Acute, Same-Day Management of Skin Tears by Clinician in the Community (for adults)

Clinician:
A competent **responder** who is able to assess the wound and manage the wound treatment route, as denoted within pathways P1 and P3 (with appropriate training at the stage of pathway implementation). This person can be expected to come into contact with wound management, and thus will have had training in wound/skin tear management.

- We would expect these include, but not be exclusive to: nurses, HCA in nursing teams, nursing associates, paramedics/emergency ambulance staff.
- We wouldn't expect this to be care staff

Identify patients at risk of sustaining a skin tear

Person sustains skin tear

What is a skin tear? (Click for more info)

Referred by non-clinician after initial first-aid has been completed

Clinician is the first responder

Has the patient had a fall or accident / other injuries?

- **Yes**
  - **Other injuries/ unwell – administer first aid within your competencies NB: Prioritise first aid/ contacting 999/ 111 according to severity of situation**
    - **Not sustained a fall**
    - **Sustained a fall**
      - **Refer to Acute Falls pathways for clinicians**
- **No**

Is skin tear significantly bleeding?

- **Yes**
  - **Give first aid to control bleeding (i.e. apply pressure and elevate limb if appropriate)**
    - **Patient unstable i.e. can't control bleed or other severe injuries/ illness**
      - **Call 999**
    - **If patient stable i.e. bleeding controlled, patient appears well with no concern of serious injuries, go to skin tear box, if available or first aid box**
- **No**
  - **If patient stable i.e. bleeding controlled, patient appears well with no concern of serious injuries, go to skin tear box, if available or first aid box**

Perform initial skin and wound assessment

Document and record findings, photograph wound with patients' consent (photograph may be more suitable after cleaning and realignment)

1. Give analgesia as prescribed, if required, to ensure patient is comfortable during procedure.
2. Review photograph (less than 24 hours old) if available to determine if dressing can remain in situ.
3. Put on sterile gloves.
4. Irrigate the wound with potable water or saline and remove any residual debris or haematoma, particularly from the inner aspect of the skin tear flap.
5. Pat the surrounding skin dry gently to avoid further injury. DO NOT RUB IT.

Classify type of skin tear using tool and red flags (Click for more info)

If viable use the skin flap as a 'dressing' by easing the flap back into place (or as close as possible). DO NOT stretch it or force it in any way. (Click for more info)

Photograph wound with patient's consent and document findings (Click for more info)

1. Protect periwound skin (e.g. use skin barrier) if appropriate
2. Apply an adherent sterile dressing - <u>Do not use wound closure strips</u>
3. It is important to mark with an arrow to indicate the correct direction of removal (see more info)
4. Protect fragile skin by covering with tubular bandage or long-sleeved clothing
(Click for more info)

Consider tetanus status – refer to GP or secondary care doctor if appropriate

Next steps are dependent on the classification of the skin tear, and presence of Red Flags

- **Type 1-2a and no red flags**
  - **Assess for risk factors of skin tear e.g. falls and frailty**
    - See pathway **Identification of Frailty**
    - See pathway **Identification of Falls**
  - **Nurse review and reassessment is required in 24-48 hours to assess viability of skin flap**
    If not in nursing home refer to community nurse for follow-up if housebound or general practice nurse if not housebound
    - See pathway for **Acute skin tear management from 24-48 hrs onwards**
- **Type 2b, 3a & 3b or any red flags (see above) present**
  - **Same day referral**
    - **Lister – refer to plastic surgery**
    - **PAH & WHHT – refer to orthopaedics. (Patient may need onward referral to plastics if required)**
  - **Assess for frailty and falls risk at acute site. Inform frailty team as appropriate**
    - See **Acute Urgent/Emergency Frailty Pathway**
    - **If not suitable for surgical intervention (due to co-morbidities)**
      - See pathway for **Acute skin tear management from 24-48 hrs onwards**
    - **If suitable for surgical intervention**
      - **Surgical debridement +/- surgical repair**

Back to pathway

Assess type of skin tear

Definition of skin tears

An international consensus panel defined skin tears as:

