Assessment framework for prescribing: lower limb skin tears.

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Assessment framework for prescribing: lower limb skin tears

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Prescribing by a variety of professionals continues its progression in response to the growing demands for health care. Prescribing by nurses was initiated in the 1990s and supported by the National Prescribing Centre's 'prescribing pyramid' or seven steps or principles for good prescribing (NPC, 1999). This article explores a new prescribing consultation model (RAPID-CASE), which is composed of elements from the prescribing pyramid and the Competency Framework for all prescribers (Royal Pharmaceutical Society [RPS], 2021). The RAPID-CASE consultation model is applied to a clinical scenario to illustrate how it can guide a systematic approach to decision-making, using the example of a lower limb skin tear injury.

KEYWORDS:
■ Prescribing ■ RAPID-CASE ■ Lower limb skin tears

Prescribing by nurses, midwives, pharmacists, and allied health professionals (AHPs) has grown substantially in recent years (*Table 1*) (Health and Care Professions Council [HCPC], 2021; Nursing and Midwifery Council [NMC], 2022). The legal authority to prescribe was first awarded to specialist practice qualified (SPQ) nurses (health visitors and district nurses) in the 1990s, with prescribing from a limited nurse prescribers' formulary (NPF) (Joint Formulary Committee [JFC] and Nurse Prescribers Advisory Group [NPAG], 2022). Incremental changes in law extended prescribing rights to other professionals and added full formulary access with some restrictions for controlled drugs (Human Medicines Regulations [HMR], 2012, 2013, 2018, Misuse of drugs regulations, amendment 2012).

'The RAPID-CASE model aims to promote safe and effective prescribing decisions that consider the person's unique situation and preferences.'

Prescribing practice was initially supported by National Prescribing Centre publications, including an assessment framework known as the 'prescribing pyramid' or '7 principles of good prescribing' (NPC, 1999). This framework focused on the steps to a safe and effective prescribing choice and retains links to the 'competency framework for all prescribers' (CFAP) (Royal Pharmaceutical Society [RPS], 2021). With the significantly increased range of prescriptions, and the emergent need to undertake remote consultations, a revised version of this model has been developed as a concise reference guide for prescribing decisions (Gould and Bain, 2022). This article applies the updated model to the example of lower limb skin tear injuries.

Most educational standards for prescribing (NMC, 2018b; HCPC, 2019) embed the CFAP (RPS, 2021), and the CFAP also acts as a continuing professional development (CPD) tool. The framework defines expectations around any prescriber's skills, knowledge, and competence in relation to consultation and governance. Clinical encounters result in some type of decision, such as advice, referral, or treatment planning, which may include prescribing (Gould and Bain, 2022). Thorough, person-centred assessment underpins safe prescribing decisions and, in many instances, this can be done efficiently by using a model to guide a systematic approach. The RAPID-CASE model (*Figure 1*) aims to promote safe and effective prescribing decisions that consider the person's unique situation and preferences. In line with the CFAP (RPS, 2021), it encourages attention to influences on prescribing, such as research evidence, formularies, expert advice, and adherence to or justified deviation from guidelines.

As per the CFAP (RPS, 2021), an appropriate biopsychosocial history and assessment should be done, leading to diagnosis, informed choice, and an agreed plan. Using a consultation model can help prevent some of the issues seen with poor assessment, such as misdiagnosis, error, variable concordance with treatment regimens, or lack of a baseline against which to judge

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deterioration or improvement. Accessing and interpreting relevant records should ideally be done before the consultation (RPS, 2021). In the authors' clinical opinion, use of a model can assist with streamlining the consultation, while ensuring important aspects such as the person's perspective are also attended to. The application of 'RAPID-CASE' is illustrated in this article through the scenario of Miss Rose Nichol, a 95-year-old care home resident who has sustained a lower limb skin tear injury. Before the consultation, available health records were accessed, with pertinent information reviewed.

