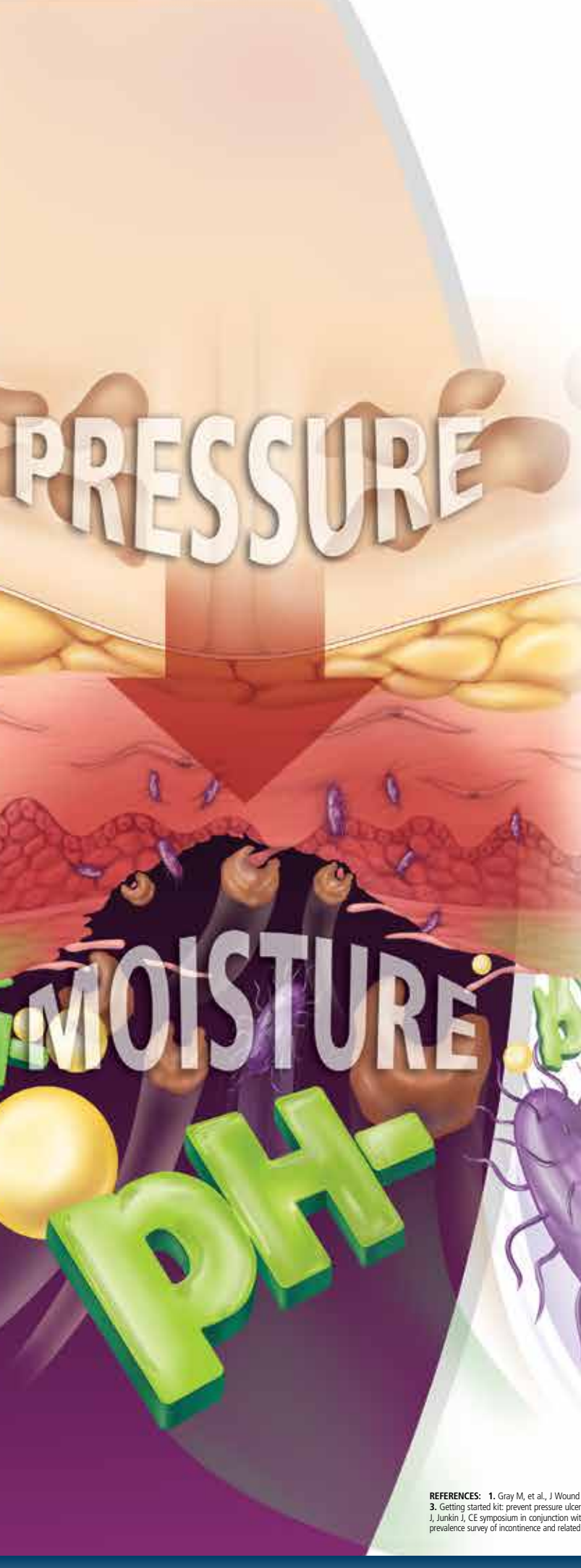
ISKUS HEALTH
IMPROVING PATIENT OUTCOMES

PREVENTING SKIN BREAKDOWN

Comfort Shield® Barrier Cream Cloths



SAGE PRODUCTS



Incontinence-Associated Dermatitis (IAD): a risk factor for pressure ulcers

IAD is defined as "an inflammation of the skin that occurs when urine or stool comes into contact with perineal or perigenital skin."[1] IAD is also a major risk factor for pressure ulcers.[2]

IAD is often grouped with pressure ulcers, but they are not one and the same. A pressure ulcer is defined as "any lesion caused by unrelieved pressure resulting in damage of underlying tissue."[3] Essentially, skin damage from a pressure ulcer occurs from the inside out, but IAD starts on the surface and works inward. Therefore, "IAD should be distinguished from wounds caused by differing etiologies, such as full-thickness wounds (caused by pressure and shear) or linear lesions (caused by a skin tear)."[1]