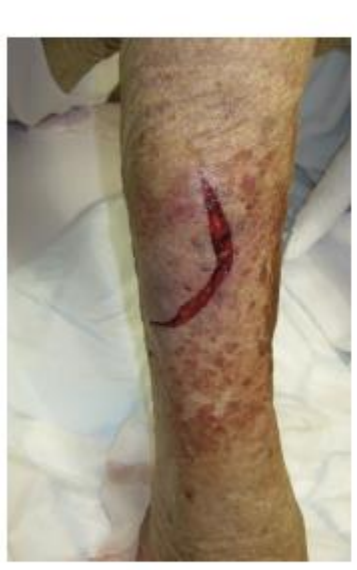
"A wound caused by shear, friction and/or blunt force resulting in separation of skin layers. A skin tear can be partial thickness (separation of the epidermis from the dermis) or full thickness (separation of both the epidermis and dermis from underlying structures)" (LeBlanc and Baranoski, 2011).

Example pictures demonstrating different severities of skin tears are shown below.

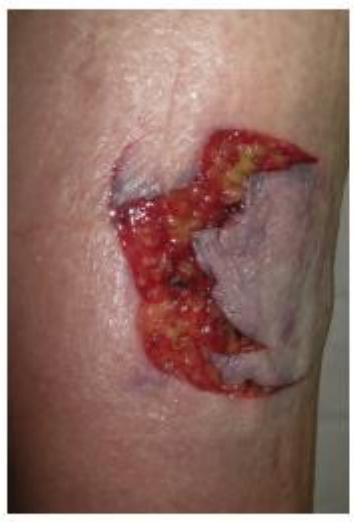
RED FLAGS:

- **Full thickness injury**
- **Haematoma**
- **Large non-viable flap**
- **Dark, discoloured skin**
- **Large swelling**

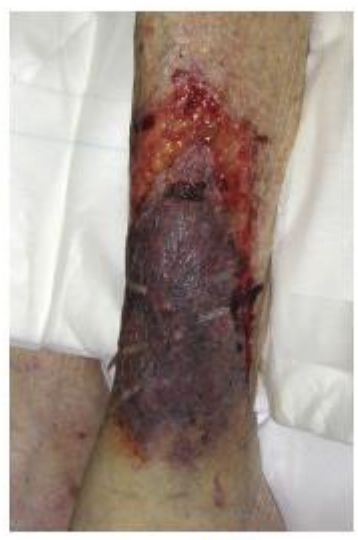
Classifications of skin tears of the lower limb



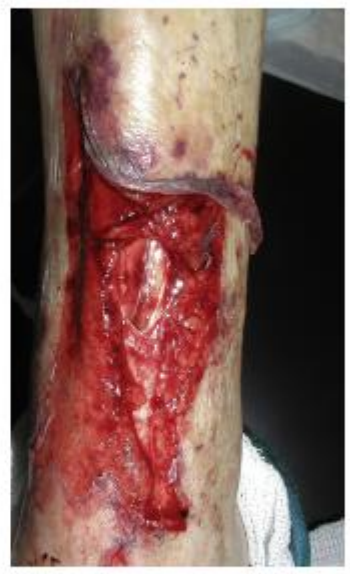
Type 1: linea laceration, no skin loss



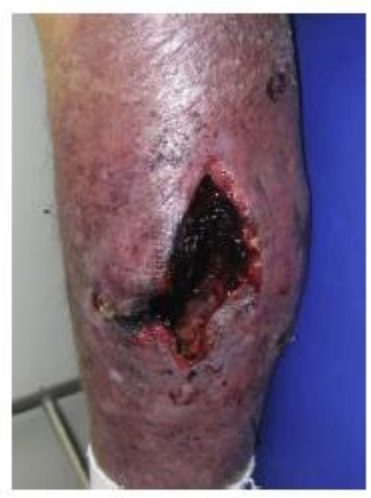
Type 2a: flap laceration, non or minimal skin loss, flap looks viable/ proximal or lateral base



Type 2b: Flap laceration, flap looks non-viable/ distal base
Red Flag



Type 3a: skin loss
Red flag



Type 3b: Associated haematoma, associated limb swelling
Red flag

The ISTAP International Skin Tear Advisory Panel (LeBlanc et al, 2013), advocates:

