

Nurses' Knowledge and Practice Gaps in Incontinence-Associated Dermatitis: Findings from a Cross-Sectional Survey

Citation: Zecca S, Zappulla M, Nicolosi B. "Nurses' Knowledge and Practice Gaps in Incontinence-Associated Dermatitis: Findings from a Cross-Sectional Survey" (2025) *International Journal of Wound Research* 1(2): 94-105. DOI: <https://doi.org/10.64115/ijwr-2025-37>

Received: September 11, 2025

Revised: December 8, 2025

Just accepted online: December 31, 2025

Published: December 31, 2025

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Data Availability Statement: All relevant data are within the paper and its Supporting Information files. This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination, and proofreading process, which may lead to differences between this version and the Version of Record.

Competing Interests: The author(s) declare(s) no conflict of interest.

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Abstract

Introduction. Incontinence-Associated Dermatitis (IAD) is an inflammatory condition of the perineal and perianal skin caused by prolonged contact with urine and feces. Despite its clinical impact, recognition and documentation remain inconsistent, with wide variability in diagnosis, prevalence, and treatment across care settings. This study aimed to provide a narrative overview of current evidence on IAD and to assess nurses' knowledge of its diagnosis, staging, and management across healthcare settings.

Methods. A descriptive cross-sectional observational study was conducted using an anonymous online questionnaire (Google Forms) developed from a literature review. The survey included 11 items on demographics, self-assessed competence, and objective knowledge. Data were collected from March to June 2025 via snowball sampling, with 186 nurses completing the questionnaire. Descriptive and comparative analyses were performed across care settings.

Results. Participants' ages ranged from 22 to 62 years (mean 41.7 ± 10.2), with an average of 15.4 ± 8.6 years of professional experience. About half felt inadequately prepared to manage IAD, while only 18% rated themselves as highly competent. Only 44% correctly distinguished IAD from pressure injuries. Barrier products, gentle hygiene, staff training, and proactive incontinence management were the most cited preventive strategies. Knowledge and tool use were higher in surgical and medical/oncology settings, while community, home care, and rehabilitation showed critical gaps. Adoption of standardized tools such as GLOBIAD was limited.

Discussion. IAD remains underrecognized and inconsistently managed across care settings. The mismatch between perceived and actual competence, together with low use of standardized assessment tools, may contribute to misdiagnosis, delayed treatment, and suboptimal prevention. Structured, context-specific educational programs and wider implementation of tools such as GLOBIAD are essential to enhance prevention, support accurate documentation, and ultimately improve patient outcomes.

Keyword: Incontinence-associated Dermatitis, Urinary Incontinence, Fecal Incontinence, Moisture-Associated Skin Damage, Skin Integrity

Introduction

Incontinence-Associated Dermatitis (IAD) is an inflammatory condition of the perineal and perianal regions caused by prolonged skin contact with urine and feces, and is classified as a form of Moisture-Associated Skin Damage (MASD).¹ It causes pain, discomfort, and has a considerable impact on care, being both difficult to treat and resource-intensive.^{1,2} However, IAD is often underestimated in clinical practice: documentation is frequently incomplete or inconsistent across care settings, and injuries may remain untreated or recorded as secondary diagnoses. This variability hampers accurate diagnosis, prevalence estimates, and effective management.²

Recent studies and consensus papers have emphasized that the implementation of evidence-based practice is hindered by the absence of standardized definitions and terminology, the limited availability of high-quality studies, and the lack of national or international guidelines.¹⁻³

The World Health Organization (WHO) included specific codes for MASD, including IAD, in the ICD-11 (effective January 2022). Yet this regulatory progress has had limited impact in practice: awareness remains low, and clinicians still face challenges in recognition, differential diagnosis, and consistent documentation.⁴

This gap between regulation and practice contributes to underestimation of IAD, heterogeneity in epidemiological data, and incomplete documentation. Although standardized tools such as GLOBIAD (2017) are available, their limited adoption underscores the need for targeted nursing education to promote their use and establish a shared diagnostic

language.⁵

Despite its clinical relevance, no study to date has systematically documented IAD in care contexts. Reported incidence varies widely, ranging up to 25% among incontinent patients in acute hospital settings and between 3.4% and 25% in nursing homes and long-term care.⁴ These data further confirm the heterogeneity in approaches to the phenomenon, in terms of diagnosis, classification, and monitoring.

