COMMENTARY

Advances in incontinence-associated dermatitis: implications of the 2026 international best practice document

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Introduction

The 2026 international practice document on incontinence-associated dermatitis (IAD) represents a significant evolution in how IAD is conceptualised, classified and managed in clinical practice. This update reflects a broader maturation of the field over the past decade, moving towards greater standardisation, implementation focus and system-level integration.

When the first international IAD best practice document was published in 2015, it marked an important milestone in formally recognising IAD as a distinct clinical entity requiring structured prevention and management.[1] Since then, increasing evidence and clinical experience[2,3] have highlighted persistent variability in diagnosis, prevention and treatment across care settings.

This 2026 revision of *Incontinence-Associated Dermatitis: Moving Prevention Forward*[4] is therefore timely. It responds not only to advances in evidence but also to implementation gaps identified across acute, community and long-term care environments. Importantly, it reflects a more globally representative and practice-informed consensus process, incorporating clinicians, researchers and specialist practitioners across multiple regions and healthcare systems.

From a practice perspective, the revised document emphasises translation into routine care: improving early identification of at-risk individuals, strengthening diagnostic accuracy, supporting prevention and embedding more consistent management approaches. It also highlights ongoing challenges in clinician knowledge, system variability and implementation sustainability.

Why this update matters

The need for an updated document was driven by substantial growth in the evidence base and evolving clinical demands over the past decade. An international expert panel was convened through an expression-of-interest process, drawing on clinicians, researchers, educators and specialist practitioners from Germany, Belgium, Finland, the United Kingdom, Brazil, Sweden, Spain and Australia. A structured two-day international workshop held in 2025 in the United Kingdom, followed by iterative expert review, underpinned the final document.[4]

This multidisciplinary composition ensured representation across wound care, continence care, stoma therapy, education and research, encompassing acute, community and long-term care settings. The deliberate move towards both evidence-informed and practice-informed guideline development ensures relevance across diverse healthcare contexts worldwide.

Evolving understanding of incidence and prevalence

Accurate estimates of IAD burden remain challenging due to historical variability in reporting and differences in population definitions. Previous prevalence estimates varied widely across care settings, reflecting inconsistent diagnostic

criteria and study designs. More recent data suggest point prevalence of 4.3% in Welsh hospitals,[5] 11.5% in Irish long-term care,[6] and 21%[7] in Belgian nursing homes, with prevalence reported at 6.7% across multiple hospitals in Australia.[8]

A notable development in the 2026 revision is the move towards reporting within clearly defined at-risk populations, particularly individuals with urinary and/or faecal incontinence or prolonged moisture exposure. This refinement strengthens comparability across studies and improves the interpretability of prevalence data for service planning. Overall, IAD remains a common and clinically significant condition, particularly in aged care settings where prevalence continues to be highest.

Strengthened understanding of IAD risk

The evidence base for IAD risk factors has become more robust and clinically actionable. The revised document identifies frequent loose or liquid stool, mixed incontinence, reduced mobility, friction, older age, and female sex as consistent contributors to risk. Faecal exposure, particularly in mixed incontinence and liquid stool, emerges as a dominant modifier, significantly increasing the likelihood of skin damage compared with urine exposure alone. This risk factor reinforces the importance of differentiating incontinence types in clinical assessment.

Importantly, IAD is now more clearly positioned as a risk factor for pressure injury development, with evidence suggesting approximately a two-fold increased risk in some populations.[9,10] This clarification represents a meaningful progression from the earlier document, which acknowledged association but did not quantify risk. The revised document does not recommend development of a separate risk assessment tool for IAD. Instead, it emphasises clinical judgement supported by awareness of key risk indicators.

Advances in classification and diagnosis

Since 2015, classification approaches have significantly evolved. The introduction and widespread adoption of the Ghent Global IAD Categorisation Tool (GLOBIAD)[11] has enabled more standardised point-in-time severity assessment. The extension of this tool through GLOBIAD-M[12] has further advanced longitudinal monitoring, enabling clinicians to track progression and healing over time.

A key enhancement in the 2026 revision is the expanded differential diagnosis content, including structured comparison tools and digital QR-linked resources. These tools and resources will support improved differentiation between IAD, pressure injuries and other dermatological conditions, particularly in complex perineal presentations.

Clinical presentation and diagnostic clarity

The clinical description of IAD remains consistent but is more explicitly articulated in the updated guidance. IAD is characterised by diffuse erythema with poorly defined margins, associated warmth, oedema and potential progression to erosion, vesiculation or moist skin loss. Pain, burning and pruritus may occur even in the absence of visible breakdown, reinforcing the importance of symptom-based assessment in early stages.