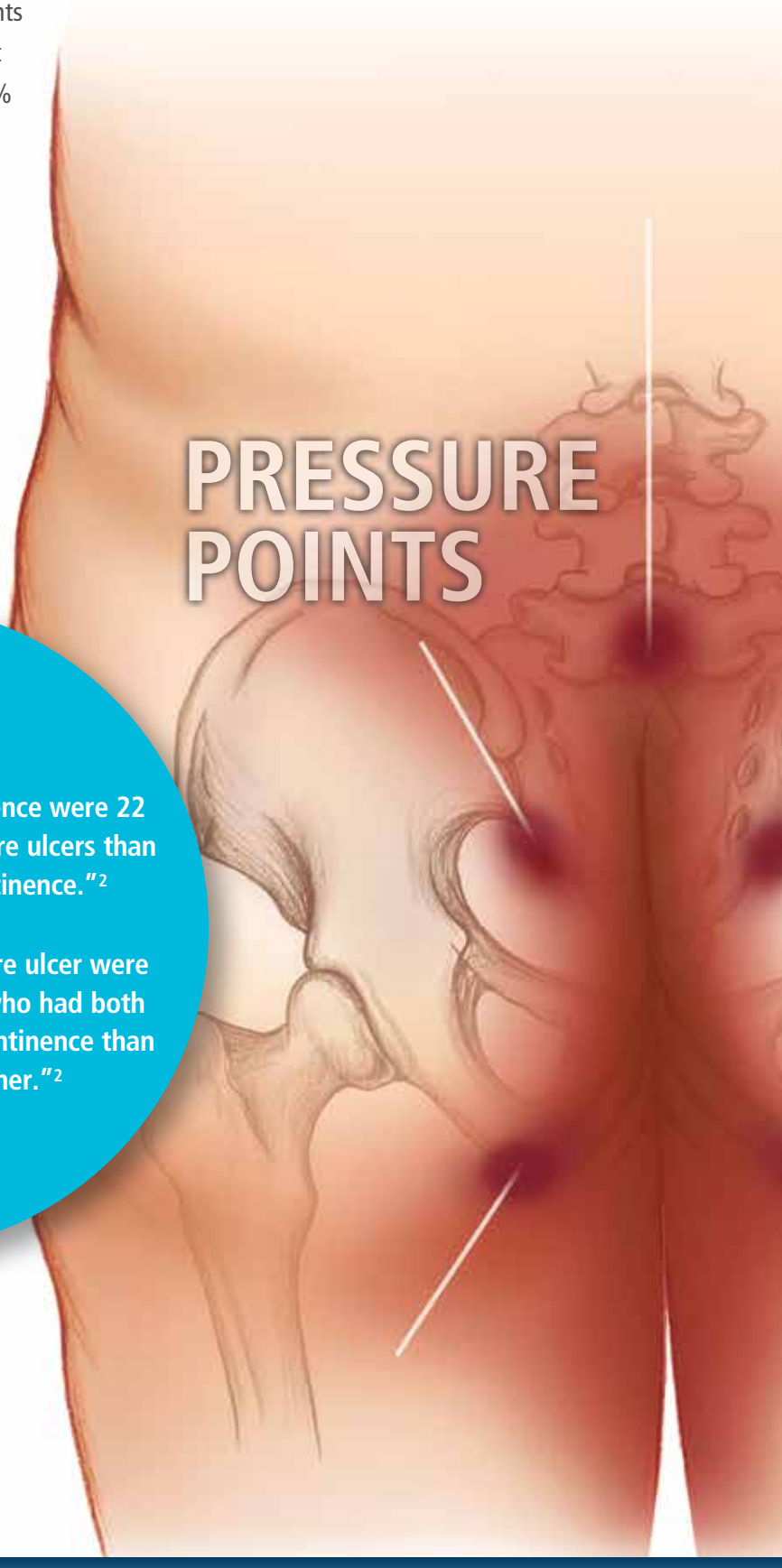
IAD risk factors:[1]

- Fecal incontinence
- Frequency of incontinence
- Poor skin condition
- Pain
- Poor skin oxygenation
- Fever
- Compromised mobility
- Double (urinary and fecal) incontinence
- Tissue tolerance impairments
- Moisture
- Alkaline pH

REFERENCES: **1.** Gray M, et al., J Wound Ostomy Continence Nurs. 2007 Jan-Feb;34(1):45-54. **2.** Maklebust J, Magnan MA, Adv Wound Care. Nov 1994;7(6):25, 27-8, 31-4 passim. **3.** Getting started kit: prevent pressure ulcers, how-to guide. Protecting 5 Million Lives From Harm Campaign, Institute for Healthcare Improvement. 2006 Dec. **4.** Gray M, Lerner-Selekof J, Junkin J, CE symposium in conjunction with 2006 WOCN Conference, Minneapolis, MN, 2006 June. **5.** Junkin J, Moore-Lisi G, Lerner-Selekof J, What we don't know can hurt us: pilot prevalence survey of incontinence and related perineal skin injury in acute care. Poster presented at the Clinical Symposium on Advances in Skin and Wound Care (ASWC), Las Vegas, NV, 2005 Oct.

