Title: Skin Tear Management

Department: District Nursing Service/PSRACS

DEFINITION

Skin Tear is the traumatic wound occurring principally on the extremities of older adults, but can develop in premature infants. They can be the result of friction alone or shearing and friction forces which separate the epidermis from the dermis (partial thickness wounds) or which separate both the epidermis and dermis from underlying structures (full thickness wounds).

SCOPE

District Nursing Services, Homecare services, Palliative Care Services

CLINICAL ALERT

Identify those at risk

- Assess / recognise fragile, thin, vulnerable ecchymotic skin
- Staff should use extreme caution and gentle touch when bathing, dressing &/or transferring individuals at risk (most skin tears occur during routine patient care activities)
- Avoid wearing jewellery that could damage the skin
- Avoid direct contact that will create a friction, or shearing force
- Protect fragile skin by covering with limb protectors, long sleeves/pants
- Use neutral PH soaps or equivalent, to avoid the drying of skin
- Ongoing hydration of skin using a moisturiser
- Traditional adhesives should always be avoided when the skin has been assessed to be at risk.
- Optimise nutrition and hydration status.
- Implement strategies that prevent falls and other trauma.
- Encourage client to cease smoking
- Review medications and reduce (if possible) those that alter skin integrity. E.g. oral or topical corticosteroids, always in consultation with the clients G.P.
- Provide client / carer with information on prevention and other relevant information. E.g. Client positioning.

EQUIPMENT

- Wound Management Chart
- Dressing tray
- Normal saline
- Steri-strips
- Barrier wipes
- Foam/silicone dressing
- Gloves
- Plastic waste bag
- Tubular dressing
- Sterile scissors (if required)

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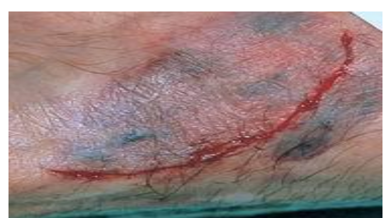
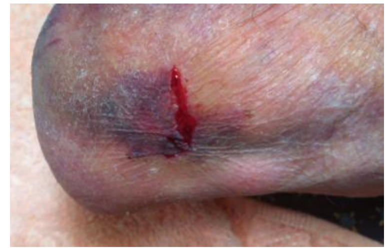
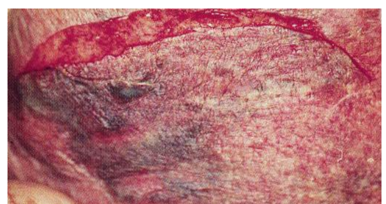
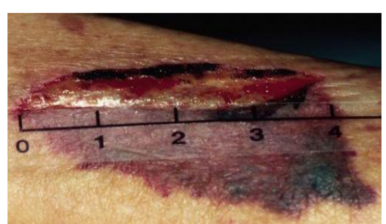
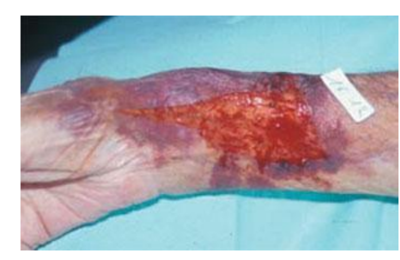
ASSESMMENT

STAR Skin Tear Classification System	
Category 1a – The edges **can** be realigned to the normal anatomical position (without stretching) and the skin or flap colour is **not** pale, dusky or darkened	
Category 1b – The edges **can** be realigned to the normal anatomical position (without stretching) and the skin or flap colour **is** pale, dusky or darkened	
Category 2a – The edges **cannot** be realigned to the normal anatomical position and the skin or flap colour is **not** pale, dusky or darkened	
Category 2b – The edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is** pale, dusky or darkened	
Category 3 – The skin flap is completely removed	

DRESSING SELECTION AND MANAGEMENT

The dressing selection and management follows the STAR acronyms below

S **STOP BLEEDING & CLEAN**	• Select cleansing product • Control Bleeding (compression/elevation) • Clean the wound bed. Consider a single use of antiseptic if injury the result of contaminated equipment or object.
T **TISSUE ALIGNMENT**	• If the skin flap is viable, roll skin flap back into place, using a moistened cotton bud. • Steri-Strips should only be used to secure the flap if silicone dressings are not available or if the flap is a complex shape. If using Steri-strips, do so sparingly leaving a space between each strip to allow exudate drainage. • **DO NOT** stretch skin in an attempt to completely approximate edges. • The flap should be left in place for approximately 5 days (unless dark or dusky – see below) to allow for the skin flap to "take".
A **ASSESS AND DRESS**	• Assess the degree the skin tear using the STAR Classification system. • Refer to a Medical Practitioner full thickness wounds where fat, muscle or underlying tissues are seen or those with large haematomas. • Use a foam dressing that has silicone over its entire wound contact surface as this will secure the flap. • **Mark the outer dressing with an arrow towards the non-attached margin to indicate the direction in which to remove the dressing.** • Mark the date for removal • Apply a tubular bandage to facilitate haemostasis and for ongoing protection • Complete the Wound Chart and document interventions in progress notes • Consider factors that negatively impact on wound healing. • If the skin tear is on an oedematous leg assess suitability for compression therapy. • Inspect the surrounding skin and environment for re-injury risk
R **REVIEW AND RE-ASSESS**	• If skin flap is pale, dusky or darkened (1b or 2b) reassess in **24 to 48** hours to ensure that the flap is now viable ie. Attached and pink in colour • If the skin flap is not viable remove the non-viable tissue with sterile scissors • If the flap is viable (1a or 2a) review the wound in **5 - 7** days • Monitor for changes in wound status (redness, pain, or increase in exudate) If dressing is full of blood/exudate, remove & replace with a new dressing. **Removal of Dressing** • Remove dressing in the direction of the arrow and reapply as required. • Complete the Wound Chart and document interventions in progress notes • Use adhesive removers to prevent recurrent trauma to skin.

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PATIENT INFORMATION

Discuss with resident/client issues related to risk E.g. nutrition, hydration, falls risk

EXPECTED OUTCOME

- All skin tears will be categorised to determine severity of injury.
- Management of skin tears will occur in a consistent and uniform manner.
- Significant reduction in the frequency of dressings required in the management of skin tears

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VALIDATION

Gippsland Regional Wound Management Steering Committee

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