RAPID — RAPPORT

Consultations should start with introductions, confirming identity and gaining consent. Assessment of mental capacity should take place when seeking consent as it must be contemporaneous (Department for Constitutional Affairs [DCA], 2013; Griffith, 2017). As the referral was from Miss Nichol's carers, her understanding of the issue would need to be established, along with her mental capacity for consenting to assessment and treatment. While capacity should be assumed (DCA, 2013), the prevalence of dementia in older females (95+) is estimated at over 44% (Prince, 2014) and not always formally diagnosed. In this instance, Miss Nichol was able to retain information, explain how the injury happened, and express awareness that it required treatment, which suggests mental capacity to consent to this assessment.

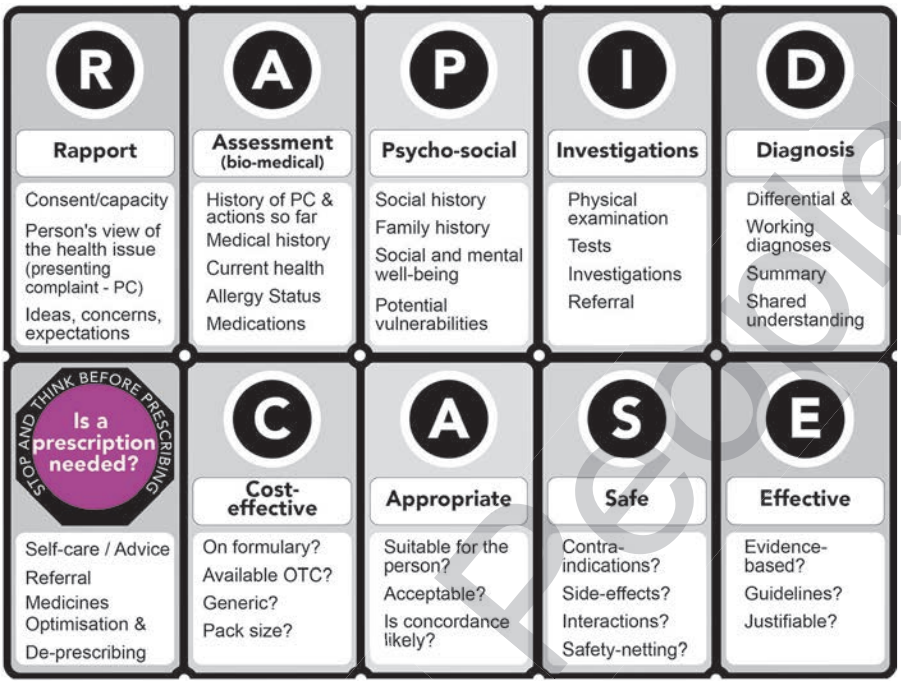

Figure 1.
RAPID-CASE assessment for prescribing model (Gould and Bain, 2022).

Developing rapport and establishing the person's view of their health issue is helped by initially exploring their ideas, concerns, and expectations (Neighbour, 1987). The assessment can begin conversationally with mainly open questions, which are useful for prompting an understanding of the person's perspective and priorities (NMC, 2018a; RPS, 2021). Applying the ICE mnemonic (Neighbour, 1987), it can be established that Miss Nichol hit her leg accidentally when getting out of bed and thinking it is a small scrape (ideas), she is worried that it might turn into an ulcer (concerns) and wants to get the wound healed as soon as possible (expectations).

Table 1: Number of prescribers (General Pharmaceutical Council [GPhC], 2021; HCPC, 2021; NMC, 2022)

Profession	Qualification	2017	2018	2019	2020	2021	+/-
Nurses and midwives	Community practitioner nurse prescriber (V100/V150)	40,612	40,748	40,879	41,049	41,301	+689
	Independent/supplementary prescriber (V300)	36,983	40,041	43,717	47,899	50,693	+13,710
	NMC total — all prescribers*	79,044	82,164	85,888	90,159	93,146	+14,102
Pharmacists	Supplementary prescriber	359	322	301	285	tbc	-74
	Independent prescriber	5061	6667	8356	9738	tbc	+4677
	Independent/supplementary	972	972	955	952	tbc	-20
Allied health professionals	Supplementary prescriber	708	1293	1688	2472	3163	+2455
	Independent prescriber	993	1555	1988	2789	3533	+2450

RAPID — ASSESSMENT OF BIO-MEDICAL

The history of the presenting complaint can start with a broad open question, followed by more specific or closed questions as appropriate. A good history of the presenting complaint and events leading to it may reveal an underlying issue or alter treatment options. *Table 2* suggests some example questions and potential underlying causes. For Miss Nichol, observing and measuring the wound area will help establish the type of skin tear, while underlying issues related to current health, such as nutritional status, weight loss, skin condition/integrity, and arterial or venous insufficiency should be considered. An assessment template or protocol can help prompt the questions, but it may be generalised to wound care, whereas the use of a more specific lower limb skin tear pathway can be beneficial (Wounds UK, 2020).