IAD prevalence

Studies at long-term care facilities show IAD prevalence can range from 5.6% to 50%, while incidence rates range from 3.4% to 25%.[1] In acute care, one 976-patient study found 20.3% of patients were incontinent.[4,5] IAD prevalence for incontinent patients was 54% at three hospitals, affecting 11% of the general patient population.[4,5]



"…Patients with fecal incontinence were 22 times more likely to have pressure ulcers than patients without fecal incontinence."[2]

"…The odds of having a pressure ulcer were 37.5 times greater in patients who had both impaired mobility and fecal incontinence than in patients who had neither."[2]

Inadequate barrier application: a gateway to Incontinence-Associated Dermatitis (IAD)

Multiple steps associated with traditional methods of incontinence care often mean barrier application is overlooked. Protecting the skin of incontinent patients is just as important as cleansing and moisturizing,[1] and failure to apply a proper barrier can lead to Incontinence-Associated Dermatitis (IAD), a known risk factor for pressure ulcers.[2] One study shows 54% of incontinent patients suffered from IAD, while 21% had two or more peri-skin injuries.[3,4]

Barriers severely underutilized

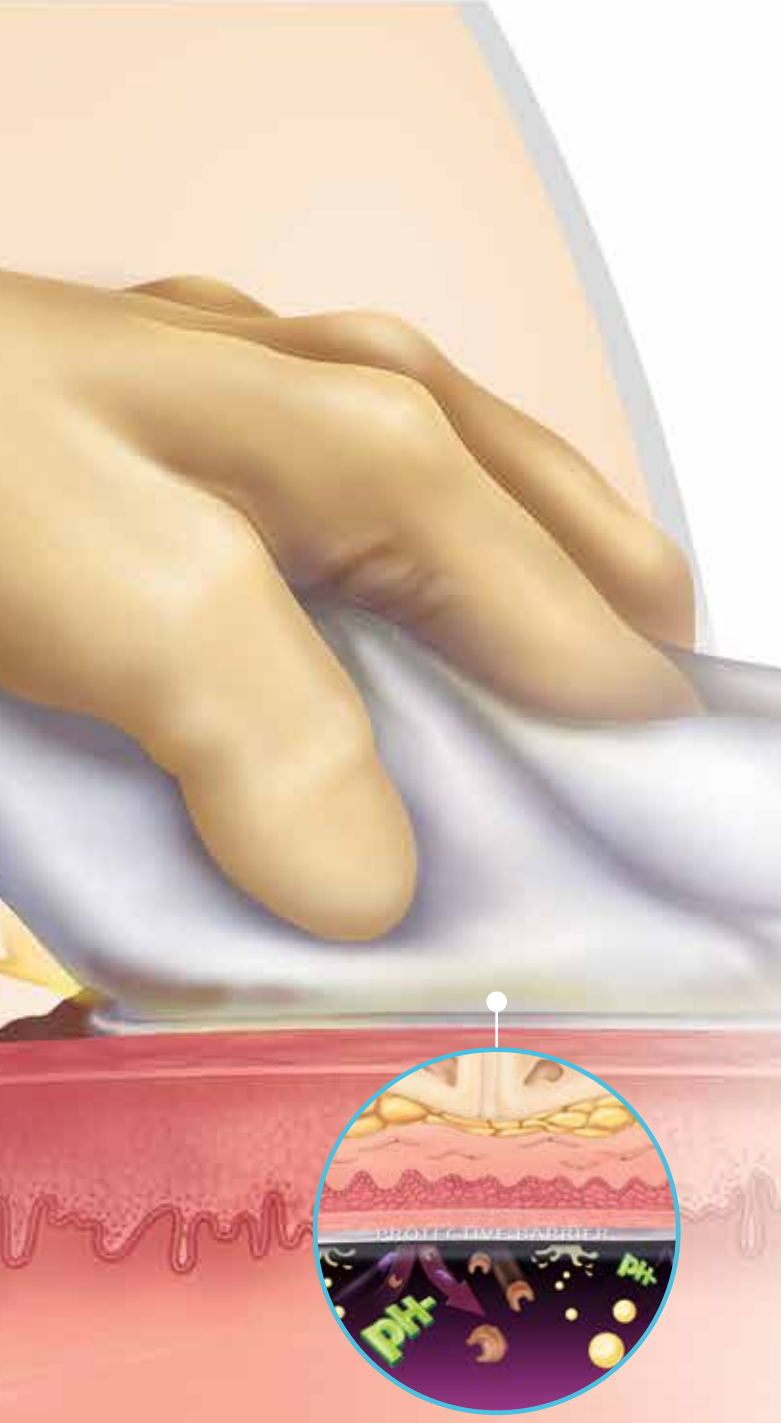
Compliance to a comprehensive protocol can help prevent skin injuries.[5,6] But tubed barriers can make compliance difficult.

