Acute Management by Non-Clinician in the Community of Skin Tears (for Adults)

Non-clinician:
A competent **responder** who is able to categorise the wound and manage the wound treatment route, as denoted within pathway P2 (with appropriate competence training at the stage of pathway implementation), but **would not** be competent to follow pathways P1 or P3. 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 this to include care staff (care homes and home care) and any other identified individual (e.g. social/ health care therapist).

Click for Prevention of skin tears

Person sustains skin tear

Click for more info: What is a skin tear?

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

Yes

Sustained a fall

Refer to Acute Falls pathways for non-clinicians
NB: Prioritise first aid/ contacting 999/ 111 according to severity of situation

Person has not sustained a fall

Person has sustained additional injuries to skin tear or appears unwell

Other injuries/ unwell – administer first aid
NB: Prioritise first aid/ contacting 999/ 111 according to severity of situation

Click for red flags

No

Is skin tear actively 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

Click for red flags

Call 999

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

If possible put on clean gloves that are suitable for first aid if available.
1. Rinse the skin tear with tap water or saline. Be careful not to make the skin tear worse.
2. Either let skin tear air dry or very carefully pat it dry. DO NOT RUB IT.
3. If possible gently lay skin flap back in place or as close as possible. DO NOT stretch it or force it in any way.
4. Take a photo of wound if possible with patient's consent, if they have capacity
5. Apply Biatain® Silicone Lite dressing. <u>Do not use wound closure strips.</u>
6. Gently draw an arrow on dressing to show direction of skin flap/tear realignment (see more info) – this is to enable clinician to avoid further trauma to skin flap/tear when eventually removing dressing

Click for more info

Contact health care professional to continue management of patient (within 24hrs)

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Prevention of skin tears including reducing associated risk factors

1. Skin
2. Mobility
3. General health

Click for skin care info

1. Skin:

- Good skin care
  - Washing with soap substitutes
  - Moisturisers
- Long/close fitting sleeves and long trousers
- Preventing skin trauma from adhesives, dressings and tapes (consider silicone adhesive dressings, cohesive retention bandages)
- Consider medications that may directly affect skin (e.g. steroids, anti-inflammatories, anti-coagulants, some immunosuppressants)
- Optimise nutrition and hydration
- Avoid sharp fingernails and jewellery in patient contact

NB: patient is at risk of further skin tears if has history of same

2. Mobility

- Refer to 'Falls Risk Identification in the Community' pathway and 'Identification of Frailty' pathway
- Avoid friction and shearing using good manual handling techniques
- Use padding for equipment and furniture
- Assess potential skin damage from pets

3. General health

- Educate person at risk on skin tear risk and prevention
- Actively involve the person at risk in care decisions where appropriate
- Ensure GP aware of any visual impairment (age related or otherwise)
- Patients with the following conditions are at higher risk of poor skin integrity, slower wound healing and infection:
  - Diabetes
  - Peripheral vascular disease
  - Anaemia
  - Immunosuppression
  - Dementia
  - Skin changes at end of life
  - Smoking
  - Lymphoedema
  - Frailty

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Emollient Guidelines (Prescribing is only recommended for managing diagnosed skin conditions, recommend purchase OTC if no diagnosis)

Intervention and When to use	Order of choice	Product	Additional information
Washing and moisturising for normal skin		Patients own skin care regime.	Unless there are medical needs, the patient should simply be educated on the benefit of good skin hygiene and regular emollients
Washing for frail skin including ulcer care	Soap substitute	Epimax or ZeroAQS or Zerocream or Emulsifying ointment or Dermol 500	Emulsifying ointment is greasier, so may be a slip hazard in showers and baths. It should be rinsed off well. Dermol 500 used for infected skin and usually short-term, long term use >4 weeks only after specialist advice
Moisturising for frail skin including ulcer care	Emollient **Creams 1st choice**	Epimax (similar to Diprobase) or Isomol gel (similar to Doublebase)	One product may be used as a soap substitute & an emollient. Creams more acceptable to some patients as less oily If tolerated oily products may be more effective
	Emollient **Creams 2nd choice**	Zerocream or ExCetra Cream or Doublebase gel	2nd choice due to higher costs.
	Emollient **ointments** (may be 1st choice)	Liquid paraffin/White soft paraffin (50/50) Or Emulsifying ointment Epimax (paraffin-free)	No excipients, useful under bandaging regimes, but may reduce compression and can affect integrity of latex/cotton **Note MHRA alert on fire hazard** **Paraffin-free emollients are higher cost. Consider only if fire-risk is a significant issue post risk-assessment**
	Special circumstances (wash &/or emollient)	Dermamist 10% spray	Could be useful if the only reason a patient cannot perform their own skin care is because they cannot reach their limb, Stand on a towel when using to reduce risk of slipping
		Dermol 500	Specialists may request use, because it contains a bacteriostatic agent, benzalkonium chloride. Useful as part of the management of secondary skin infection. Used for flare ups and to prevent infections in conditions prone to infection.
Managing cracked or hyperkeratotic skin	1st	Balneum Cream	5% urea and ceramide, so good if very dry/hyperkeratotic skin
	2nd	Flexitol 10% urea	

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What are Skin Tears?