In this example, no current medical conditions, medications, or allergies were reported and there were no previous incidents with leg wounds or history of leg ulceration. Miss Nichol described general discomfort, and was taking no over-the-counter medication, alternative medicines, or herbal

Table 2: Examples of assessment questions

When did this happen?
▸ How long ago? ▸ Has there been any treatment applied?
How did this happen?
▸ Was there a fall? ▸ Was there loss of consciousness?
Why did this happen?
▸ Medical history: • Is there reduced tissue perfusion? e.g. Raynaud's, arterial or peripheral vascular disease, anaemia etc • And/or comorbidities? diabetes, cardiac/respiratory/renal disease, malignancy, rheumatoid arthritis, impaired immune response, impaired cognition (sensory, visual, auditory), history of falls ▸ Medication history • Steroid, cytotoxic, immunosuppressant therapies, opioids, medicines affecting the nervous system, polypharmacy, etc? • General health, nutrition, hydration, mobility and activity level? • Skin health and condition (e.g. thin, dry, friable, fragile)? • Previous episodes: any previous skin tears?

Table 3: ABCDEs of skin tear wound assessment (Gould and Bain, 2022, based on Wounds UK, 2020)

A. Anatomical location	▸ Be precise and use noted locations or an image chart
B. Bleeding or haematoma	▸ Note amount or size of haematoma; treat bleeding
C. Condition and integrity of skin flap and surrounding skin	▸ See diagnosis section for types/classification of skin tears
D. Dimensions and wound bed	
E. Exudate	▸ Volume, type, colour and odour
S. Signs of infection	▸ Redness, increased temperature at site

products. Being thorough with medicine usage is important, as polypharmacy and drug interactions can increase the risk of adverse events (National Institute for Health and Care Excellence [NICE], 2018). The prescriber may be following a specific template, but clinical judgment should also guide the use of additional assessments. For example, a scoring tool for nutritional status, pressure ulcer risk assessment, or a sepsis or pain scale may be needed. A recognised tool, such as 'SOCRATES' (*Box 1*), can be used for a more rounded assessment of pain (Gregory, 2019).

Assessments, such as a pain score, should be recorded to act as a baseline against which to measure when evaluating treatment. Specific to wound care, an assessment and record of the wound and its characteristics are needed. This should include the 'ABCDEs' skin tear assessment in *Table 3* as a minimum (Wounds UK, 2020; Gould and Bain, 2022). The condition of the wound and wound bed should be assessed against the classification system (as per the diagnosis section).

'In relation to vulnerabilities, the RPS (2021) explains this as safeguarding those who are vulnerable (with possible signs of abuse, neglect, or exploitation) and considering both physical and mental health.'

RAPID — PSYCHOSOCIAL AND CONTEXT

Psychosocial assessment involves looking at the wider picture and considering some of the influences on the presenting problem and its treatment. A brief account of contributing factors to consider is found in *Table 4*. Miss Nichol's increased frailty meant that she required residential care. She reported feeling less isolated but has been 'a bit low' since the move. Research involving people with leg ulcers has shown that quality of life and pain are not always discussed or dealt with sufficiently (Green et al, 2018a). This prompted the development of a quality-of-life wound checklist to remind practitioners to raise and address these issues (Green et al, 2018b). Additional assessments, such as for depression and anxiety, may be required, and/or referral indicated. It is important to be alert to the possibility of depression and be familiar with the two core questions ('Whooley questions') that have been shown to indicate depression (Bosanquet, 2015; NICE, 2021a).

