

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Assess the extent of tissue damage and tick the relevant box  
ISTAP (2011)



**Type 1 - No Skin Loss**   
Skin flap without skin loss that can be repositioned to cover the





**Type 2 - Partial Flap Loss**   
Partial skin loss which cannot be repositioned to cover the wound



**Type 3 - Total Flap Loss**   
Total skin loss exposing wound bed.

First responder management for skin tears. Please write initials in the box when action is completed.

Action	Date and Initials
Control the bleeding. Apply gentle pressure and elevate the limb. <b>Seek urgent assistance if unable to control the bleeding or there is a significant loss of tissue.</b>	
Gently cleanse the wound with sterile saline. (sachet or pod)	
Where able, gently bring the skin flap edges as close together as possible. <b>DO NOT PULL</b> the skin flap to join the edges. <b>DO NOT USE WOUND CLOSURE STRIPS</b>	
Communicate explanation of actions with resident/client and carers, at each stage of care.	
Measure and record the wound in the resident/client records, in line with local guidance e.g. ST2 (cm x cm)	
If the skin tear is present on the lower leg, advise the resident/client to elevate the limb. <b>Ensure referral is completed for assessment and suitability of compression.</b>	
Ensure you have the correct size of Biatain Silicone Lite for the wound. The dressing foam pad should overlap the wound edges by 1 – 2cm.	
Draw an arrow on the dressing to indicate the correct direction of removal. The arrow should indicate the direction of which the skin flap has been closed. ie if the skin flap has been closed from left to right, the arrow should point in the direction of the right side.	
  <p>Scan to watch an application and removal video</p>	
Apply the Biatain Silicone Lite dressing.	
Ensure you refer the resident/client to the District Nurses, for review by them in 24 hours.	
<b>Observe for signs and symptoms of infection *.</b>	
In the first few days following the injury, inflammation and redness is part of the <b>NORMAL</b> healing response.	
Assess and manage pain and ensure this is documented in the resident/clients' notes.	

**CLINICAL SIGNS OF INFECTION \***

- Raised temperature (Pyrexia)
- Increasing inflammation (redness and heat)
- Oedema
- Increased pain
- Increase in exudate or pus

In darker skin tones, please observe for heat, swelling and skin colour changes, these may present as a darkening of the skin.

**ADDITIONAL SIGNS**

- Delayed healing
- Dark / discoloured granulation tissue
- Increased friability (tissue which bleeds easily)
- Painful / altered sensation to the wound site / surrounding skin.
- Altered odour.
- Wound breakdown
- Pocketing / bridging at the base of or across the wound
- Increased watery / serous exudate rather than pus.