- A study of 76 protocols found barriers should cost 23.5 cents for each application, but facilities actually spend only **10 cents per day per incontinent patient**.[7]

REFERENCES: **1.** Haugen V, Gastroenterology Nursing, 1997;20(3):87-90. **2.** Maklebust J, Magnan MA, Adv Wound Care. Nov 1994;7(6):25, 27-8, 31-4 passim. **3.** Gray M, Lerner-Selekof J, Junkin J, CE symposium in conjunction with 2006 WOCN Conference, Minneapolis, MN, 2006 June. **4.** Junkin J, Moore-Lisi G, Lerner-Selekof J, What we don't know can hurt us: pilot prevalence survey of incontinence and related perineal skin injury in acute care. Poster presented at the Clinical Symposium on Advances in Skin and Wound Care (ASWC), Las Vegas, NV, 2005 Oct. **5.** Lyder CH, et al., Ost/Wound Mgmt Apr 2002;48(4):52-62. **6.** Clever K, et al., Ost/Wound Mgmt Dec 2002;48(12):60-7. **7.** Nix D, Ermer-Seltun, J Ost/Wound Mgmt Dec 2004;50(11):32-41.

Comfort Shield® Barrier Cream Cloths deliver proven IAD prevention and treatment

Comfort Shield Barrier Cream Cloths provide easy, all-in-one incontinence care. Each premoistened, disposable cloth delivers one-step perineal cleansing, moisturizing and deodorizing—all while treating and protecting skin with 3% dimethicone. The barrier is in the cloth, so you can be assured it is applied every time. Plus, our Peri Check™ Guide helps promote early identification of IAD through increased communication with staff.



One-step: Clean + treat + protect

Shield Barrier Cream Cloths are soft, skin-friendly and guarantee barrier application every time they're used. Keeping the skin protected means IAD and other skin problems can be prevented.

PROVEN IAD TREATMENT—SEE THE DIFFERENCE![1]

72-year-old patient with severely denuded, blistered skin and extreme pain from incontinence.

After only 3 days using Shield Barrier Cream Cloths, patient's skin vastly improved; no discomfort.

REFERENCES: **1.** Sluser S, Consistency the key for treating severe perineal dermatitis due to incontinence. Poster presented at Clinical Symposium on Advances in Skin and Wound Care (ASWC), Las Vegas, NV, 2005 Oct.

PROFESSIONAL GUIDELINES

2009 EUROPEAN PRESSURE ULCER ADVISORY PANEL AND NATIONAL PRESSURE ULCER ADVISORY PANEL[1]

Prevention and Treatment of Pressure Ulcers

Skin Care

12. "Protect the skin from exposure to excessive moisture with a barrier product in order to reduce the risk of pressure damage."

GLOBAL IAD EXPERT PANEL[2]

Prevention and Management of IAD

"After cleansing, skin should be protected to prevent IAD".

"The performance of an individual product is determined by the total formulation and not just the skin protecting ingredient(s)".

"Continence care wipes (i.e. 3-in-1 products) may have the advantage of simplifying care by combining products to reduce the number of steps involved, saving clinician/ caregiver time and potentially encouraging adherence to the regimen".

"A skin cleanser with a pH range similar to normal skin is preferred over traditional soaps".

2010 WOCN GUIDELINE FOR PREVENTION AND MANAGEMENT OF PRESSURE ULCERS MANAGING INCONTINENCE[3]

"Combined products can be used to save time and make providing perineal care easier for the care giver. Combined products include moisturizing cleansers, moisturizer skin protectant creams, and disposable washcloths that incorporate cleansers, moisturizers, and skin protectants into a single product." (Beeckman, et al., 2009)