In relation to vulnerabilities, the RPS (2021) explains this as safeguarding those who are vulnerable (with possible signs of abuse, neglect, or exploitation)

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Whooley questions for depression screening include:

During the past month, have you been bothered by feeling down, depressed or hopeless?

During the past month, have you been bothered by little interest or pleasure in doing things?

'Yes' to one (or both) questions means a positive test and further evaluation is needed.

'No' to both questions means a negative test, i.e. the patient is not depressed.

Table 4: Contributing psychosocial factors

Psychological	▸ Social isolation ▸ Anxiety or low mood, signs of depression
Lifestyle factors	▸ Alcohol intake/illicit drug use ▸ Smoking
Social and setting	▸ Family/carers, support system ▸ Falls safety (e.g. stairs, furniture, rugs, lighting etc)
Other	▸ Was this preventable? ▸ Vulnerabilities, safeguarding?

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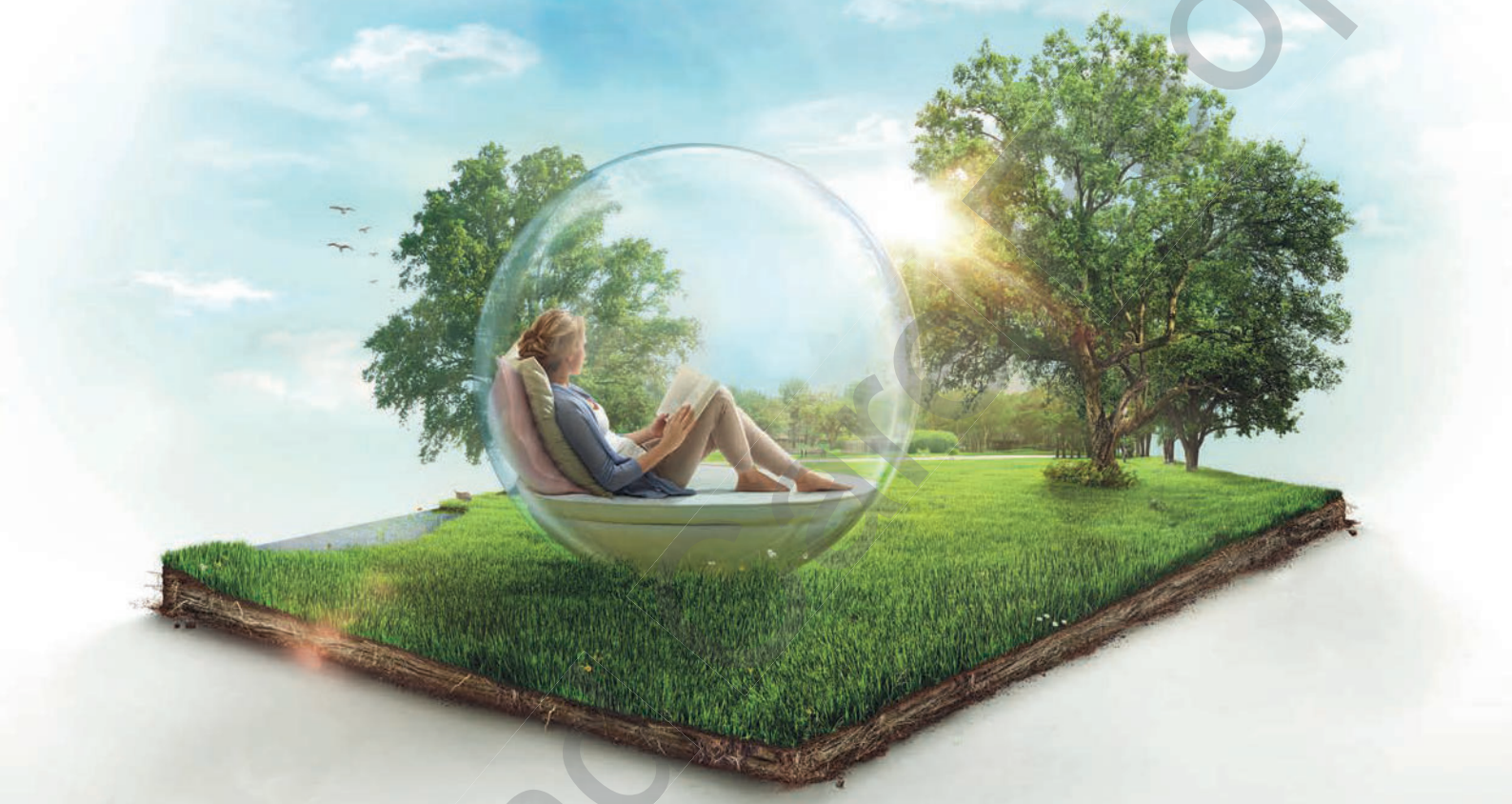

