

# The classification of, and dressing choice, for skin tears in the pre-hospital setting

## KEY WORDS

- ▶▶ Ambulance staff
- ▶▶ Ambulance service
- ▶▶ Skin tears
- ▶▶ Classification tools
- ▶▶ Wound closure

Skin tears can have significant consequences for both the patient and the healthcare provider. An ageing population, together with an increasing variety of comorbidities with associated medications, all combined with the volume of emergency calls related to slips, trips and falls, ambulance staff have become a front-line service for wound interventions (Bateman, 2014; Brown et al, 2019; Hickey & Ayers, 2021). Therefore, it is important that ambulance staff are educated in the assessment and management of wounds. Skin tears are a wound type commonly seen by ambulance staff when called out to attend patients in the pre-hospital setting. This review will look at the various assessment tools available for classifying skin tears to determine which assessment tool would be most appropriate for use within the ambulance service, with an additional focus on the present dressing regimen used within the East of England Ambulance Service (EEAST) for the management of skin tears in the pre-hospital setting.

Skin tears are defined as “a traumatic wound caused by mechanical forces, including removal of adhesives. Severity may vary by depth (not extending through the subcutaneous layer)” (LeBlanc et al, 2018). In addition, a skin tear is a wound type that is at risk of not healing if managed inappropriately from its inception (LeBlanc and Baranoski, 2011). Skin tears can have significant consequences for the patient and the healthcare provider. Pain and poor management of the wound can reduce the patient’s quality of life and cause an increase in healthcare costs for on-going treatment (Chang et al, 2016). Guest et al (2020) carried out a retrospective cohort analysis of the electronic records of 3000 patients managed in the UK’s NHS in 2017/2018. Data was collected from The Health Improvement Network (THIN) database. The aims of this analysis were: to evaluate the prevalence of wounds; associated health outcomes; resource use; and costs. There was no separate wound category for skin tears in this analysis, but certainly skin tears will have been present in this group of 3000 patients and possibly categorised within one of the other categories such as unspecified leg ulcer (9%), open wound (9%), trauma (7%) or unspecified wound (16%). Guest et al (2020) concluded that it was essential that clinicians get the wound management right at the first wound assessment.

With an ageing population, together with an increasing variety of comorbidities and associated medications and combined with the volume of emergency calls related to slips, trips and falls, ambulance staff have become a front-line service for wound interventions (Bateman, 2014; Hickey & Ayers, 2021). In addition, ambulance staff follow clinical guidelines set by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). These guidelines have a section covering falls in older adults that recommends ambulance staff perform a skin inspection on patients who have had a fall (Brown et al, 2019). Again, this is another opportunity for ambulance staff to identify skin tears and initiate treatment. It is, therefore, important that ambulance staff are educated in the assessment and management of wounds, especially skin tears, and that their practice becomes standardised, with the aim of providing both a consistent and effective service for patients. If ambulance staff get it right at the first assessment, it would have the additional benefit of confirming ambulances staffs’ clinical credibility within the multidisciplinary team. With these aims in mind, this article will explore the various assessment tools available for classifying skin tears. This will allow an evidence based consideration of the most appropriate tool to use within the East of England Ambulance Service Trust (EEAST), with