Skin aging represents an important risk factor for IAD development in older adults, a population that is rapidly growing worldwide. This trend reinforces the need for standardized strategies across care settings, given that IAD, despite its clinical significance, continues to be underestimated and inadequately addressed in daily practice.⁶

The objectives of this study were to (1) briefly review the current evidence on IAD and (2) conduct a cross-sectional survey assessing nurses' knowledge of IAD diagnosis, staging, and management across healthcare settings to identify educational gaps and inconsistencies in clinical practice.

The pathophysiology of IAD is driven by recurrent chemical and physical irritation of the skin barrier, leading to inflammation and subsequent skin damage.^{1,2} Fletcher J. et al. (2020) describe the condition as the result of combined chemical, physical, and microbial factors that compromise skin integrity. Prolonged exposure to urine and/or feces causes maceration of the stratum corneum and overhydration of the cutaneous environment, with water migrating into keratinocytes.¹ These cells swell, undergo lysis, and eventually rupture their membranes, causing direct structural damage to the skin.

Altered pH levels, particularly in the presence of fecal matter, activate proteolytic and lipolytic enzymes that degrade structural proteins and lipids. Additional irritants, such as ammonia produced by urea damage, further compromise the skin, while friction and shear forces exacerbate injury. The warm, humid environment promotes microbial proliferation, raising the risk of superinfection. Together, these mechanisms result in inflammation characterized by erythema, pain, and eventual erosion of the skin.¹⁻⁴

The clinical presentation of IAD is mainly characterized by erythema and maceration, which in more advanced cases may be associated with loss of skin integrity, edema, and blister formation.³ Initially, the epidermis retains its structure, but as the condition progresses, epidermal flattening and partial or complete destruction occur, manifesting as eczema, exudative or bleeding injuries, and extensive

erosions. Symptoms include discomfort, pain, burning, and itching, often worsened by handling or postural changes.^{3,7} Persistent itching may lead to scratching, excoriations, and worsening of skin damage.³ Severe cases of IAD predispose patients to recurrent urinary tract infections and pressure injuries, with the latter occurring at rates up to six times higher than in unaffected individuals.

IAD and Pressure Injuries

Accurate recognition of IAD is essential not only for guiding appropriate treatment but also for avoiding misdiagnosis with other skin conditions. Pressure Injuries (PIs) represent the primary differential diagnosis. Differentiating IAD from PIs is crucial, as both may coexist and interact in the same patient, yet they differ in etiology, location, clinical features, and management strategies (Table 1).

Table 1. Comparison between IAD and PIs in terms of etiology, location, clinical characteristics, and preventive strategies.⁸⁻¹¹

Parameter	IAD	PI
Main etiology	Prolonged exposure to urine and/or feces (chemical, physical, and microbial factors)	Pressure and/or shear forces on bony prominences or under medical devices
Pathogenetic mechanism	“Top-down” lesion injury – damage originating from the skin surface	“Bottom-up” lesion injury – damage originating in underlying soft tissues
Typical location	Perineal, perigenital, gluteal, skin folds, inner thighs, lumbar region (may extend beyond bony prominences)	Primarily on bony prominences (sacrum, heels, trochanters, malleoli) or under medical devices
Clinical appearance	Diffuse erythema with irregular, poorly defined edges; possible maceration, edema, superficial erosions, blisters	Lesion Injuries with well-defined edges; ranges from non-blanchable erythema to partial/full-thickness tissue loss with possible necrosis
Depth	Superficial or partial-thickness; rarely full-thickness	May involve all layers down to muscle and bone
Associated symptoms	Pain, burning, itching; possible signs of superficial infection (e.g., candidiasis)	Localized pain; possible signs of soft tissue infection
Infectious involvement	Common superficial fungal or bacterial superinfection	Possible deep tissue infection
Classification	GLOBIAD – 4 categories	NPIAP – EPUAP – PPPI – 6 categories
Prevention	Incontinence management, skin protection (barriers, polymers), reduction of friction and moisture	Reduction of pressure and shear forces, use of support surfaces, mobilization