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A non-adherent mesh contact layer, such as a lipidocolloid mesh, is one of the recommended dressings for use on lower limb skin tears (LeBlanc et al, 2018).

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1. Meaume S. Urgotul®: a novel non-adherent lipidocolloid dressing. British Journal of Nursing. 2002, Vol 11, N°16.
2. Bernard FX et al. Effets d'un pansement lipidocolloïde sur a production de matrice extracellulaire. Journal des Plaies et Cicatrisations, 2007 (study conducted on Urgotul).
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Box 1

Example application of the SOCRATES for pain assessment

- S Site: reportedly from wound area with some radiation
- O Onset: started when she hit her leg, worse initially
- C Character: described as a dull ache, but sometimes sharp when she moves
- R Radiation: mainly just the wound, but says her lower left leg is uncomfortable
- A Associated symptoms: none reported
- T Time: reports it there nearly all the time
- E Exacerbating or relieving factors: standing makes it worse. Has had some paracetamol which reportedly helped
- S Severity of the pain: the pain is mild to moderate (5 on a scale of 1–10)

and considering both physical and mental health. As part of wound care capability (National Wound Care Strategy Programme [NWCSP] and Skills for Health, 2021), staff are expected to consider safeguarding issues, recognise vulnerabilities (such as frailty), and take appropriate action.

Local policies fluctuate, but referral for safeguarding is indicated where harms appear to have occurred through neglect or poor practice. To improve care, Wounds UK (2020) note skin tears as adverse events that should be reported whenever they compromise the person's safety, or according to local protocol. Some areas have adopted a strategy of educating care home staff to treat most skin tears themselves, resulting in a large reduction in referrals to community nursing services (Mangan and Shoreman, 2021). While this may be beneficial within highly pressured community services, particularly during Covid-19, it potentially makes it more difficult to quantify the prevalence of injuries and put measures in place if needed.

RAPID — INVESTIGATIONS/ CLINICAL EXAMINATION(S)

Wounds UK (2020) and NICE (2021b) suggest a structured approach to investigations, including those listed in *Table 5*. In this example, a small wound of 2mm depth, irregular shape, with a partially absent skin layer was noted in the lateral gaiter area of Miss Nichol's left leg. There was minor redness to the surrounding area, no active bleeding, scant exudate, no pitting oedema or hair loss of the lower limb was evident, and peripheral pulses were strongly palpable. In addition to the more general physical examination, an ankle brachial pressure index (ABPI) measurement can be done to check suitability for compression hosiery or bandages (NWCSP, 2020). An ABPI and random BM (Boehringer Mannheim) check can also reveal signs or history of confounding factors, such as arteriosclerosis, calcification or undiagnosed diabetes. Investigations for full blood count (FBC), erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) (markers for inflammation and infection) had been undertaken within the past two months and a repeat may be indicated if signs of infection.

In the example of Miss Nichol, there were no signs of wound infection, 'red flag' symptoms, or causes for urgent referral such as signs of arterial disease (ABPI <0.5), dusky periphery or necrosis (NICE, 2019; 2021c).

RAPID — DIAGNOSIS

Making a diagnosis is a necessary step in the prescribing process, but it may need to be a working rather than definitive diagnosis. For example, if wound infection is suspected, but not yet confirmed, broad-spectrum antibiotic treatment can be based on the working diagnosis of an infection until a wound swab result is available. For skin tears, as with other diagnoses, it is important to have a clear definition against which to assess. Although not recognised as a separate type of wound by the World Health Organization's (WHO, 2022) International Classification of Diseases (ICD) system, skin tear injury has a recognised definition, and three types are classified as illustrated in *Box 2*. According to the best practice statement by Wounds UK (2020), skin tears should be graded using a validated tool known as the International Skin Tear Advisory Panel (ISTAP) classification (LeBlanc et al, 2013).