Type 1 – no skin loss

Type 2 – partial skin loss

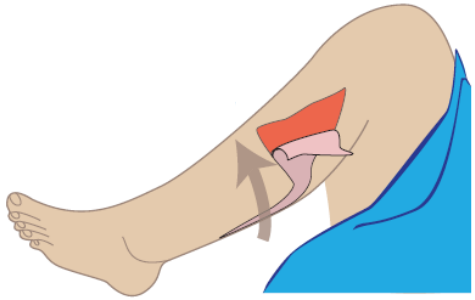
Type 3 – total skin loss

Classification and management of skin tear types

Skin Tear Type	Flag Rating	Meaning of Classification	Implication/ Management	Timeframe for referral
Type 3b	Red*	A skin tear with underlying haematoma. The features will be a haematoma (swelling) or an expanding haematoma with tense tissues	Requiring urgent plastic surgeon opinion to consider surgical debridement and surgical repair options	3b - ***Refer immediately**
Type 3a	Red	A skin tear where the skin flap is absent, exposing the wound bed. There is no haematoma	Requiring plastic surgeon opinion to consider surgical repair options	3a - Refer ASAP within 24 hours
Type 2b	Red	A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap is non-viable i.e. colour **is** pale, dusky or darkened	May require surgery if flap non-viable	2b - Refer ASAP within 24 hours
Type 1 and 2a	N/A	2a - A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is not** pale, dusky or darkened	Can treat conservatively with regular dressings - provided it is adequately debrided	May refer to Plastics Dressing Clinic (PDC) for advice during hours (nurse to nurse)
		1 - A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is not** pale, dusky or darkened		

Back to pathway

If viable use the skin flap as a 'dressing' by easing the flap back into place (or as close as possible). DO NOT stretch it or force it in any way



- Ease the flap back into place using a gloved finger, dampened cotton tip, tweezers or a silicone strip.
- If the flap is difficult to align consider using a moistened non-woven swab. Apply for 5-10 minutes to rehydrate the flap.

Back to pathway

Document and record findings

It is important to document wound assessment findings and the treatment goals. These should be used to develop a care plan, which should be individualised for the patient. Seeking and including the patient's experiences and priorities in the assessment process, and sharing the consequent decision-making, are important ways of empowering patients

(Wounds International, 2012).

http://www.welshwoundnetwork.org/files/8314/4403/4358/content_11623.pdf

Back to pathway

Protect periwound skin

Application of dressings / wound protection

1. Periwound protection

- Consider using a skin barrier product to protect the surrounding skin if required (e.g. if the wound is heavily exuding, to prevent maceration).
- Consider using an emollient to protect wider skin area and prevent further tears.

2. Apply adherent dressing (if skin is fragile see point 4)

- Select an appropriate dressing — the ideal dressing should optimise the healing environment and provide a barrier to protect against shear forces.

Names of suitable dressings: Tegaderm Absorbent clear acrylic dressing, or if not available other non adherent dressing from first aid box.

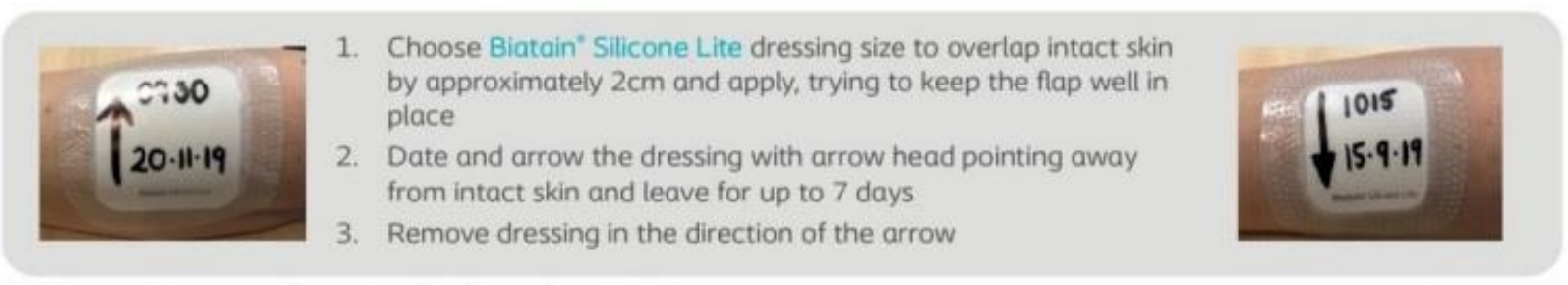
- Dressings should be easy to apply and minimise trauma on removal/dressing change; select either an atraumatic wound contact layer or atraumatic all-in-one dressing.
- Apply dressing in the direction that the skin flap has been laid over wound – so that when the dressing is removed the flap is not disrupted (see figures 5a and 5b)
- If possible, use a dressing with extended wear time, so that it can be left in place to avoid disturbing the skin flap (ideally for 5-6 days). Dressings need to be changed more frequently if high exudate or signs of infection are present.
- Adhesive removers can be used when changing the dressing to minimise trauma.

