
















Skin Tear Prevention and Management Addendum

A skin tear is 'a wound caused by shear, friction and/or blunt force resulting in separation of skin layers'¹

Skin Tear Risk Factors	Skin Tear Prevention Strategies
<ul style="list-style-type: none"> • Advanced age • Impaired mobility or vision • History of previous skin tears • Poor nutrition and/or hydration • Sensory and cognitive impairment • Dry fragile skin • Ecchymosis • Medications – e.g. steroids, anticoagulation therapy • Predisposition to falls • Dependence on others for activities of daily living (ADL). 	<p>Refer to the following WACHS policy documents in conjunction with the information found in this section:</p> <ul style="list-style-type: none"> • Cognitive Impairment Clinical Practice Standard • Falls Prevention and Management Clinical Practice Standard • Pressure Injury Prevention and Management Policy • Wound Management Policy

Implement prevention strategies for patients at risk of skin tears^{3,4}.

Safe Environment ⁴	Injury Prevention ⁴	Appropriate Skin Care	Clinical Considerations
<ul style="list-style-type: none"> • Encourage clothes, which are not restrictive, loose long sleeves and long trousers • Ensure safe environment – no equipment with sharp edges. Foam padding may be required • Encourage patients to wear their glasses, hearing aids and appropriate non-slip footwear • Ensure clinical staff and patients avoid wearing jewellery, watches and maintain short nails. • Ensure clinical staff adhere to 'bare below the elbows' principles as outlined in the WACHS Hand Hygiene Policy. 	<ul style="list-style-type: none"> • Remove dressings with care and adhesive remover spray or wipes • Encourage patient mobilisation with care – communication and plan prior to patient movement • Correct manual handling technique to prevent friction and shear when turning, lifting and transferring. Use of slide sheets, hover mat etc • Prevent falls injuries. Undertake mobility and falls risk assessment and implement falls risk strategies • Protect patients' skin and limbs from skin injury – consider extra padding of limbs e.g. foam held insitu with tubular band • Provide patient education to patients regarding promoting healthy skin e.g. ceasing smoking, preventing friction and shear • Discuss cause and risk of sustaining a skin injury with your patient/ family/carer and prevention and management plan. 	<ul style="list-style-type: none"> • Avoid the use of drying or pH altering soaps and cleansers • Moisturise skin twice daily with non-perfumed moisturiser or emollient. 	<ul style="list-style-type: none"> • Optimise nutrition and hydration. Refer to Dietician When Nutritional score >2 on MST • Review long-term use of medications known to alter skin integrity e.g. long-term use of steroid ointments.

Assessment	Management of Skin Tears										
<ul style="list-style-type: none"> Assess the skin tear using the STAR Skin Tear classification system and document it on the MR122 WACHS Wound Assessment and Management Plan Report all hospital acquired skin tears via Datix CIMS. <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>STAR Classification System</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> </tr> <tr> <td> <p>Category 1a A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.</p> </td> <td> <p>Category 1b A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened.</p> </td> <td> <p>Category 2a A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky or darkened.</p> </td> <td> <p>Category 2b A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened.</p> </td> <td> <p>Category 3 A skin tear where the skin flap is completely absent.</p> </td> </tr> </table> <p style="font-size: small; margin-top: 5px;">Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010. Reprinted August 2012.</p> </div>						<p>Category 1a A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.</p>	<p>Category 1b A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened.</p>	<p>Category 2a A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky or darkened.</p>	<p>Category 2b A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened.</p>	<p>Category 3 A skin tear where the skin flap is completely absent.</p>	<p>First Aid</p> <ul style="list-style-type: none"> Control bleeding by applying pressure over the wound and/or elevation of the limb Cleanse wound thoroughly with normal saline and remove any haematomas, foreign bodies or debris Realign (if possible) any skin or flap to its normal anatomical position If there is extensive tissue loss or excessive/uncontrolled bleeding notify MO Apply dressing as per below¹.
											
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Bleeding or exudate	Dressing	Frequency
Minimal	<ul style="list-style-type: none"> Apply a silicone foam dressing Mepilex Border ® For larger skin tears use a silicone dressing (Mepitel ®) and secondary dressing (Zetuvit ®) secured with tubular bandage (Tubifast ®) or crepe bandage. 	Review 3 rd daily or sooner if <ul style="list-style-type: none"> increased exudate dressing soiled dressing lifting off wound bed.
Mod/Heavy	If the wound is bleeding use a calcium alginate dressing to achieve haemostasis (Algisite ®) and a secondary dressing (Zetuvit ®) secured with tubular bandage (Tubifast ®) or crepe bandage ² .	Reassess in 24 hours and change to silicone dressing (Mepilex Border ® or Mepitel® if bleeding resolved ² . If calcium alginate is adhered to the wound soak to remove ³ .

Do not apply films, hydrocolloids, film dressings or retention tapes (e.g. Fixomull®) to skin tears. These products are inappropriate for skin tears and can result in harm.

Use skin barrier wipes to protect skin and adhesive remover sprays / wipes for atraumatic removal of dressings when required.

Mark dressing with an arrow in direction which it should be removed to ensure the flap is not disturbed

References

- Carville K. Wound care manual. 6th ed. Perth: Silver Chain Foundation; 2012.
- Royal Perth Hospital. Wound Management Nursing Practice Standard. Perth, WA: Nursing Director Surgical Division. 2020
- Fiona Stanley Hospital. Skin Tear Assessment and Management. 2018
- Sir Charles Gairdner Osborne Park Health Care Group. Nurse Practice Guideline Wound Management.2020
- Skin Tear Audit research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery. Curtin University of Technology. Revised 4/2/2010. Reprinted August 2012.