REFERENCES: **1.** European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: quick reference guide. Washington DC: National Pressure Ulcer Advisory Panel; 2009. **2.** Beeckman, D et al., "Evidence-based Practice in Wound Care: Toward Addressing Our Knowledge Gaps." The Journal of Rehabilitation Research and Development JRRD 48.3 (2011): Vii. Incontinence-Associated Dermatitis: Moving Prevention Forward. Wounds International. Web. 21 Jan. 2015. **3.** Wound Ostomy and Continence Nurses Society. Guideline for Prevention and Management of Pressure Ulcers; June 2010. **4.** Beeckman D, et al., A 3-in-1 perineal care washcloth impregnated with dimethicone 3% versus water and pH neutral soap to prevent and treat incontinence-associated dermatitis. Journal of Wound, Ostomy and Continence Nursing, Nov/Dec 2011; 38(6). **5.** Pukiova I. Clean, Moisturise and Protect! A Standardization Approach to Preventing Incontinence-Associated Dermatitis. Poster presented at EWMA 2015; London, UK; 13-15 May, 2015. **6.** Heinemann K. Effectiveness of a clinically proven 3-in-1 perineal care washcloth in the prevention of IAD on a geriatric unit. Poster presented at EPUAP 2015; Ghent, Belgium; 16-18 September. **7.** Hall K, Clark R, Henderson K, Implementing nurse-driven interventions to improve incontinence-associated dermatitis and hospital-acquired pressure ulcers. Poster presented at Clinical Symposium on Advances in Skin & Wound Care, Sept 2011.

Proven clinical outcomes

Randomized controlled trial proves effectiveness

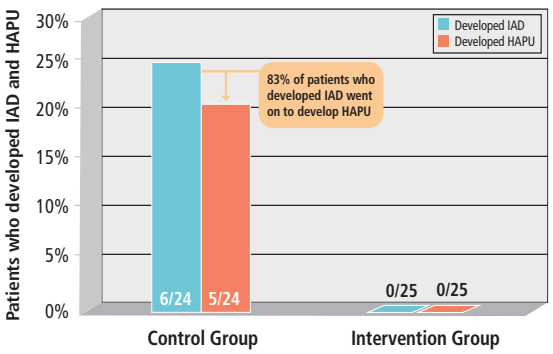
A 4-month study of 464 nursing home residents evaluated use of Shield Barrier Cream Cloths versus water and pH neutral soap. Residents using Shield saw a reduction in the prevalence of IAD from 22% to 8%, while residents using soap and water saw IAD prevalence increase from 23% to 27%. The study also found a decrease in IAD severity in residents using Shield, while no improvement was seen with soap and water.[4]

A UK study found a 54% reduction in IAD after implementing the Shield Barrier Cream Cloths.[5]

A German study found a 57% reduction in IAD after implementing the Shield Barrier Cream Cloths.[6]

- In a study on a high-risk patient population, patients receiving an intervention that included Shield Barrier Cream Cloths following each incontinence episode had an IAD rate of zero versus patients using multiple products who had an IAD rate of 25%. Patients using Shield had a rate of zero hospital-acquired pressure ulcers versus a rate of 83% for those using multiple products.[7]

DEVELOPMENT OF IAD AND HAPU



Comfort Comfort Shield Barrier Cream Cloths are strong and absorbent. They gently cleanse while delivering a proven layer of barrier protection.

Comfort Shield®

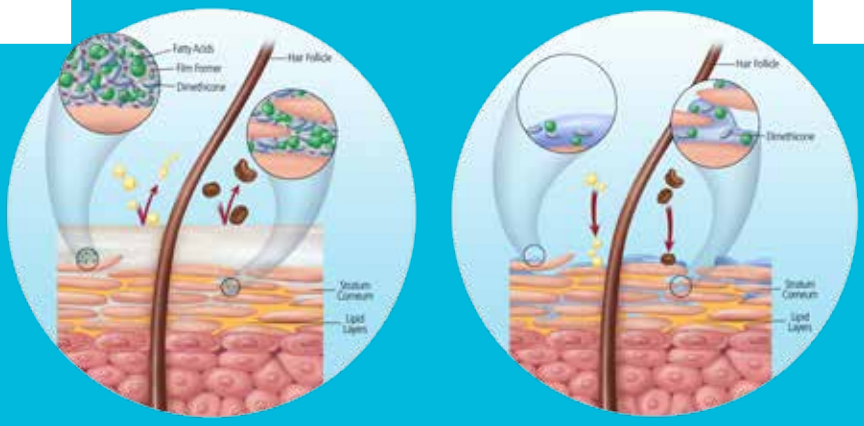
Barrier Cream Cloths
with Dimethicone

Clinically proven to help prevent IAD and HAPU when used as part of a standardized incontinence cleanup intervention/protocol.

The all-in-one skin cleansing, moisturizing, deodorizing, treatment and barrier protection with ever use that helps maximize compliance to incontinence care protocols.

