

MANAGING THE TREATMENT OF AN OLDER PATIENT WHO HAS A SKIN TEAR

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Skin tears usually occur in people who have paper-thin skin that bruises and breaks easily, such as the elderly or neonates. As skin ages the epidermis gradually thins, allowing it to be more susceptible to damage (Baronski and Ayello, 1995). The skin also experiences a reduction in elastin which again makes it more prone to damage.



Figure 1. Trauma to the hand causing displacement of tissue — skin tear.

In neonates, skin is initially thinner than that of an adult, it produces fewer secretions and is more susceptible to infection (Singleton, 1997). A tear to the skin usually occurs through trauma and is often located on the individual's extremities such as the arms or lower leg, where an accidental bump or knock causes injury. The epidermis is displaced when the skin is torn but still retains a blood supply.

The most efficient way to manage a skin tear is to reapply the skin

flap, trying to bring the wound edges together to heal by first intention.

If the skin is reapplied at the time of injury, good coverage can be achieved even in the most friable of skin.

The aim of this case study is to demonstrate the treatment given for an episode of acute trauma with the aim of preventing the tear from turning into a chronic wound.

PATIENT ASSESSMENT

The patient was a 79-year-old woman who had low blood pressure. She was frail and required a walking stick to help her mobilise. She lived alone in a one-bedroom flat and was visited daily by her daughter. She had fainted while going to the toilet and had fallen on the bathroom floor, sustaining a trauma injury to her hand, and was discovered by her daughter the next morning.

She was taken to A&E where she was examined and a primary non-adherent dressing and a secondary borderless foam dressing were applied and secured with a bandage. She was then transferred to the orthopaedic unit for further investigation. An X-ray revealed that she had fractured her left collar-bone, but had no injuries to her arms. A referral to the department of tissue viability was made to review her hand wound and to advise on its appropriate dressing.

Initial assessment by the tissue viability nurse showed that a



Figure 2. A skin tear treated with steri-strips.



Figure 3. A skin tear where the edges have separated.



Figure 4. Soft silicone dressing used in the treatment of a skin tear.



Figure 5. Skin tear following reapplication of displaced skin. A large part of the skin has survived and been successfully reapplied.

skin tear had occurred (Figure 1). On examination, the skin was still attached and had a blood supply, but had been displaced and had curled over on itself. The treatment aim was to try and reapply the skin to achieve good skin cover.

TREATMENT AND OUTCOMES

Cooling the wound inhibits cell division and could therefore delay the healing process (Miller and Gilchrist, 1997) so the wound was cleansed using warmed sterile saline. This ensured that the wound did not contain any contaminants or debris from the original trauma which may have increased the risk of infection.

By moistening the wound bed it was easier to roll out the still attached tissue across the wound to cover as much of the injury as possible. Forceps were used to hold and move the skin without causing the tissue any trauma. The skin was then fixed in place. This can be done using a number of methods:

- ▶▶ Steri-strips can be used to secure the skin edges. Due to the friable nature of the skin they may need to be pre-moistened before they are removed (Figure 2)
- ▶▶ A silicone non-adherent or low-adherent dressing could be applied to secure the skin (Figures 3 and 4)
- ▶▶ Wound glue can be used to secure the wound edges together.

As the patient's skin was very friable and not all the edges had been realigned, the tissue was held in place

using a silicone non-adherent dressing. This was secured with a non-adhesive foam to prevent further trauma to the surrounding skin from the dressing adhesive. Orthopaedic padding was used with a retention stockinette dressing.

OUTCOMES

The wound was left undisturbed for three days. Figure 5 shows the wound on examination. There was a 90% take of the skin that was replaced and the remaining wound bed looked clean and showed signs of healing. The dressing was reapplied and left for another three days. Following reassessment this treatment continued until complete healing occurred.

CONCLUSION

When faced with a skin tear it is important to treat the wound immediately and to reapply the skin. It is then necessary to choose a method of securing the skin which best meets the patients needs. The dressing needs to be left for 3–7 days if possible to allow the skin to re-establish itself. However, if you are concerned about infection then the wound should be reviewed more frequently. **WE**

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Singleton JK (1997) Pediatric dermatoses: three common skin disruptions in infancy. *Nurse Pract* **22**: 32–50

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