A skin tear is a wound caused by shear, friction and/ or blunt force (e.g. after a fall) resulting in separation of skin layers. A skin tear can be full or partial thickness. Example pictures including severity are shown below.

Classifications of Skin Tears of the Lower Limb

No Skin Loss

A Type 1 skin tear is where a linear flap can be repositioned to cover the wound bed



Partial Flap Loss

A Type 2 skin tear has partial flap skin loss - the flap does not cover the entire wound when repositioned



Total Flap Loss

A Type 3 skin tear has total flap loss leaving the wound bed exposed



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Red flags assessment (major injury/illness)

Do not move*, call 999 and perform first aid (as indicated):

Life threatening:

- Airway/breathing problems
- Signs of a stroke (FAST positive – Face (droop/cannot smile), Arms (+- legs new weakness), Speech (slurred), Time (to call 999))
- New or unusual chest pain
- Severe or/and uncontrollable bleeding
- The person is very warm, or cold, or clammy to touch
- Major chest or abdominal injury

Head injury/blackout:

- Loss of consciousness (blacked out)
- Reduced levels of consciousness (e.g. not alert or changing; person appears drowsy)
- New dizziness or vomiting
- Head injury and at least one of the following: confusion, memory loss, blurred vision, vomiting, loss of consciousness, dizziness, or person is on anticoagulant/blood thinning medication e.g. warfarin.

Injuries:

- New neck or/and back pain
- Pain on moving limbs
- New limb deformity (including if one leg appears shorter than the other or leg looks rotated)
- New extensive swelling to a limb or joint
- New extensive bruising
- Significant skin tear – type 2b, 3a and 3b (see photo in 'What are skin tears' box)
  - Where uncertainty exists regarding type of skin tear, manage as the worst likely type (e.g. if unsure if type 3a or 3b manage as 3b)
- New immobility (cannot move arms or legs normally) or unable to weight bear
- New numbness to a limb/ altered sensation
- Limb appears pale or feels cold
- Person is acting abnormally compared to their usual behaviour
- Person has signs of being under the influence of drugs or alcohol (this could mask more serious symptoms and injuries)

If trained carry out physical observations (e.g. blood pressure, pulse rate, etc.) and neurological observations (e.g. pupils equal and reacting) – if abnormal escalate as per local protocol

Please note: If cause of injury was unwitnessed, use your judgement and assess environment for potential hazards - do rule out fall from height or head injury.

If the person has dementia or another issue which effects their understanding or communication where possible assess for injuries/signs of pain and compare to what is normal for them. When there is uncertainty manage as if the red flag is present.

**Moving a person should be avoided due to the risk of worsening of injury. However in some cases, where not moving a person would cause more harm (e.g. in contact with hot pipes/radiator risking burns, vomiting and risk of choking) the person should be moved the minimum amount necessary in the safest and least disruptive way to move them out of danger. Carers should not put themselves at risk of danger.*

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Apply Biatain® Silicone Lite Dressing



1. Choose Biatain® Silicone Lite dressing size to overlap intact skin by approximately 2cm and apply, trying to keep the flap well in place
2. Date and arrow the dressing with arrow head pointing away from intact skin and leave for up to 7 days
3. Remove dressing in the direction of the arrow



Example of skin flap realignment and drawing of arrow on dressing:

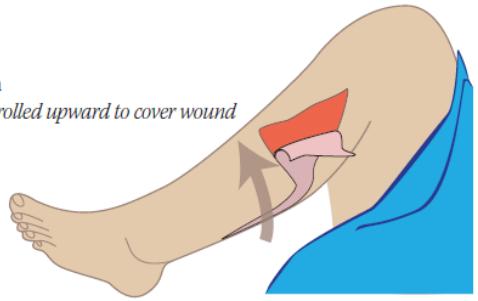


Figure 5a
Skin flap rolled upward to cover wound

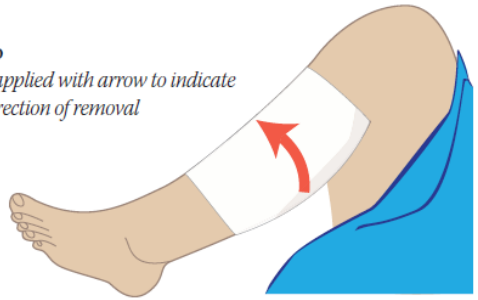


Figure 5b
Dressing applied with arrow to indicate correct direction of removal

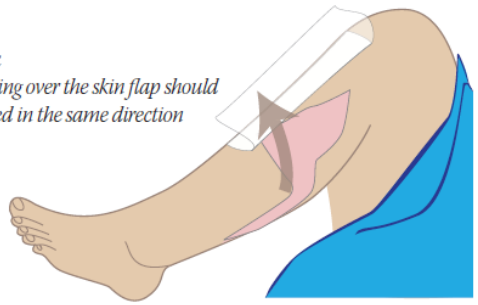


Figure 5c
Any dressing over the skin flap should be removed in the same direction