- Proven barrier protection. 3% dimethicone formula was proven equivalent to traditional tube barrier creams by Northwestern University's Department of Dermatology.[1]
- Hypoallergenic, gentle and non-irritating.
- Breathable, transparent dimethicone barrier makes skin assessment easy.
- Allows the use of other products such as anti-fungals without removing dimethicone barrier.
- Helps eliminate mess of standard zinc oxide and petroleum-based barriers; makes each cleanup easier.
- Helps treat and prevent perineal dermatitis; helps seal out wetness.
- Convenient tubs contain 24 cloths for extended use.

Not all skin barrier cloths are equal



Comfort Shield thick emulsion **Vs.** **Others**

A study designed to test the effectiveness of incontinence barriers found that Comfort Shield **"significantly outperformed all other products."** Comfort Shield allowed 3-5 times less artificial urine to pass through than the leading competitors.[2]

Barrier effectiveness and product performance characteristics should be considered when choosing skin protectant products designed for barrier effect.

REFERENCES: **1.** West D, Northwestern Univ Dept of Dermatology, Chicago, IL, Feb 2000. **2.** West D, Comparison of Skin Barrier Effectiveness for Products Containing Dimethicone. Poster presented at: Symposium on Advanced Wound Care, Fall 2014, Oct. 16-18; Las Vegas, NV.

Maximize compliance

Help meet IHI recommendations to keep supplies at the bedside of at-risk incontinent patients[1]

Implementing Shield Barrier Cream Cloths and providing bedside access enhanced staff compliance to an incontinence care protocol and resulted in a near-zero rate of HAPUs. The rate was maintained over time and resulted in significant cost savings.[2]

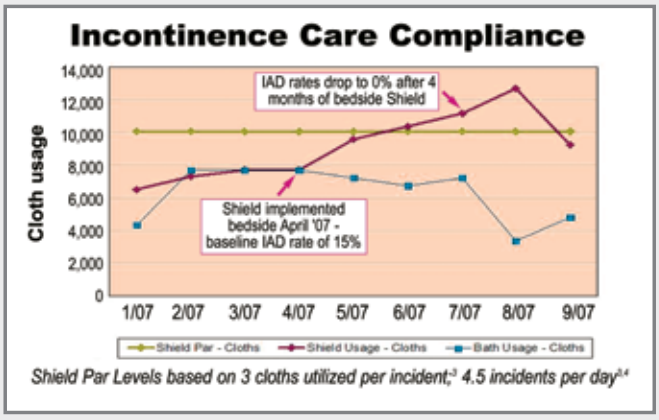
- Point-of-use access. 24-packs, 8-pack, and 3-pack all compatible with Shield Barrier Station.

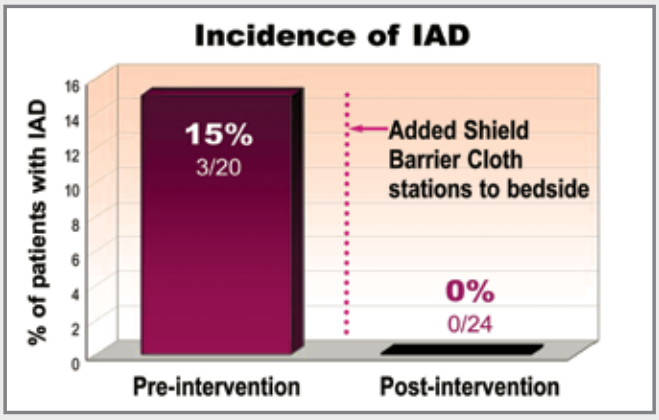
Help meet
IHI recommendations
to keep supplies
at the bedside
of at-risk incontinent patients[1]

REDUCE IAD, IMPROVE COMPLIANCE

Adding Shield Barrier Station reduced one facility's IAD incidence to 0% and boosted compliance to 97%!*

*Schmitz T, Location, location, location: incontinence care supplies at the bedside. Nursing Management, Dec 2010, 45-49. CE available.





REFERENCES: **1.** Getting started kit: prevent pressure ulcers, how-to guide. Protecting 5 Million Lives from Harm Campaign, Institute for Healthcare Improvement, 2006 Dec. **2.** Krapfl L, Improved access to incontinence care products leads to a reduction in facility acquired pressure ulcers. Poster presented at 42nd Annual WOCN Conference, June 12-16, 2010.

Peri Check™ Guide

Promote early identification of a major pressure ulcer risk factor

Comfort Shield® Barrier Cream Cloths feature Peri Check Guide peel-and-stick labels to facilitate daily skin inspection. They empower staff to observe and report skin issues to the patient's nurse, and promote rapid response through early identification of skin breakdown and Incontinence-Associated Dermatitis (IAD), a known risk factor for pressure ulcers.