Materials and Methods

Narrative review to inform questionnaire development

A narrative review was conducted to summarize current evidence on the definition, risk factors, differential diagnosis, and prevention and management of incontinence-associated dermatitis and to inform questionnaire development. The review focused on the

PubMed database and was carried out between 3 and 12 February 2025. We combined free-text terms and Medical Subject Headings (MeSH) related to incontinence-associated dermatitis and moisture-associated skin damage (e.g., “incontinence-associated dermatitis,” “IAD,” “moisture-associated skin damage,” “diaper dermatitis,” “urinary incontinence,” “fecal incontinence,” “skin integrity,” “older adults”). Boolean operators (AND/OR) were used to link

concepts, and searches were limited to articles involving human participants and adult or older adult populations, without language restrictions.

Titles and abstracts were screened for relevance to IAD pathophysiology, epidemiology, risk factors, differential diagnosis with pressure injuries, and prevention and treatment strategies. Full texts were retrieved when at least one of these areas was addressed. Reference lists of key papers and consensus documents were also examined to identify additional relevant publications. The evidence collected through this process was used to map the main conceptual domains – definition and classification of IAD, risk factors, staging tools (e.g., GLOBIAD), differential diagnosis with pressure injuries, and preventive and treatment measures – which directly informed the generation of questionnaire items.

Study Design

A descriptive, cross-sectional observational study was conducted to evaluate nursing knowledge on the diagnosis, prevention, and management of IAD across different care settings, with the aim of identifying training gaps and areas for improvement. Data were collected using an anonymous online questionnaire (Google Forms®).

Questionnaire Development

The questionnaire items were developed based on a narrative review conducted on PubMed (03-12 February 2025).

The questionnaire comprised 11 mandatory items, divided into three sections: (1) sociodemographic data; (2) self-assessment of training and competence; and (3) specific knowledge of definition, risk factors, staging tools, differential diagnosis, and preventive/treatment measures. The questionnaire included multiple-choice items and Likert-scale questions rated on four levels. Prior to administration, the instrument underwent peer review (n = 3 wound care nurses) to ensure clarity and relevance.

Instrument development

The initial pool of items was generated by mapping the key domains emerging from the narrative review, namely: conceptual definition and classification of IAD, risk factors and predisposing conditions, differential diagnosis with pressure injuries, use of staging tools (in particular GLOBIAD), and preventive and

treatment strategies. For each domain, we drafted items aiming to capture both self-perceived competence (via Likert-scale questions) and objective knowledge (via multiple-choice questions).

Content validity and clarity were assessed through a peer-review process involving three wound care nurses with expertise in IAD management, who independently evaluated each item for relevance, wording, and comprehensiveness. Their feedback was discussed and used to refine item phrasing, response options, and the overall structure of the questionnaire. No formal pilot study was conducted; however, the instrument was iteratively revised until all reviewers agreed on its face and content validity. The final version of the questionnaire is reported in Appendix 1.

Sampling

Anon-probabilistic snowball sampling approach was adopted to reach nurses working across a variety of care settings (medical/oncology, surgical, critical care, rehabilitation, and home care) throughout the country. Data collection was conducted between March and June 2025 via a Google Forms® link distributed through email and professional group chats. Inclusion criteria required participants to be employed in Italy, working in one of the specified settings, and voluntarily completing the questionnaire. Ensuring anonymity and requiring mandatory responses helped minimize social desirability bias and missing data. However, given the non-probabilistic snowball sampling approach and the use of snowball dissemination strategies, it was not possible to reliably estimate how many nurses actually received the survey link; therefore, response rates could not be calculated. To further minimize selection bias, coordinators distributed the questionnaire widely across diverse clinical settings.

Data collected through Google Forms® were exported into Microsoft Excel® and cleaned to verify completeness and consistency of responses. Descriptive analyses were performed to summarize the characteristics of the sample and the distribution of responses to each questionnaire item.

Categorical variables (e.g., care setting, multiple-choice responses, Likert scale options) were reported as absolute frequencies and percentages. Continuous variables (e.g., age, years of work experience) were described using

mean, standard deviation, minimum, and maximum values.