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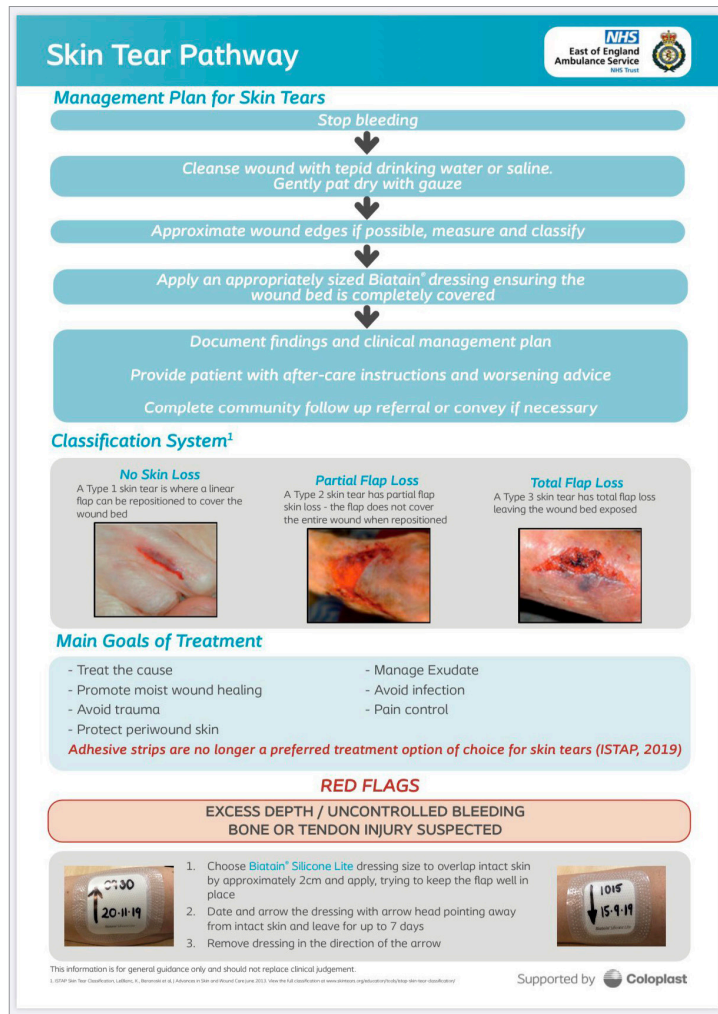
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**Figure 1. Skin tear pathway (EEAST, 2021)**

an additional focus on the present dressing regimen used within the East of England Ambulance Service (EEAST) for the management of skin tears in the pre-hospital setting.

The National Audit Office (2017) reports that the UK ambulance services described 10.7 million 999 calls in 2015/16, with 6.6 million people receiving face-to-face assessments by an ambulance clinician; 8–10% of these calls were for falls. The majority of calls for falls are from elderly patients who are at a higher risk of minor wounds, particularly skin tears (McInulty, 2017). Despite these perceived high numbers of patients suffering from minor wounds and skin tears, which the ambulance service is attending, there is a dearth of published papers around this important area. However, an audit carried out in 52 care homes in Worcestershire UK by Stephen-Haynes et al (2011) identified that overall in the 12-week audit period 49/2200 residents

developed a skin tear. This audit reported 20% of these patients were either taken to an emergency department (ED) or were treated by ambulance staff at the scene. This compared with 23% who were treated by district nurses. Despite this being a small audit from ten years ago, it does highlight that ambulance staff have an important role to play in skin tear management. In a more recent systematic literature review Strazzieri-Pulido et al (2017) identified and evaluated the available literature on the incidence of STs in adults and the elderly. Five studies reporting incidence of STs met the selection criteria and were included in the review. Strazzieri-Pulido et al (2017) reported incidence rates of skin tears in a range of 2.23% up to 92% in long-term care facilities. Again this highlights the potential size of the skin tear problem.

The role of the ambulance service has undoubtedly transformed over the years, as has the role of the ambulance clinician. According to the Keogh review (2017), only 8% of calls are for life threatening emergencies, signifying that the majority of patients are calling for lower acuity complaints. The Keogh review (2013) proposed enhancing the 999-emergency service into a mobile urgent treatment service, in order to reduce the number of patients conveyed to EDs for the initiation of care. If ambulance staff are trained to take on more primary healthcare activities, then this will provide a number of benefits, such as relieving pressure on EDs and going some way to addressing the anxieties that many patients have regarding attending an ED, especially in the current climate of the SARS-Cov-2 (COVID-19) pandemic. As a result of the 2013 Keogh review, the role of the advanced paramedic was formed, leading to experienced paramedics enhancing their assessment and management skills. These include managing acute-on-chronic long-term conditions including wound care, social care assessments, mental ill-health, and a range of urgent care presentations.

At the height of the COVID-19 pandemic in 2020, with local services being reduced and community staff having been redeployed, ambulance staff have stepped into the role of managing the closure of minor wounds, such as skin tears and lacerations. The East of England Ambulance Service NHS Trust (EEAST) follow the International Skin Tear Advisory Panel (ISTAP)

## Box 1. EEAST 2021

### Inclusion:

- Wounds with clean edges and wound beds
- Wounds 5cm or less in length
- Wounds that do not involve sub-dermal layers
- Wounds with limited risk factors for infection
- Type 1, 2 and 3 skin tears
- STs that are over joints
- Older wounds can be cleaned and dressed with Biatain; however, a more urgent referral is needed for rapid follow up with a district nurse or GP surgery.