The expanded diagnostic content strengthens clinical decision-making by supporting clearer differentiation from pressure injuries and other skin conditions affecting the perineal region.

Prevention and management: a shift towards structured care

One of the most notable developments is the strengthening of prevention and management recommendations through implementation-focused evidence. Core prevention strategies include:

- systematic continence assessment
- structured use of classification tools
- prompt cleansing following incontinence episodes
- application of barrier products
- minimisation of moisture and friction exposure

The revised guidance emphasises escalation pathways based on repeated skin assessment at each continence episode, reflecting a shift from reactive to proactive prevention. Tailored recommendations for high-risk populations, including older adults, critically ill patients, individuals with darker skin tones, and those with obesity or complex skin folds, reflect growing recognition of diagnostic variability and equity considerations in skin assessment.

Education, training and workforce capability

A major strength of the revised guidance is its explicit focus on clinician capability as a determinant of implementation success. Validated tools now support structured assessment of knowledge and attitudes: the Know-IAD instrument identifies gaps across aetiology, risk factors, diagnosis, prevention and management,[13] while the APrIAD tool assesses attitudes towards prevention practices.[14] These tools provide a foundation for targeted education and workforce development strategies. Their value lies not only in assessment but in enabling tailored interventions to address variability in practice.

Emerging practice: digital and AI-supported care

The revised guidance acknowledges emerging applications of artificial intelligence (AI) in supporting IAD identification, documentation, and workflow efficiency. These approaches show potential to enhance standardisation and clinical decision support. However, the evidence base remains preliminary and the guidance appropriately cautions against premature adoption.

Beyond the need for robust validation, several specific concerns merit attention. First, AI-based skin assessment tools have demonstrated variable performance across

skin tones, with studies showing reduced sensitivity for wound and skin change detection in individuals with darker complexions.[15] Given that IAD commonly affects older and clinically vulnerable populations, this is an important consideration for equitable care. Second, dermatological AI applications may be affected by under-representation of darker skin tones in image datasets, creating a risk of algorithmic bias that may perpetuate existing health disparities if deployed without appropriate validation.[16] Third, real-world implementation requires careful evaluation of workflow integration, interoperability with electronic medical record systems and cost-effectiveness at scale.

The requirement for external, independent validation across diverse populations and clinical settings before routine adoption therefore remains essential, not discretionary.

Implications for practice

The 2026 update marks a decisive move towards standardised, system-wide approaches to IAD prevention, diagnosis and monitoring, with direct implications for uptake, dissemination and implementation. Priority for clinical adoption should focus on embedding structured classification tools (such as GLOBIAD[11] and GLOBIAD-M)[12] into routine documentation and care pathways to improve diagnostic consistency, multidisciplinary communication and continuity of care.

Integration of differential diagnosis resources, including structured tools and digital supports (such as QR-enabled content), should be incorporated into point-of-care workflows to reduce misclassification as pressure injuries and to guide appropriate management.

Successful implementation will depend on workforce capability and sustained education. Tools such as Know-IAD[13] and APrIAD[14] provide a mechanism to identify knowledge and behavioural gaps and should inform targeted, role-specific training and ongoing professional development. These should be embedded within organisational education strategies to support consistent evidence-based practice across settings.

From a system perspective, standardised classification and reporting enable more reliable benchmarking, surveillance and quality improvement across jurisdictions, supporting broader dissemination and comparability of outcomes. Implementation strategies should prioritise integration within electronic medical records and alignment with existing clinical governance frameworks to support scalability.

Emerging digital and AI-enabled approaches represent an important future direction but require robust validation, including across diverse skin tones and clinical populations, and implementation science-informed evaluation prior to widespread adoption.

Conclusions

The 2026 IAD best practice document[4] represents a significant advancement in the standardisation of classification, prevention and management of incontinence-associated dermatitis. Key developments include the adoption of structured tools such as GLOBIAD[11] and GLOBIAD-M[12] and strengthened evidence to support risk assessment and clinical decision-making. The document also highlights the importance of workforce capability, with education and attitudes identified as key determinants of implementation success. While digital approaches to IAD assessment show emerging promise, further validation, including for algorithmic bias and skin tone diversity, is required before routine integration into practice. Overall, the revised guide provides a more structured and consistent framework to support improved clinical care and patient outcomes internationally. The next challenge for the field is no longer defining best practice, but ensuring its consistent implementation, evaluation and sustainability across healthcare systems globally.

Author contribution

MBJ drafted the commentary. DB critically reviewed and revised. Both authors approved the final version.

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Conflict of interest

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Ethics statement

An ethics statement is not applicable.

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