Results were presented overall and, where relevant to the discussion, stratified by care setting to highlight potential exploratory differences. Data processing and graphical representation were carried out using Microsoft Excel®.

Semi-quantitative scoring for the heatmap

To facilitate visual comparison of competence levels across care settings, we derived a semi-quantitative score for five key indicators: subjective knowledge, objective knowledge, use of clinical tools, misclassification rate, and perceived need for training. For each domain and setting, we transformed the underlying percentages into a three-level ordinal scale, where 1 indicated a low level, 2 a moderate level, and 3 a high level. As a general rule, values below approximately 40% were assigned a score of 1, values between 40% and 69% a score of 2, and values of 70% or higher a score of 3. Higher scores reflect more favourable conditions for knowledge, tool use, and perceived training needs, while a higher score for misclassification indicates a greater proportion of incorrect answers and therefore a more critical area.

Ethical Considerations

Participation was voluntary and anonymous; no sensitive data were collected. Data were treated in aggregate form in compliance with EU Regulation 2016/679 (GDPR). Ethical committee approval was not required as the study did not involve clinical interventions or personally identifiable data. The study was conducted in accordance with the institutional policy on survey-based research involving healthcare professionals, and the Scientific Directorate was informed of the project and its objectives.

Results

Questionnaire Findings

The analysis of the results follows the structure of the administered questionnaire, which comprised three main sections. The first section collected participants' sociodemographic and professional data (age and years of work experience), providing a profile of the sample. The second section explored nurses' self-perceived preparation, competence, and perceived usefulness of clinical tools for

managing Incontinence-Associated Dermatitis (IAD). Finally, the third section assessed objective knowledge through multiple-choice questions on the definition of IAD, risk factors, differential diagnosis, staging tools, and prevention and treatment strategies.

Results are presented descriptively, with graphical illustrations and tables for each section, and exploratory comparisons across different care settings. A total of 186 questionnaires were completed by nurses working in different care settings (Table 2). Because of the snowball sampling strategy, the number of nurses who received the survey link could not be determined, and response rates by setting could not be estimated.

Table 2. Distribution of respondents by care setting (n = 186).

Setting	Responses (n)	Response Rate (%)
Rehabilitation	37	56.9
Critical care	45	40.2
Medical/Oncology	33	82.5
Surgical	26	86.7
Home and community care	45	75.0

The data were analyzed using descriptive statistics (absolute frequencies, percentages, means, and standard deviations), with stratification by care setting. An exploratory comparative analysis was also conducted to highlight potential differences across clinical areas (Figure 1).

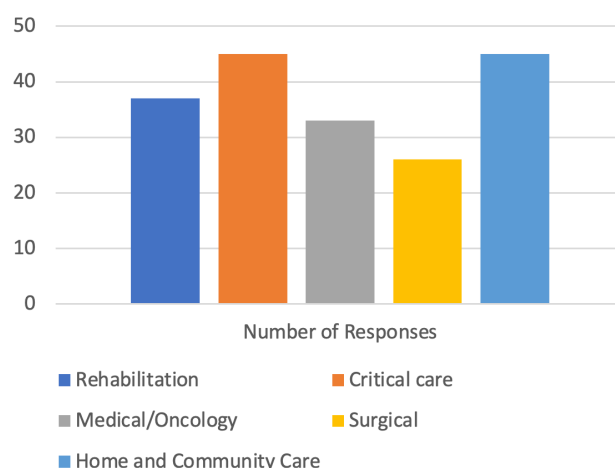


Figure 1. Distribution of Survey Responses by Care Setting.

The following presents the results organized by each section of the questionnaire. The first section included two open-ended questions on age and years of work experience. Participants' ages ranged from 22 to 62 years (mean 41.7 ± 10.2), while the average length of professional experience was 15.4 ± 8.6 years (range 1–38) (Table 3).

Table 3. Demographic and Professional Characteristics of the Sample (n = 186)

Variable	Value
Mean age (years)	$41,7 \pm 10,2$
Age range	22 – 62
Mean years of work experience (years)	$15,4 \pm 8,6$
Range of years of work experience	1 – 38

The second section, consisting of three closed-ended questions with a four-point Likert scale (“Not at all,” “Slightly,” “Moderately,” “Very”), explored nurses’ self-perceived preparation, competence, and perceived usefulness of clinical tools for managing IAD. Across all care settings, approximately half of the nurses felt poorly prepared on the topic (Figure 2) and lacking competence in injury management. Specifically, 52% of nurses reported feeling minimally competent in the clinical management of IAD, while only 18% considered themselves highly competent. These results were relatively consistent across the different settings.