In one study, Peri Check helped reduce pressure ulcers to zero in a facility.[2] The same study found that Peri Check improved non-licensed staff's knowledge about pressure ulcer development and "resulted in enhanced communication between non-licensed staff and RNs."

2009 EUROPEAN PRESSURE ULCER ADVISORY PANEL AND NATIONAL PRESSURE ULCER ADVISORY PANEL[3]

Prevention and Treatment of Pressure Ulcers

Skin Assessment

3. "Inspect skin regularly for signs of redness in individuals identified as being at risk of pressure ulceration."

7. "Document all skin assessments, noting details of any pain possibly related to pressure damage."

JOINT COMMISSION 2009 National Patient Safety Goals[4]

Improve Staff Communication

"Create steps for staff to follow when sending patients to the next caregiver. The steps should help staff tell about the patient's care. Make sure there is time to ask and answer questions."

* Excerpts from the Joint Commission 2009 Hosp Nat Pt Safety Goals.

IHI 5 MILLION LIVES CAMPAIGN[5]

2. Reassess Risk for All Patients Daily

"Adapt documentation tools to prompt daily risk assessment, documentation of findings, and initiation of prevention strategies as needed."*

3. Inspect Skin Daily

"Educate all levels of staff to inspect the skin any time they are assisting the patient … Upon recognition of any change in skin integrity, notify staff so that appropriate interventions can be put in place."

*Processes that "can be put in place to ensure daily inspection of the skin."

REFERENCES: **1.** Federal Register, Vol. 72 No. 162, 2007 Aug; 47201-47205. **2.** Carr D, Benoit R, The role of interventional patient hygiene in improving clinical and economic outcomes. Advances in Skin and Wound Care, Feb 2009 22 (2): 74-78 **3.** European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: quick reference guide. Washington DC: National Pressure Ulcer Advisory Panel; 2009. **4.** 2009 Hospital/Critical Access Hospital National Patient Safety Goals. Joint Commission, 2009. **5.** Getting started kit: prevent pressure ulcers, how-to guide. Protecting 5 Million Lives from Harm Campaign, Institute for Healthcare Improvement, 2006 Dec.

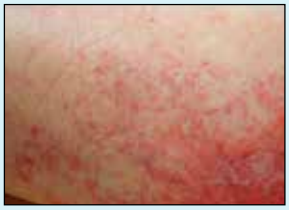
IAD-IT

INCONTINENCE-ASSOCIATED DERMATITIS INTERVENTION TOOL (IAD-IT)

Skin Care for Incontinent Persons

The #1 priority is to address the cause of incontinence. Use this tool until incontinence is resolved.

1. Cleanse incontinence ASAP and apply barrier.
2. Document condition of skin at least once every shift in nurse's notes or per organization's policy for documenting skin breakdown.
3. Notify primary care provider when skin injury occurs and collaborate on the plan of care.
4. Consider use of external catheter or fecal collector.
5. Consider short term use of urinary catheter only in cases of IAD complicated by secondary infection.