In the example of Miss Nichol, a diagnosis of lower limb skin tear, type 2, partial flap loss was noted. The type of skin tear is important to establish as it influences the treatment options. These are now considered using 'CASE' from the 'RAPID-CASE' model.

Box 2

Skin tear definition and classification

Definition (LeBlanc et al, 2019)

'A traumatic wound caused by mechanical forces, including removal of adhesives. Severity may vary by depth (not extending through the subcutaneous layer).'

ISTAP classification (LeBlanc et al, 2013)

Classifies as type 1, 2 or 3 based on skin loss:

- Type 1: No skin loss: Linear or flap tear which can be repositioned to cover the wound bed
- Type 2: Partial flap loss — which cannot be repositioned to cover the wound bed
- Type 3: Total flap loss — exposing entire wound bed

Table 5: Investigations

Observing for signs of underlying causes/risks	▸ Dizziness, confusion, ataxia ▸ Weight loss, cachexia or malnutrition (MUST score) ▸ Peripheral vascular/circulatory issues • ABPI assessment as indicated
Infection	▸ Check warmth, exudate, colour, odour ▸ Wound swab

Note: Infection is the most common complication of a laceration (NICE, 2021b). Although not specific to skin flaps, NICE (2021b) guidance states:

There is a high risk of infection in people with a laceration contaminated with soil, faeces, body fluids, or pus. The risk of infection is increased further with factors such as:

- Wound length of more than 5cm
- Foreign body present before cleaning of wound
- Diabetes mellitus
- Oral corticosteroid treatment and other causes of immunosuppression
- Age older than 65 years
- Stellate shape or jagged wound margins
- Wound location on the lower extremity
- Presentation more than six hours after injury

TREATMENT OPTIONS

Treatment options were discussed with Miss Nichol and influenced by wound management guidelines (Wounds UK, 2020), the local prescribing formulary, the British National Formulary, and with attention to NICE (2021b) guidance around the management of lacerations. The decision is outlined below using 'CASE' (part of RAPID-CASE), considering cost-effectiveness, appropriateness, safety, and effectiveness.

STOP AND THINK BEFORE PRESCRIBING

In the case of wound care, a prescription is normally required, although some organisations choose to supply dressings and other wound care products through a 'store' or supply chain. Medicines optimisation and deprescribing can be pertinent where the person's wound or deteriorating health is caused by the effect of medicines. For example, someone missing doses of an antihypertensive due to memory issues can be at risk of hypotension and falls when they start receiving it regularly. Deprescribing may also be needed in cases where the benefit of a product no longer outweighs the risk of harm, such as long-term steroid use.

CASE — COST-EFFECTIVE

Most prescribing is from a selection of approved items on local formularies, which are influenced by cost. In this example, items may be the lowest price, but if they cause further damage on removal, they are not necessarily the most cost-effective. The person's preference can also impact as, for example, Miss Nichol expressed she would prefer an alternative to a bulky bandage. Once the choice of product is made, decisions around quantities and pack sizes also needs to be considered to optimise cost-effective prescribing and reduce waste.

CASE: APPROPRIATE

Choice of treatment was influenced by the information gleaned from history-taking to check if it was suitable for Miss Nichol. As she had no known allergies or sensitivities, or cautions from pre-existing medical conditions, it was deemed appropriate to use the recommended treatment. Assessing for sensitivities is important and where the surrounding skin is frail, the product needs to be easily removed. Where there is delayed wound healing, and compression therapy is to be added, it is important to be alert to undetected problems with peripheral arterial circulation (NWCSP, 2020). Concordance with a treatment plan is dependent on a shared understanding and agreement between the prescriber and the person in their care.