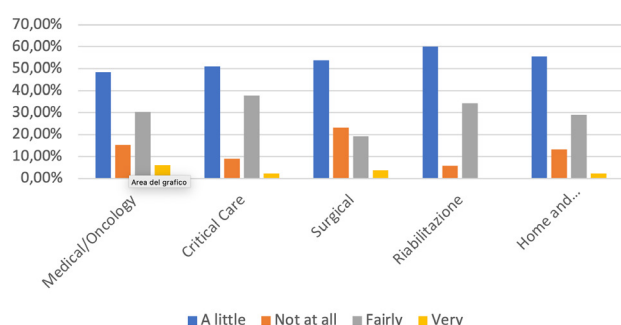


Figure 2. Responses to the question “How knowledgeable do you consider yourself to be on this topic?”.

After exploring participants’ subjective perception of preparation and competence, the third section assessed objective knowledge through multiple-choice questions. This section, comprising five multiple-choice items, showed that, at the aggregate level, 66–73% of participants correctly identified the definition

of IAD, while 54% selected at least one incorrect response regarding risk factors (Figure 3). These aggregated results are presented for the entire sample, without stratification by clinical setting.

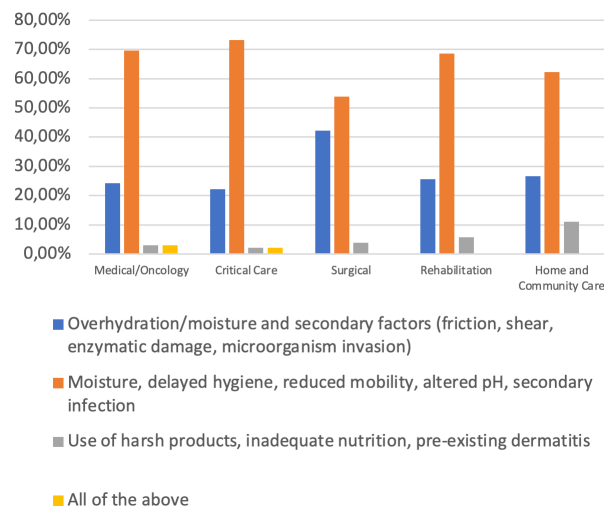


Figure 3. Responses to the question “What are the risk factors that increase the likelihood of IAD?”.

Furthermore, the EPUAP staging system emerged as the second most frequently selected option, despite not being appropriate for IAD staging. (Figure 4).

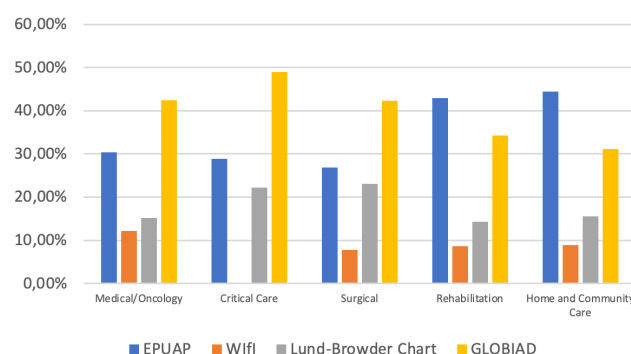


Figure 4. Responses to the question “Which scale is appropriate for staging IAD?”.

The correct definition of IAD was recognized by 70% of participants, with similar rates in the surgical (73%) and medical/oncology (71%) settings, and slightly lower in the community setting (65%).

Similar challenges were observed in the differential diagnosis between IAD and PIs: only 44% of the sample correctly identified the distinctive symptoms of IAD compared to PIs. The most common errors involved interpreting

localized redness and well-defined edges as characteristic of IAD.

The strategies considered most effective for prevention and treatment, listed in order of frequency, included: use of barrier products (82%), gentle hygiene without friction (76%), staff training (65%), and proactive incontinence management (63%). Less frequently cited but still relevant interventions were the use of collection devices (28%) and periodic review of care protocols (25%).

