Moisture Associated Skin Damage (MASD) Pathway A

Assessment

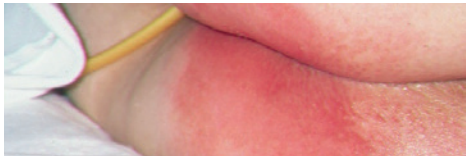
Carry out a full holistic assessment.
Observe for changes in skin tones, red, pink for paler skin tones or paler, darker, purple, dark red or yellow in patients with dark skin tones.
Consider: mobility, nutritional status, personal hygiene, sensitivities.
Moisture specific: continence, excessive perspiration, skin folds.
Patients with moisture lesions are at high risk of developing pressure ulcers therefore follow the pressure ulcer prevention pathway and trust policy.

Is the skin damage caused by:

1 Incontinence Associated Dermatitis (IAD)

Source of MASD: Urine and / or faeces

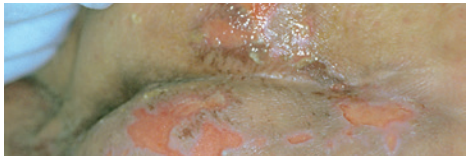
Erythema, inflammation and maceration, may cause erosion of the skin, as a result of exposure to urine and faeces (this may present as weeping skin)



2 Intertriginous Dermatitis (MASD within skin folds)

Source of MASD: Perspiration +/- friction

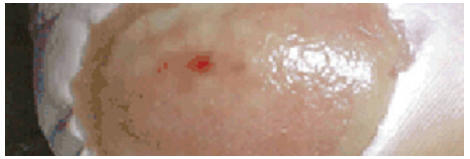
Mild, mirror image erythema on each side of the skin fold. May have damaged or weeping skin as result of exposure to chronic perspiration and possibly friction



3 Periwound Dermatitis

Source of MASD: Exudate +/- adhesive skin stripping

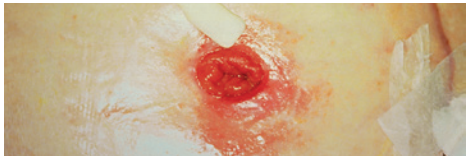
Erythema and inflammation of skin within 4cm of wound edge, may show as maceration or erosion of the skin



4 Peristomal and Peri-tube Moisture Associated Dermatitis

Source of MASD: Bodily fluids e.g. urine, faeces, gastric

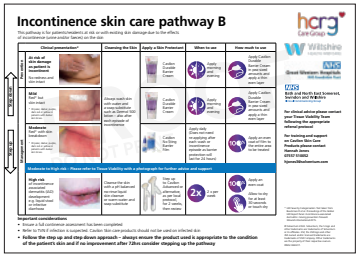
Inflammation and erosion of skin related to moisture from bodily fluids such as urine, faeces, gastric fluids and saliva



Management

1 Incontinence Associated Dermatitis (IAD)

- Ensure a full continence assessment has been completed
- Refer to Incontinence Skin Care Pathway



2 Intertriginous Dermatitis (MASD within skin folds)

- Examine entire area of the skin folds, including base
- Gently lift the fold without creating or exacerbating traction and fissure formation
- Avoid products containing chlorhexidine gluconate, alcohol, or perfumes as these can be absorbed by damaged skin
- Primary treatment strategy should be to reduce moisture to the skin
- Cavilon No Sting Barrier Film to be applied every 24 hours. Frequency can be reduced to 48–72 hours in line with skin improvement
- If symptoms persist, contact TVN service and consider Cavilon Advanced


3 Periwound Dermatitis

- Refer to exudate pathway for choice of dressing and consider frequency of dressing change
- Consider the potential for wound infection
- If the wound is not healing or progressing, further investigation may be required to establish co-morbidities
- Protect peri-wound area from further breakdown, maceration and adhesive trauma. Apply Cavilon No Sting Barrier Film at every dressing change or as per protocol
- If symptoms persist, contact TVN service and consider Cavilon Advanced


4 Peristomal and Peri-tube Moisture Associated Dermatitis

- Consult Stoma Nurse specialist for guidance on appliances
- Protect peri-stomal/peri-tube area from further breakdown, maceration and adhesive trauma. Apply Cavilon No Sting Barrier Film at every pouch/appliance change or as per protocol
- Alternatively step up to Cavilon Advanced if there is high risk of damage or extensive skin loss


2 3 4 Once skin condition has resolved, discontinue use of Cavilon No Sting Barrier Film unless patient continues to be at high risk of skin breakdown

For clinical advice please contact your Tissue Viability Team following the appropriate referral protocol
For training and support on Cavilon Skin Care Products please contact Hannah Jones, 07557 510052, hjones3@solventum.com

Community Tissue Viability, July 2024.