Skin Check Log

Two weeks on one page — because “her bottom is sore” gets a cream, and a written pattern gets an assessment.

DAY TO DAY DEMENTIA

Why this exists

The red, raw skin that comes with incontinence has a name: **incontinence-associated dermatitis**. It is a chemical injury from prolonged contact with urine and stool — closer to a burn than to a rash — and it is routinely mistaken for a pressure sore, including by clinicians.

That confusion matters, because the two are managed differently. A pressure injury is treated by relieving pressure. Dermatitis is treated by getting the moisture off the skin and keeping it off. Treat one as the other and weeks go by while the actual cause carries on unchanged. Nobody can answer “is this worse than last week” from memory in the middle of caregiving. A written record answers it in five seconds.

How to tell them apart

DERMATITIS FOLLOWS THE WETNESS	PRESSURE INJURY FOLLOWS THE BONE
Perineum, buttocks, groin, inner thighs. Spread over a broad area with irregular edges. Often several shallow patches. Skin looks shiny, then weeping. Burns rather than itches.	Sacrum, tailbone, sit bones, heels, or under a device. More localized, more defined edges, and it can be deep. May look purple or black rather than red.

They often occur together. Damaged skin is also more vulnerable to pressure damage — which is why this is worth catching early.

How to use it

- Keep it where the changes happen — inside the bathroom cabinet door, not in a folder.
- Score redness **0** none **1** pink **2** red **3** raw, weeping or broken.
- Record the *location* every time. Location is what separates dermatitis from a pressure sore, and it is the detail most often left out.
- Note product changes on the same sheet. A flare that starts two days after switching brands is worth seeing.
- Photograph it and send it through the patient portal before an appointment — that gets it into the record.

> **The pattern that changes the treatment.** Small separate spots scattered around the edge of the red area — “satellite” lesions — usually mean a *fungal* infection rather than simple dermatitis. Barrier cream will not touch it and steroid creams can make it worse. If your log shows that pattern, say to the nurse or doctor: *“There are satellite lesions — could this be candida?”*

Two-week skin record

Name _____ Two weeks beginning _____

DATE	CHECKS TODAY	REDNESS 0–3	WHERE EXACTLY	SKIN BROKEN?	BARRIER PRODUCT USED	NOTES — PAIN, BEHAVIOR DURING CARE, PRODUCT CHANGE

Redness: 0 = none · 1 = pink · 2 = red · 3 = raw, weeping or broken | **Where:** perineum · buttocks · groin · inner thighs · tailbone · heels · skin folds

ANYTHING THAT CHANGED THESE TWO WEEKS

Product or brand changed	
Change interval got longer or shorter	
New medication, illness or antibiotic	

CALL THE SAME DAY IF

- There is fever, spreading redness, heat, swelling or pus
- The skin is broken, deep, or has a dark or leathery area
- Pain is new or severe, or personal care has suddenly become a fight
- It is not improving after a week of consistent cleansing and protection

The routine that protects skin

No cleanser or barrier product has been shown to beat another — a 2025 Cochrane review found the evidence for every comparison very uncertain. What is established is the mechanism. **The variable you control is how long the skin stays wet**, not which brand you buy.

EVERY CHANGE, IN THIS ORDER

1 Cleanse	A gentle, pH-balanced, no-rinse cleanser rather than soap and hot water. Soap is alkaline, and alkaline is the problem you are correcting.
2 Dry	Pat, never rub. Friction on compromised skin does real damage, and this is the step most often rushed.
3 Protect	A thin layer of zinc oxide, petrolatum, or a no-sting barrier film on clean, dry skin. Thin enough to still see skin through it.
4 Air	Time without a product on, whenever it is practical. One of the few genuinely free interventions.

FIVE MISTAKES THAT QUIETLY MAKE IT WORSE

- **Buying the most absorbent product available.** Absorbency buys comfort, not permission to wait. The outside can feel dry while the skin against it is not.
- **Putting a pad inside a brief.** It defeats the wicking layer, holds moisture against the skin, and adds a seam that rubs.
- **Applying barrier cream thickly.** A heavy layer can clog the product so it stops drawing moisture away, and it hides the skin you need to assess.
- **Scrubbing the barrier cream off.** Remove the urine and stool. It does not need to come back to bare skin every time.
- **Starting products before they are needed.** It can accelerate the loss of continence. Timed toileting on a schedule is worth trying first, and worth continuing alongside products for as long as it works.

> **Skip entirely:** talc and cornstarch, which cake and abrade · alcohol or fragranced wipes, which sting broken skin and dry it further · antibiotic ointment applied to something that is not infected.

WHAT TO SAY TO GET A PROPER ASSESSMENT

Read your log back rather than summarizing it. The difference in response is considerable.

Instead of	“Her bottom is sore.”
Say	“Redness across both buttocks and the perineum, *not* over the tailbone, present nine days now, worse on the two nights we used the overnight brief, no improvement with zinc oxide. Can we have a wound or continence nurse look at it?”

Ask specifically for a **wound care or continence nurse** if one is available through home health, hospice or the facility. This is exactly their specialty.