	DEFINITION	INTERVENTION
HIGH-RISK	Skin is not erythematous or warmer than nearby skin but may show scars or color changes from previous IAD episodes and/or healed pressure ulcer(s). Person not able to adequately care for self or communicate need and is incontinent of liquid stool at least 3 times in 24 hours.[1]	1. Use a disposable barrier cloth containing cleanser, moisturizer and protectant.[2] 2. If barrier cloths not available, use acidic cleanser (6.5 or lower), **not soap** (soap is too alkaline); cleanse gently (soak for a minute or two – **no scrubbing**); and apply a protectant (ie: dimethicone, liquid skin barrier or petrolatum). 3. If briefs or underpads are used, allow skin to be exposed to air. Use containment briefs only for sitting in chair or ambulating – not while in bed. 4. Manage the cause of incontinence: a) Determine why the patient is incontinent. Check for urinary tract infection, b) Consider timed toileting or a bladder or bowel program, c) Refer to incontinence specialist if no success.[3]
EARLY IAD 	Skin exposed to stool and/or urine is dry, intact, and not blistered, but is pink or red with diffuse (not sharply defined), often irregular borders. In darker skin tones, it might be more difficult to visualize color changes (white or yellow color) and palpation may be more useful. Palpation may reveal a warmer temperature compared to skin not exposed. People with adequate sensation and the ability to communicate may complain of burning, stinging, or other pain.	
MODERATE IAD 	Affected skin is bright or angry red – in darker skin tones, it may appear white, yellow, or very dark red/purple. Skin usually appears shiny and moist with weeping or pinpoint areas of bleeding. Raised areas or small blisters may be noted. Small areas of skin loss (dime size) if any. This is painful whether or not the person can communicate the pain.	↑ ***Include treatments from box above plus:*** 5. Consider applying a zinc oxide-based product for weepy or bleeding areas 3 times a day and whenever stooling occurs. 6. Apply the ointment to a non-adherent dressing (such as anorectal dressing for cleft, Telfa for flat areas, or ABD pad for larger areas) and gently place on injured skin to avoid rubbing. Do not use tape or other adhesive dressings. 7. If using zinc oxide paste, **do not scrub the paste completely off** with the next cleaning. Gently soak stool off top then apply new paste covered dressing to area. 8. If denuded areas remain to be healed after inflammation is reduced, consider BTC ointment (balsam of peru, trypsin, castor oil) but remember balsam of peru is pro-inflammatory. 9. Consult WOCN if available.
SEVERE IAD 	Affected skin is red with areas of denudement (partial-thickness skin loss) and oozing/bleeding. In dark-skinned persons, the skin tones may be white, yellow, or very dark red/purple. Skin layers may be stripped off as the oozing protein is sticky and adheres to any dry surface.	↑ ***Include treatments from box above plus:*** 10. Position the person semiprone for 30 minutes twice a day to expose affected skin to air. 11. Consider treatments that reduce moisture: low air loss mattress/overlay, more frequent turning, astringents such as Domeboro soaks. 12. Consider the air flow type underpads (without plastic backing).
FUNGAL APPEARING RASH 	This may occur in addition to any level of IAD skin injury. Usually spots are noted near edges of red areas (white or yellow areas in dark skinned patients) that may appear as pimples or just flat red (white or yellow) spots. Person may report itching which may be intense.	Ask primary care provider to order an anti-fungal powder or ointment. Avoid creams in the case of IAD because they add moisture to a moisture damaged area (main ingredient is water). In order to avoid resistant fungus, use zinc oxide and exposure to air as the first intervention for fungal-appearing rashes. If this is not successful after a few days, or if the person is severely immunocompromised, then proceed with the following: 1. If using powder, lightly dust powder to affected areas. Seal with ointment or liquid skin barrier to prevent caking. 2. Continue the treatments based on the level of IAD. 3. Assess for thrush (oral fungal infection) and ask for treatment if present. 4. For women with fungal rash, ask health care provider to evaluate for vaginal fungal infection and ask for treatment if needed. 5. Assess skin folds, including under breasts, under pannus, and in groin. 6. If no improvement, culture area for possible bacterial infection.

1. Bliss DZ, Zehrer C, Savik K, et al. Incontinence-associated skin damage in nursing home residents: a secondary analysis of a prospective, multicenter study. Ostomy Wound Manage. 2006;52:46–55. 2. Institute for Healthcare Improvement. Prevent Pressure Ulcers: How-To Guide. May 2007. Available at: http://www.ihi.org/nr/rdonlyres/5abab051-93b3-4d88-ae19-be88b7d96858/0/pressureulcerhowtoguide.doc, accessed 10/21/07. 3. Gray M, Bliss DB, Ermer-Seltun J, et al. Incontinence-associated dermatitis: a consensus. J Wound Ostomy Continence Nurs. 2007;34:45-54.

INCONTINENCE CARE

BARRIER CREAM CLOTHS

COMFORT SHIELD® BARRIER CREAM CLOTHS
with dimethicone

24-pack
peel and reseal package
large size cloths

18 packages/case
Reorder #7526-X

CE 0086

COMFORT SHIELD® BARRIER CREAM CLOTHS
with dimethicone

8-pack
peel and reseal package
large size cloths

48 packages/case
Reorder #7905-X

CE 0086

COMFORT SHIELD® BARRIER CREAM CLOTHS
with dimethicone

3-pack
easy-tear package
large size cloths

90 packages/case
Reorder #7453-X

CE 0086

COMFORT SHIELD® BARRIER STATION
with removable adhesive strips
for wall-mounting near bedside

24 stations/case
Reorder #7599

HARDWARE

CART

1 Cart/case
Reorder #7920

12-COUNT WARMER

1 Warmer/case
Reorder #7937-X

c UL us CLASSIFIED CE

28-COUNT WARMER

1 Warmer/case
Reorder #7939-X

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