## Box 2. EEAST 2021

### Exclusion:

- No consent to treatment
- Allergy to wound care product
- Wounds with associated nerve, vascular and tendon (including sheath) damage
- The location of the wound which includes:
- Injuries to lips, mouth and nose
- On the hand (including palm)\*
- On the feet\*
- Any areas over joints\*
- Injury to tendon
- Wounds on the face. Wounds on the forehead and scalp can be considered for closing with tissue adhesive, providing the clinician is able to exclude:
- Fracture or bony tenderness
- Loss of consciousness
- Neurological deficit
- Any other relevant complications of head injuries
- Location of wound may lead to poor cosmetic appearance (consider
- Injury site and patient age)
- Pre-tibial lacerations and skin tears; separate guidance for closure
- Any sign of localised infection including cellulitis
- Foreign body suspected in wound, e.g. glass
- Complex wound edges and anatomical location meaning they are unable to be secured for effective closure and/or cosmetic appearance
- Children under 5 years of age (phone clinical advice line for advice)

\* skin tears on hands/feet/over joints can be managed with Biatain via the EEAST skin tear pathway if no red flags are present on assessment

guidance (LeBlanc et al, 2018) for the assessment and management of skin tears. EEAST's protocol. Criteria for skin tears are outlined in *Figure 1*.

This was created by the urgent care management team, which consists of advanced paramedics in urgent care, with support from industry (Coloplast), and peer-reviewed by tissue viability specialists across the East of England. EEAST's skin tear guidance was underpinned by case study evidence (Hickey and Ayres, 2021) and implemented using a structured training programme, as a Service Improvement Project, to support its clinical use. Treatment for skin tears within the EEAST ambulance service, is dependent upon the type and location of the wound (*Boxes 1 and 2*) (EEAST, 2021), the availability of wound closure trained ambulance staff, and the condition of the patient. Wound closure is not a mandatory component in the training of ambulance staff, so the clinician will volunteer for further courses when they feel ready to develop their skills. Because of this current approach, there may not always be a member of staff who is trained in wound care on all frontline vehicles. In view of this challenge EEAST have now incorporated wound care training into their online Learning Management System (LMS), enabling staff to access it during a time that is convenient for them. EEAST have also started to integrate skin tear management training into their Higher Education Institution (HEI) partner academic programmes. This means newly qualified paramedics joining the trust from universities are up to date with wound care knowledge and are able to support best practice on joining the service as frontline ambulance staff.

### The development of the Skin Tear Pathway by the East of England Ambulance Service NHS Trust

In their editorial, Hickey and Ayers (2020) clearly documented the background and process to the development of the skin tear pathway to be used by ambulance staff working in the EEAST. This section will consider two areas of the skin tear pathway: the classification of skin tears; and the dressing choice for management of skin tears.

The first step in the development of the skin tear pathway for the EEAST was to facilitate ambulance staff in identifying and classifying the skin tears with the use of a validated skin tear classification tool. The first recognised classification tool for STs was the Payne-Martin Classification System (Payne and Martin, 1993), which enabled health care providers

a consistent approach to assessing skin tears. This early tool requires the clinician to work out the percentage of tissue loss in order to grade the wound. Measuring tissue loss can be difficult and subjective (LeBlanc, et al, 2013). The Payne-Martin System was never validated, but it did pave the way for the development of other skin tear classification tools and highlighted the importance of skin tears to the wound care community. The Skin Tear Audit Research (STAR) system was introduced as a moderated version of the Payne-Martin system (Carville et al, 2007), and is particularly focused on the epidermal loss and the condition of the epidermal tissue. At the outset of its development, this specific focus was a clear study objective for the research team developing the STAR tool, which ultimately would lead to clinician agreement on the classification of the skin tear being assessed. The STAR system has not been adopted on a global level due to the overlapping of the categories and the potential for subsequent confusion that this may cause when the clinician is classifying the skin tear using the STAR tool (LeBlanc et al, 2013).

The International Skin Tear Advisory Panel (ISTAP) classification method was introduced to bring in a standardised, methodical and a validated approach to ST assessment (LeBlanc et al, 2013; LeBlanc et al, 2018). It consists of three simple categories:

- ▶▶ Type 1: No skin loss
- ▶▶ Type 2: Partial flap loss
- ▶▶ Type 3: Total flap loss (*Figure 1*).