Comparative Analysis Across Care Settings

Exploratory analysis of responses stratified by care setting revealed notable differences in knowledge levels, competence, and use of tools for IAD management (Table 7).

The surgical and medical/oncology settings showed the highest scores in objective knowledge, particularly regarding the correct definition of IAD and the identification of the most effective preventive measures. Both settings also demonstrated greater familiarity with the use of barrier products and specific devices for incontinence management.

The community/home care setting exhibited

Table 4. Comparison of Care Settings Based on Survey Results. No critical issues identified according to the survey responses.

Setting	Strengths	Identified Weaknesses
Surgical	High objective knowledge on IAD definition and prevention; familiar use of barrier products	NI*
Medical/ Oncological	Familiarity with tools and preventive strategies	NI*
Territorial/ Home Care	Interest in the topic, but fragmented training	Confusion between IAD and pressure injuries; limited use of standardized assessment tools
Critical Care	High awareness of the importance of support tools (e.g., GLOBIAD)	Marked heterogeneity in perceived competence; internal knowledge gaps within the team
Rehabilitation	Good baseline knowledge; interest in the topic	Limited practical use of standardized tools and protocols

*NI: Non Identified.

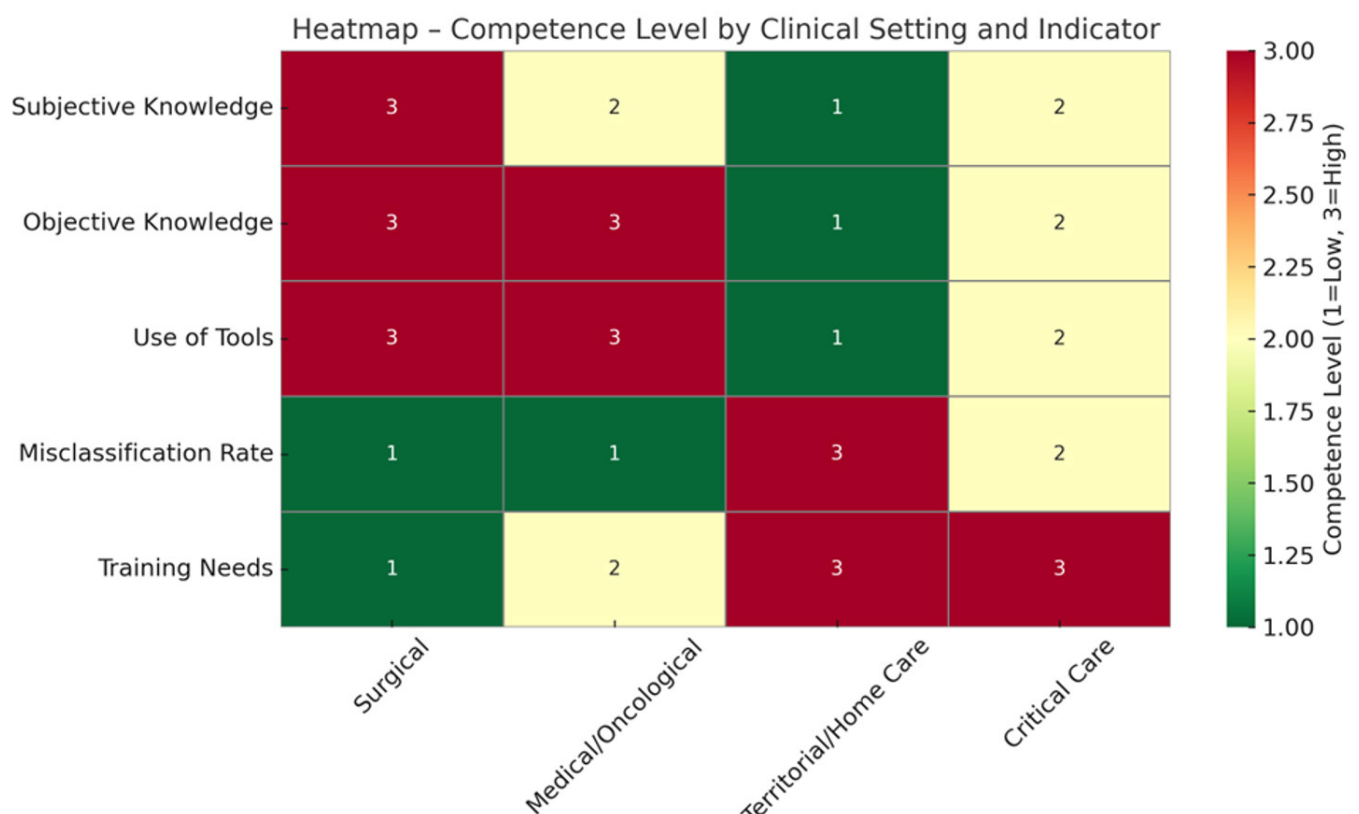


Figure 5. Comparative heatmap of competence levels by setting and domain. The scale ranges from 1 (low) to 3 (high). Indicators include subjective knowledge, objective knowledge, use of tools, misclassification rate, and perceived training needs.

more critical gaps, especially in recognizing risk factors and differentiating IAD from pressure injuries. These difficulties appear linked to lower exposure to standardized assessment tools and structured training programs.

The critical care area showed a high perceived usefulness of support tools such as the GLOBIAD; however, perceived competence levels were highly heterogeneous, with some professionals reporting being very well-prepared while others felt completely unprepared, indicating internal training disparities.

The rehabilitation setting displayed consistent interest in the topic and solid basic knowledge, but there is room for improvement in the practical application of assessment tools and shared protocols.

These differences underscore the need to develop targeted, context-specific training interventions, with particular attention to community-based settings and areas with internal heterogeneity, which are often less supported by common protocols and validated tools.

To complement the table, the data were further summarized using a semi-quantitative heatmap (Figure 5), which compares perceived and actual competence across care settings. The heatmap evaluates five key indicators: subjective knowledge, objective knowledge, use of clinical tools, misclassification rate, and perceived need for training. Scores were derived using predefined thresholds, as detailed in the Methods section. Scores are presented on a 1-3 scale, where higher scores reflect more pronounced levels of the indicator under consideration.