CASE: SAFE

Linked to the above considerations specific for Miss Nichol, it was important to consider risks of harm and the need to prescribe cautiously. In relation to wound care products for skin tears, 'medical adhesive-related skin injuries' (MARSI) are a known cause of injury (LeBlanc et al, 2020). As a prescriber's duty of care extends to ensuring safe use of the product, education of care home staff around correct use and risk factors may be needed. As the products themselves can lead to further tissue damage, safety-netting around their removal and signs of sensitivity reaction are important. With an increased risk of infection due to age and other factors, safety-netting should also include looking for signs of infection or worsening of the trauma injury.

CASE: EFFECTIVE

Best practice recommendations for skin tears (LeBlanc et al, 2019) outline treatment aims linked to the stages of injury. For example, controlling bleeding and treating the cause of the injury where appropriate. In this example, the aim is primarily to create the ideal wound healing conditions (Joint Formulary Committee [JFC], 2022), while managing exudate, protecting surrounding skin and avoiding infection (LeBlanc et al, 2019).

The *British National Formulary* (BNF) (JFC, 2022) describes a list of attributes for the ideal dressing to promote moist wound healing, but these may not all be appropriate for skin tears, particularly where an overly dry wound bed, or excess moisture can cause further skin loss (Wounds UK, 2020). Anecdotally, some practitioners continue to use iodine impregnated dressings (e.g. Inadine™) and the manufacturer describes them as a non-adherent dressing suitable for use with 'minor traumatic skin loss injuries' (3M KCI, 2020). However, iodine-based

dressings are not recommended as they can cause drying of the wound and surrounding skin (Wounds UK, 2020). With a low-to-moderate exudate volume, selection could be a non-adherent mesh, foam, or acrylic dressing (LeBlanc et al, 2019; JFC, 2022). Considerations such as exudate volume, wound bed (and amount of skin flap), and skin fragility influence selection, with the aim of promoting wound healing without the risk of further skin damage (Wounds UK, 2020; JFC, 2022).

PRESCRIBE, PROVIDE INFORMATION, MONITOR AND REVIEW (RPS, 2021)

A shared decision involves ensuring that there is an understanding of the options, risks, and benefits of treatment before the prescription is issued. Safety-netting should include eliciting the person's understanding of what to do if the problem persists, worsens, or if new problems emerge (Neighbour, 1987).

Miss Nichol and her care manager were provided with information around signs of worsening, such as fresh bleeding, pain, inflammation, signs of infection (increased discomfort, redness and swelling), and advice about analgesia. Safety-netting places the responsibility from the healthcare professional to the person receiving care, or in the case of Miss Nichol, appropriate care home staff. Wound healing progress would be monitored and where delays to healing noted, it would be appropriate to assess for underlying causes and potentially, compression therapy (LeBlanc et al, 2019).

PRESCRIBING GOVERNANCE (RPS, 2021)

The consultation, any supplementary assessments and treatment plan should be documented on the shared electronic record, with Ms Nichol's consent to share the record with other healthcare professionals (Department of Health and Social Care [DHSC], 2016). Prescribing decisions should ideally be reflected upon to promote learning and identification of CPD needs.

CONCLUSION

This article has provided an example of applying the RAPID-CASE consultation model for prescribing in practice. Safe, effective practice involves being able to clearly articulate what underpins prescribing decisions and the use of a structured approach is beneficial.

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KEY POINTS

- Prescribing by a variety of professionals continues its progression in response to the growing demands for health care.
- Most educational standards for prescribing embed the competency framework for all prescribers (CFAP).
- Thorough person-centred assessment underpins safe prescribing decisions and, in many instances, this can be done efficiently by using a model to guide a systematic approach.
- In line with the CFAP, the RAPID-CASE model encourages attention to influences on prescribing, such as research evidence, formularies, expert advice, and adherence to or justified deviation from guidelines.
- Appropriate biopsychosocial history and assessment should be done, leading to diagnosis, informed choice, and an agreed plan.
- Use of a model can assist with streamlining the consultation, while ensuring important aspects such as the person's perspective are also attended to.
- Making a diagnosis is a necessary step in the prescribing process, but it may need to be a working rather than definitive diagnosis.
- A shared decision involves ensuring that there is an understanding of the options, risks and benefits of treatment before the prescription is issued.
- The consultation, any supplementary assessments and treatment plan should be documented on the shared electronic record, with the patient's consent to share the record with other healthcare professionals.