ISTAP has been validated for external, internal and intra-reliability and was found to have 86% agreement, (LeBlanc, et al, 2013). The methodology used to reach this agreement was a consensus panel of 12 internationally recognised key opinion leaders, who formulated the classification system, then tested for inter-rater and intra-rater reliability (proving consistency across the variables) before being tested on a wider scale of 327 healthcare professionals in practice. An international study (Van Tiggelen et al, 2019) set out to determine the reliability of the ISTAP tool. This study included a two round Delphi procedure involving 17 experts from 11 different countries for phase one and 1601 health professionals from 44 countries for phase two. A high level of agreement was reached

regarding a definition for skin tears, inter-reliability was reported as moderate to substantial, with the intra-rater reliability recorded as substantial to almost perfect (Van Tiggelen et al, 2019). Clearly the findings offer a strong recommendation for the effectiveness of ISTAP being employed by ambulance staff in the EEAST. There have been a range of global studies published to validate international versions of the ISTAP system. For example, Bassola et al (2019) confirmed this tool is reliable when translating into the Italian version, advocating its validity for clinical use. In conclusion, the ISTAP system has been incorporated into the EEAST skin tear pathway due to its simplicity and because the published evidence supports the reliability and validity of the system. In local practice it has been observed that ambulance staff can have difficulty communicating a wound description to other health professionals, including the ISTAP system into the EEAST skin tear pathway will assist with the transfer of reliable information between disciplines on skin tears. Another important benefit of using such a tool is that it will facilitate the auditing of our wound care assessment and documentation, with the aim of supporting and encouraging best practice.

### Dressing choice

Management of skin tears should be aimed at choosing a good wound care product (dressing) to optimise wound healing and prevent further skin damage (LeBlanc et al, 2016; LeBlanc et al, 2018). When selecting a dressing, it is advised that the clinician should consider the goals that need to be achieved for effective healing, such as protection of the periwound area and respecting the environment of the wound bed presentation in order to aim for moist wound healing (Sibbald et al, 2007) and the prevention of infection. This guidance also applies when considering how to manage a skin tear wound.

For many years, the go-to wound care product for skin tear management within the ambulance service was adhesive skin closure strips. However, the use of adhesive skin closure strips is now deemed controversial in wound care, particularly for use on skin tears. Stephen-Haynes and Carville (2011) advised that if room is left between the strips, this will facilitate drainage



and avoid unnecessary tension over the wound. In contradiction to this, it has been stated that adhesive skin closure strips are usually applied under tension by clinicians and therefore there is a risk of further trauma during removal (Meuleneire, 2002). Rayner et al (2015) affirm, in their review of skin condition and skin tears, that due to the fragility of skin around skin tears, the use of adhesive skin closure strips is no longer recommended for use on skin tears. In her review on skin tears, Benbow (2017) recommends that adhesive skin closure strips should be avoided in the management of skin tears. This view is supported by the ISTAP panel, evidenced from case studies and expert opinion, who also advise adhesive skin closure strips should no longer be considered as a preferred treatment for skin tears, due to the risk of further injury (LeBlanc et al, 2016). Likewise, the best practice document for *"Prevention and Management of Skin Tears in Aged Skin"* (LeBlanc et al, 2018) advises against hydrocolloid dressing use in skin tear management due to the significant adhesive properties that a hydrocolloid dressing contains. This document also advises against iodine and gauze dressings due to the drying properties which can result in trauma on removal.

EEAST, therefore, needed to find a dressing that was suitable for use on skin tears that could be directed to within the skin tear pathway. The objective of this search was to reduce the variation in dressings used for skin tears across EEAST and provide a simple-to-use dressing product. The search for a dressing took into consideration the advice from ISTAP (2018) that the ideal dressing for use on skin tears is one that can: stay in place for 7 days; maintain a moist wound healing environment, while also addressing the exudate that will be present; and is able to protect the periwound skin, particularly during removal of the dressing. A dressing aids healing if it has the ability to conform, and therefore fills the gap between the dressing and the wound bed, so reducing the potential for exudate-pooling (Wilson et al, 2019).