Discussion

The findings of this study confirm the fragmentation of nursing knowledge related to Incontinence-Associated Dermatitis (IAD), aligning with existing international literature, which highlights significant variability in both diagnostic accuracy and the implementation of evidence-based preventive strategies.^{8,9} Although a portion of the sample demonstrated solid knowledge in specific areas, particularly regarding the definition of the condition and certain preventive measures, the heterogeneity observed across clinical settings and levels of experience suggests the absence of a systematic and standardized national training pathway.

A particularly critical issue is the discrepancy

between nurses' self-perceived competence and their actual knowledge, as measured by the multiple-choice questions. This gap, also described in studies conducted in both hospital and community settings^{12,14,21,22} may represent a significant clinical risk: a healthcare professional who perceives themselves as competent but lacks up-to-date and consolidated knowledge may fail to recognize IAD in its early stages or may confuse it with a pressure injury, thereby delaying the initiation of effective interventions. This gap increases the likelihood of underdiagnosis, inappropriate treatment, and incomplete or inaccurate collection of epidemiological data, ultimately affecting the quality of care and hindering the implementation of targeted prevention strategies.⁸

Beyond documentation and process measures, these gaps in knowledge and diagnostic accuracy are likely to translate into poorer patient outcomes. Inadequate recognition and staging of IAD may lead to delayed initiation of appropriate skin care regimens, prolonged exposure to irritants, and progression from mild erythema to more extensive erosions and secondary infections.^{1,4,8} Misclassification between IAD and PIs can result in the use of suboptimal preventive strategies and support surfaces, potentially increasing the incidence and severity of both conditions.^{3,8} Previous studies have shown that patients with IAD are at higher risk of developing pressure injuries and experience significant pain, discomfort, and reduced quality of life, underscoring the importance of timely and accurate identification.^{3,8,9,11} Strengthening nurses' knowledge, training, and use of standardized tools such as GLOBIAD is therefore essential not only for improving documentation, but also for reducing IAD incidence, mitigating severity, and preventing avoidable complications.^{5,8,23}

The adoption of standardized tools such as GLOBIAD represents a concrete opportunity to standardize terminology, enhance interdisciplinary communication, and ensure accurate and consistent classification of moisture-associated skin damage.⁵ However, the limited use of such tools observed in our sample reflects both poor integration into operational protocols and insufficient institutional promotion. Their adoption could be encouraged through ongoing professional development programs, supported by periodic clinical audits to monitor adherence to best practice recommendations.