3. Mark dressing with arrow

- It is important to mark with an arrow to indicate the correct direction of removal and make sure that this is clearly explained in the notes (Figure 5b and 5c).

4. Protect fragile skin

- Apply a basic wound contact dressing – low adherence (see BNF category) with a non-adhesive dressing pad on top to absorb exudate, held in place by a tubular bandage, retention bandage or stockinette.



Example of skin flap realignment and drawing of arrow on dressing

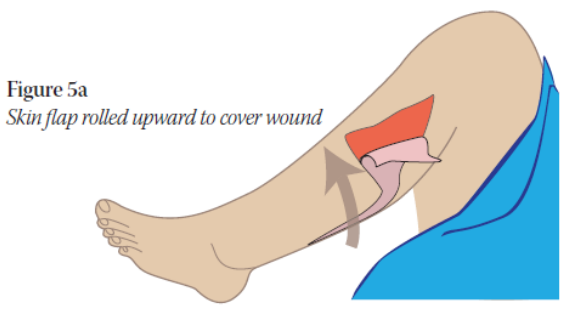


Figure 5a
Skin flap rolled upward to cover wound

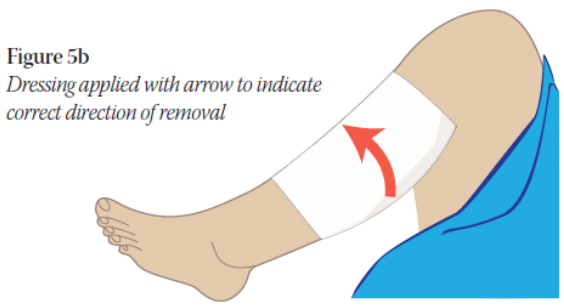


Figure 5b
Dressing applied with arrow to indicate correct direction of removal

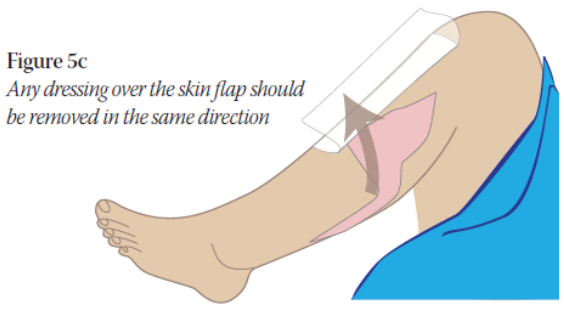


Figure 5c
Any dressing over the skin flap should be removed in the same direction

Back to pathway

Identifying patients at risk of sustaining a skin tear

Refer to Falls and Frailty pathways

Patients at higher risk of slower wound healing and infection
Some conditions can affect wound healing and skin integrity e.g.:

- Diabetes
- Peripheral vascular disease
- Anaemia
- Immunosuppression
- Dementia
- Skin changes at end of life
- Smoking
- Lymphoedema
- Frailty

Medications can affect skin integrity e.g.

- Steroids
- Anti-inflammatories
- Anti-coagulants
- Some immunosuppressants

If skin tear box available in care homes (or in patient's home) refer to skin tear box
To contain:

- Saline
- Sterile gauze
- Disposable gloves
- Aprons
- Skin tear dressing