LeBlanc and Woo (2021) carried out a randomised control trial (n=126) to evaluate the use of soft silicone dressings versus a control group of non-adhesive dressings in the healing

of skin tears. Results demonstrated 89.2% (n=58) of patients achieved complete wound closure at week two in the treatment group (silicone dressing), compared with 27.9% (n=17) in the control group (non-silicone dressing). They also found that skin tears healed over 50% (11 days) faster in this group of elderly patients who had a silicone dressing when compared with the non-silicone dressings (22 days). With this evidence, supporting the use of soft silicone dressings, in mind, EEAST also studied the Clinical Review of Foam dressings by the NHS Clinical Evaluation Team (Hall et al, 2018). This document reviewed the range of foam dressings available through the NHS national procurement provider's framework as of August 2016. These were further divided into sub-categories including silicone adhesive foam, and silicone non-adhesive foam lite. Each dressing was scored for a variety of clinical criteria use under the categories of packaging, operation and preparation for use, clinical use and disposal. Once EEAST had determined which clinical indicators were of high priority for a dressing for pre-hospital use, they could then use this NHS clinical guidance document in order to select the appropriate dressing for skin tear management for ambulance clinicians. This resulted in the EEAST selecting Biatain Silicone Lite as their skin tear pathway dressing of choice.

Further rationale for choosing Biatain Silicone Lite (Coloplast) for the management of skin tears across EEAST was as follows:

- ▶▶ It is a silicone dressing (in line with the ISTAP 2018 best practice guidance document) which: is easy to apply and remove; will not cause trauma on removal; will provide a protective anti-shear barrier; is flexible; and will mould to contours
- ▶▶ Suitable for use on type 1, 2 and 3 skin tears (ISTAP classification, *Figure 1*), which will coincide with the EEAST's skin tear pathway, which includes the ISTAP classification assessment
- ▶▶ It has a range of available sizes
- ▶▶ Ease of use, which is important for ambulance staff who have limited experience using dressings, and does not require ambulance staff to remain with the patient for lengthy periods of time when there are other calls to attend
- ▶▶ Cost
- ▶▶ 5–7-day wear time (minimising painful, disruptive dressing changes for patient and creating more time

for community nursing teams to better plan their follow up visits)

- ▶▶ Reduction in clinical variation in management of skin tears across the Trust
- ▶▶ Reduction in adverse incident reports caused by poor skin tear wound management practice.

In addition to delivering wound care to patients sustaining a skin tear, ambulance staff are also instructed to leave an after-care leaflet with the patient which offers practical information regarding caring for the wound and when to seek further medical help. This leaflet offers advice on signs of infection, showering with the dressing *in situ* and what to do should the dressing become damaged. Alongside this, ambulance staff request community follow up with a referral to the community nursing service where continued care of the wound can be delivered. The introduction of a skin tear pathway within the ambulance service in the EEAST for the care of a patient sustaining a skin tear has been standardised and this in turn should lead to improved healing times of the skin tear.

### CONCLUSION

In conclusion, the clinical advantage of a standardised assessment structure for skin tears will facilitate best practice for skin tear care within the ambulance service. The priority of the initial assessment is to classify the skin tear and thus be able to determine the best treatment plan for that patient. Research into the classification systems has indicated that the ISTAP system is a validated tool and is considered to be the most appropriate for use among an international panel of experts (Van Tiggelen et al, 2019). The use of the skin tear pathway enables ambulance staff to provide a detailed description of the wound presentation in their documentation, including the classification grade, with a subsequent thorough and comprehensive handover of the wound management plan to health professionals who are to take over the care of the wound in 3–5 days' time, usually community nursing staff. It is, therefore, advisable for ambulance staff trainers to not only teach the ISTAP classification tool in their wound care training, but to also offer updated training packages to health professionals who are already wound-care qualified within the ambulance

service, therefore ensuring high quality assessment of skin tears is being delivered by ambulance staff.

When considering a treatment strategy for each skin tear management plan, it is essential that this is individualised to each patient. For example, one patient may require different goals of care to another: one patient may require different pain relief; wound healing for some patients may be impacted by comorbidities, such as diabetes, which may need to be managed by a specialist clinician; yet another may require skin tear prevention strategies to be implemented, which might include a further assessment of their living and social needs etc. In the initial assessment of a patient with a skin tear by ambulance staff, s/he will not necessarily have the time or necessary resources to carry out such a holistic assessment of the patient and their circumstances, but ambulance staff are able to refer the patient on, thus facilitating the long-term holistic assessment. The introduction of a skin tear pathway by the EEAST has certainly made the referral process more efficient. What needs to happen in the future is an evaluation of the impact of this skin tear pathway on the outcomes of the patients, and their skin tear, to realise the benefits of the introduction of the skin tear pathway in the EEAST. Results from this evaluation would be reviewed and considered for further learning to be identified, developed, and incorporated into annual mandatory training updates for all grades of ambulance staff. **WUK**

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