The comparative analysis across clinical settings showed that surgical and medical-oncology areas benefit from greater exposure to structured training pathways and dedicated skin assessment tools, probably due to well-established local protocols and a higher level of specialized care. In contrast, community, home care, and rehabilitation settings demonstrated more difficulty in accurately identifying risk factors and distinguishing IAD from pressure injuries. This scenario suggests that training initiatives should be targeted and context-specific, integrating theoretical and practical modules, clinical simulations, and field-based education to strengthen both foundational knowledge and applied skills.²³

The lack of consolidated and shared knowledge emerges as one of the main barriers to effective management of IAD. This gap contributes to underdiagnosis, inappropriate treatment, and poor epidemiological data, ultimately compromising care quality and hindering prevention strategies.²⁴ It also reflects a broader knowledge-to-practice gap frequently described in nursing education – where theoretical awareness fails to translate consistently into clinical competence and standardized practice – as conceptualized in the seminal framework by Kitson et al. (1998) on enabling the implementation of evidence-based practice.^{25,26}

Finally, the results of this study can serve as a foundation for the development of educational and organizational interventions aimed at addressing the identified gaps. Standardizing procedures and adopting shared assessment tools, combined with continuous training, could substantially contribute to improving care quality and reducing the incidence of IAD across different healthcare settings.

Limitations of the study

This study has several limitations that should be acknowledged. First, the cross-sectional design precludes any causal inference between nurses' knowledge, training, and clinical practices, and actual patient outcomes related to IAD. Second, the use of a non-probabilistic snowball sampling strategy limits the generalizability of the findings and prevents the calculation of response rates, as it was not possible to determine how many nurses were exposed to the survey invitation.

Third, data were self-reported and may be subject to recall and social desirability bias, particularly regarding perceived competence and

reported clinical practices. Although mandatory responses and anonymity may have mitigated these effects, they cannot be fully excluded. Fourth, while the questionnaire was grounded in a narrative review and underwent expert content review, no formal psychometric validation was conducted, and the scoring approach used to generate the heatmap represents a semi-quantitative synthesis rather than a validated measurement scale.

Finally, despite efforts to include nurses from diverse care settings, the uneven distribution of respondents across settings may have influenced comparative analyses. Nevertheless, the study provides valuable insights into knowledge gaps and educational needs related to IAD across multiple healthcare contexts.

Recommendations for future research

Future research should move beyond cross-sectional assessments of knowledge and self-reported practices to evaluate how educational interventions and the use of standardized tools translate into clinical outcomes. Prospective cohort studies and quasi-experimental designs could examine whether variables such as participation in structured training programs, higher knowledge scores, or routine use of GLOBIAD and other assessment instruments predict lower incidence and severity of IAD, reduced misclassification with pressure injuries, and improved pain control. Longitudinal studies may also explore the sustainability of educational effects over time and identify organizational factors that facilitate or hinder the integration of IAD-related best practices into routine clinical care.

Conclusion

This study reveals significant gaps in nursing knowledge regarding incontinence-associated dermatitis (IAD), highlighting how insufficient training contributes to missed diagnoses, clinical underestimation, and inconsistency in data collection. To address these shortcomings, it is essential to implement structured, continuous, and context-specific educational programs that not only provide updated theoretical content but also encourage critical reflection on nursing practices and the appropriate use of assessment tools. In this regard, the systematic adoption of GLOBIAD across care settings could foster a meaningful cultural and organizational shift.

Integrating targeted education, validated assessment tools, and updated care protocols is essential to enhance care quality, reduce IAD incidence, and mitigate severity in at-risk patients. The findings of this study may serve as a foundation for local policies and coordinated initiatives aimed at strengthening the diagnosis, treatment, and documentation of IAD, with the active involvement of nursing leadership, training units, and professional networks.

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