Advancing Prevention: Key Insights from the 2026 Best Practice Update on Incontinence-Associated Dermatitis

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Incontinence-associated dermatitis (IAD) is an inflammation of the skin that occurs from contact with urine and/or feces. Its severity varies, ranging from erythema—with or without loss of skin integrity—to infection. Lack of prevention and effective management often leads to deeper tissue damage.[1] Since the 2015 publication of a pivotal document addressing IAD prevention,[2] significant progress has been made toward implementing best practice principles.[3] Despite these achievements, misdiagnosis of IAD and pressure ulcers/injuries remains a significant problem.[4]

Responding to a growing body of evidence and insights from healthcare professionals (HCPs) worldwide, members of an international expert panel have recently published a 2026 update to synthesize the latest evidence regarding IAD, and translate it into practical, clinically relevant guidance to support frontline clinicians, inform quality improvement initiatives and research, and improve patient outcomes.

The 2026 update[5] is significantly more extensive than the 2015 consensus document.[2] Notably, the update presents 40 implementation-ready Best Practice Statements in contrast to the narrative guidance of the earlier version. Key advancements detailed in the 2026 update, compared to the original 2015 document, are shown below.

Key Revisions to the 2026 Consensus Document Update Compared to the Original 2015 Publication

- A strong focus on IAD prevention as a measurable, system-level practice of accountability
- An emphasis on proactive rather than reactive organization-wide approaches to IAD prevention
- A recognition of IAD as a preventable harm, quality indicator and system-level safety issue, as opposed to strictly a clinical measure
- The importance of integrating pressure injury prevention into IAD prevention initiatives
- More comprehensive guidance on product selection, addressing durability, breathability, wash off resistance and cost effectiveness
- Clearer directives for organizational accountability and standardized implementation
- An expanded understanding of IAD risk factors beyond continence-related factors-now encompassing medication-related, physiology-related, cognition-related, and care-related factors
- Enhanced guidance on documentation, reassessment intervals, escalation procedures, and the use of standardized tools (Ghent Global IAD Tool [GLOBIAD] for classification, GLOBIAD-M for monitoring progression, and Minimum Data Set [MDS]-IAD for structured data capture)
- Increased attention on patient experience, dignity, pain management and equity
- Improved alignment of IAD prevention strategies with current healthcare priorities, including cost-effectiveness, sustainability, antimicrobial stewardship and the emerging role of digital and AI-enabled decision support systems

A summary of the recently published 2026 Best Practice Update[5] follows.

Understanding IAD

IAD is a type of moisture-associated skin damage (MASD) caused by prolonged contact with urine and/or feces, affecting perineal and adjacent areas.[6] It is essential to differentiate between IAD and moisture-associated skin damage, with IAD established as a specific subtype within the broader MASD framework.

The 2026 *IAD Moving Prevention Forward* consensus document outlines best practice statements to standardize terminology, simplify classification systems, improve recognition and management of IAD, and address this condition that can develop even in individuals who are continent.

Key points include:

- Consistent, standardized terminology for all subtypes of MASD to ensure effective diagnosis, documentation and treatment
- The need for clear treatment pathways and bundles that can be applied universally
- Effective IAD assessment and management in all patient populations, regardless of continence status

Etiology

Although IAD results primarily from skin barrier damage due to overhydration and/or elevation of skin surface pH, the condition can arise from a multitude of factors, necessitating comprehensive risk assessment and prevention strategies, especially for those with fecal exposure.[7] HCPs should recognize that repeated washing and vigorous drying can exacerbate IAD.

Prevalence and Incidence Etiology

There is variability in reported IAD prevalence and incidence due to differences in care settings, underlying rates of incontinence, patient case mix, and diagnostic criteria.[8, 9] Despite these inconsistencies, recent studies indicate that IAD is a widespread global health issue.[10-12] Prevalence refers to the proportion of individuals with a condition at a specific point or period, while incidence refers to the number of new cases that develop over a defined time period. HCPs must properly understand and apply the concepts of prevalence and incidence to ensure accurate data reporting.

Impact of IAD

IAD places a substantial burden on individuals receiving care, caregivers, HCPs and healthcare systems, leading to pain, discomfort, and increased care complexity.[13, 14] It can worsen quality of life and psychological well-being and is associated with chronic wounds and infections.[15] Proactive, preventive IAD management are essential components of a high-quality person-centered approach that acknowledges individual experiences.

IAD Contribution to Pressure Ulcer/Injury Development

The 2026 update[5] elaborates on the relationship between IAD and increased risk of pressure ulcers, secondary infection and morbidity.[16] Incontinence is a well-established risk factor for pressure ulcer/injury development and, in some populations, has been shown to approximately double the risk of pressure ulcer/injury.[17, 18] An integrated approach to risk assessment and prevention for both IAD and pressure injuries is essential. Best practice statements emphasize that IAD can occur independently of pressure injury-related risk factors and that pressure injuries may likewise develop in the absence of IAD.

Preventing IAD

IAD is largely preventable through proactive, systematic, and organization-wide strategies, rather than reactive treatments.[19] All HCPs should understand skin assessment principles, pathophysiology of incontinence and the multifactorial contributors to IAD. The presence of urinary and/or fecal incontinence should automatically trigger implementation of an evidence-based IAD prevention protocol, even in the absence of additional risk factors, with the aim of minimizing skin exposure to urine and feces and maintaining skin integrity. Preventing IAD involves optimizing continence, prompt gentle cleansing after each incontinence episode, proper skin protection, and routine review of prevention strategies.

The 2026 update[5] details specific risk factors, such as prolonged skin exposure to urine and/or feces, poorly designed or inappropriate absorbent or containment devices, excessive or inappropriate use of thick, occlusive skin protectant products, skin vulnerability, mobility issues, and care-related challenges.[20]

Recognizing and Classifying IAD

Accurate assessment and classification of IAD are critical, as its symptoms overlap with pressure-related skin damage and other conditions, including contact dermatitis, infection-related lesions (e.g. herpes simplex), or other moisture-related conditions. These diagnostic challenges contribute to under-recognition and misclassification in routine practice. The best practices document advises that, in cases when the etiology of erythema is uncertain, a standardized, evidence-based bundle addressing both IAD and pressure ulcer/injury prevention should be promptly implemented.[5] HCPs should be aware that reduction of moisture exposure is not possible by applying products that contain moisture components and are designed to increase hydration.

IAD Distribution

Depending on the extent of contact with urine and/or feces, IAD may affect large areas of skin, not just the skin of the perineum. It is important to consider the effects of gravity and the positions the patient favors, being sure to assess skin that may not be in direct contact with the source of urine and/or feces.

IAD Symptoms

The clinical presentation of IAD varies by skin tone and severity, with light skin typically showing erythema and dark skin exhibiting more subtle color changes. Affected areas usually have poorly demarcated borders and may present as patchy lesions or diffuse changes, with inflammation causing skin to feel warmer, firmer, or edematous. As IAD progresses, secondary skin changes such as vesicles, papules, and potential erosion of the epidermis may arise. Severe cases may result in partial or complete erosion of the epidermis, exposing a moist, weeping dermis.

IAD Classification and Monitoring

Comprehensive assessment of the skin and any wounds is essential in individuals presenting with IAD. The consensus document details use of the GLOBIAD tool which provides a standardized assessment approach, classifying IAD into categories based on severity.[21] Healthcare records should include dedicated

fields for skin assessment, diagnostic reasoning, IAD classification and the progression of IAD-related lesions.

IAD Reporting

Accurate and consistent documentation of clinical assessments and interventions is fundamental to continuity of care and to establish epidemiological indicators of care burden and effectiveness. Healthcare organizations should adopt standardized data collection approaches, including clinical photographs, to reduce documentation burden and minimize variability in the reporting of IAD.

IAD Management

Two key interventions essential for effective IAD management are: 1) managing exposure to urine and feces, and 2) implementing a structured skin care regimen. The skin care regimen to be performed daily or after each incontinence episode should prioritize gentle cleansing and proper drying, skin protection, and restoration when appropriate. Recommended are no-rinse, non-ionic or amphoteric skin cleansers with surfactants.

After cleansing, durable and breathable skin barrier products that resist wash-off and allow for ongoing skin inspection are preferred. Film-forming barrier products, such as formulations with cyanoacrylate tetrapolymer, can help maintain skin integrity by reducing moisture exposure, minimizing irritation from urine and feces, and supporting early identification of skin changes needing clinical intervention.[22]

Complications and Pain Management

The best practice update[5] notes that managing severe IAD involves skin damage that may present as weeping erosions and/or areas of partial skin denudement. In these cases, application of dressings that support moist wound healing may be appropriate to protect exposed tissue, manage exudate and promote epithelial repair.

Pain associated with IAD remains under-recognized and undertreated,[23] despite its potential to worsen skin damage through scratching and increased infection risk. Timely and appropriate pain management is therefore an essential component of comprehensive IAD care.

IAD Guidelines and Education

The consensus document[5] stresses the need for updated guidelines and educational programs for HCPs, patients, and caregivers to improve recognition and management of IAD. Emphasis is placed on developing rigorous educational interventions supported by validated assessment tools. Messaging that should be emphasized in all HCP and patient education programs is summarized.

Artificial Intelligence (AI) Tools in IAD Management

The update[5] acknowledges that artificial intelligence (AI) presents a promising avenue to address challenges in IAD management, from diagnosis to treatment planning.[24, 25] However, it advises that clinical judgment remains paramount when utilizing AI technologies, and that AI should never replace the clinical judgement of healthcare professionals in skin care.

Conclusions

The 2026 update[5] consolidates and advances evidence-based practices for IAD, aimed at improving patient outcomes through standardized care models. Recent advances in IAD research have substantially strengthened the evidence base and contributed to a more comprehensive, person-centered understanding of IAD.

Despite progress, challenges remain in achieving diagnostic accuracy and comprehensive education. Many HCPs remain insufficiently informed about the comparative effectiveness and safety of IAD-related products, including cleansers, skin barrier protectants and absorbent continence systems. A global effort is needed to transition from outdated practices to evidence-based recommendations to ensure effective prevention and management of IAD.

This summary encapsulates the main themes and best practices proposed in the original manuscript, highlighting the critical need for improved awareness and management of IAD in clinical settings. The original manuscript can be accessed at: https://woundsinternational.com/best-practice-statements/incontinence-associated-dermatitis-moving-prevention-forward-2/

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