Skin tears

Standardised care process

Objective

To promote an evidence-based approach in the assessment, management, and prevention of skin tears for older people who live in a residential aged care setting.

Why the risk assessment, prevention, skin assessment and management of skin tears is important

Skin tears begin as acute wounds that can be painful. They can become complex and hard-to-heal when inadequate wound hygiene is performed and risk factors for delayed healing, including comorbidities, are not assessed and addressed. Complications include infection and delayed wound healing. They are the most common wound in older adults but are largely preventable.

Definitions

Acute wound: 'is associated with trauma, immediate injury or surgery, with the resulting skin damage progressing through the healing phases' (Annesley 2019, p. 290).

Biofilm: a community of multispecies microbes that stick tenaciously to the wound bed (Murphy et al. 2020, p. S5).

Hard-to-heal (formerly chronic) wound: a wound that has a slow progression through the healing phases, shows delayed, interrupted, or stalled healing due to intrinsic and extrinsic factors that impact on the individual and their wound. (IWII 2016). Wounds that are difficult to heal must have the underlying causes and comorbidities addressed AND be assumed to have a biofilm (Murphy et al. 2020).

Hard-to-heal skin tear: If the skin tear takes longer than 4 weeks to heal, consider that it is hard-to-heal (LeBlanc et al. 2018).

International Skin Tear Advisory Panel: An expert panel focused on research into best practice prevention and management of skin tears with the aim of providing guidelines for health care providers (LeBlanc et al. 2018).

Skin tear: '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. 2018b, p. 2).

Skin flap (In the context of a skin tear): 'a portion of the skin (epidermis/dermis) that is unintentionally separated (partially or fully) from its original place due to shear, friction, and/or blunt force. This concept is not to be confused with tissue that is intentionally detached from its place of origin for therapeutic use e.g. surgical skin grafting' (Van Tiggelen et al. 2020, p. 149).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), wound consultant, nurse practitioner (NP), leisure and lifestyle staff, general practitioner (GP), pharmacist, allied health professionals (such as a dietitian, physiotherapist, occupational therapist, exercise physiologist), residents and/or family/carers.

Acknowledgement

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Brief standardised care process

Recognition and assessment

Complete a comprehensive skin tear risk assessment:

- on admission
- whenever the resident's condition changes.

On presentation of a skin tear:

- stop the bleeding and cleanse the skin tear
- assess the wound and categorise the skin tear using the International Skin Tear Advisory Panel (ISTAP) classification system
- document the details of the wound
- establish the cause of the injury
- conduct a general health assessment of the resident
- identify the intrinsic and extrinsic factors that may affect the healing environment
- identify risk factors for skin tear development.

Interventions

- Control the bleeding.
- Clean the wound to remove any residual debris or clotted blood.
- Dry the wound.
- Where viable, realign the skin flap (as recommended by the ISTAP tool).
- Debridement is indicated if the skin flap is non-viable.
- Manage oedemas and haematomas.
- Choose an appropriate dressing based on the wound's characteristics.
- Apply the dressing and secure it with non-adhesive materials.
- Protect the site from further injury.
- Manage any wound-related pain.
- Prevent future skin tears.

Referral

- Wound care specialist (nurse or physician) or wound clinic where indicated
- Dietitian
- Pharmacist

Evaluation and reassessment

- The frequency of dressing change is guided by the wound's condition.
- Exercise caution on removing the dressing.
- Observe the wound for signs of infection.
- Monitor overall skin health and the incidence of any new skin tears.
- Refer to an appropriate specialist if there is no improvement.

Resident involvement

- Provide education on preventing skin tears.
- Involve the resident in treatment decisions.

Staff knowledge and education

- Risk factors for skin tear development
- Strategies to prevent skin tears
- Skin hygiene and lubrication
- Assessment and management of skin tears
- Appropriate use of wound dressings, adhesives, and non-adhesive products for securing dressings

Full standardised care process

Recognition

Skin Tear Risk Assessment

- On admission
- Whenever the person's condition changes
- Repeated according to local policy

Skin Tear Injury Identification

- At time of injury
- During routine care
- During comprehensive skin assessments:
  - on admission
  - whenever the person's condition changes
  - repeated according to local policy.

Assessment

Skin tear risk assessment

A comprehensive assessment of risk factors should include the following.

Skin

- Advanced age
- A skin inspection for dryness and discolouration (such as elastosis and purpura)
- Fragile or vulnerable skin
- History of skin tears
- Mechanical trauma from adhesive tape removal
- Factors that prolong skin contact with moisture (incontinence and sweating)

Mobility

- Level of dependency, mobility, paralysis, and associated use of assistive devices
- History or risk of falls
- Limb stiffness (joint stiffness/contractures) and spasticity
- Prosthetics and other peripheral access devices that have contact with the skin

General health

- Medical history
- Comorbidities that compromise vascularity and skin status
- Psychosocial, wellbeing and quality of life factors
- Bariatric status
- Mental health
- Presence of cognitive and sensory impairments
- Nutrition and hydration status
- Oncological conditions
- Medicines that affect skin health or increase the risk of falls

Skin tear injury assessment

FIRST: Stop bleeding and cleanse skin tear (see Interventions below)

Assess the degree of tissue loss and categorise the skin tear using the International Skin Tear Advisory Panel (ISTAP) classification system:

- Type 1: a linear or flap tear that can be repositioned to cover the wound bed
- Type 2: partial flap loss that cannot be repositioned to cover the wound bed
- Type 3: total flap loss exposing the entire wound bed (LeBlanc et al. 2013, p. 465).

A skin tear injury assessment should establish:

- the cause of the injury (when, where and how acquired)
- its anatomical location
- the dimensions (length, width, depth) of the skin tear and digital wound imaging
- the characteristics of the wound bed:
  - tissue colour (pink, red, yellow, black)
  - tissue type (granulation, slough, necrosis, epithelialisation)
  - degree of moisture
  - degree of flap necrosis (percentage of viable/non-viable tissue)
- the type and amount of exudate
- the presence of bleeding, haematoma or foreign body
- the condition of the surrounding skin for fragility, maceration, dryness, swelling, discolouration or bruising
- signs and symptoms of infection
- the level of wound-related pain using self-report and observational pain rating tools.

Document the details of the wound (ISTAP classification, size, evidence of infection and wound bed characteristics including exudate level).

Assess the resident's:

- medical history and underlying comorbidities
- general health status
- potential for wound healing.

Identify the intrinsic and extrinsic factors that may affect the healing environment, including:

- comorbidities that compromise vascularity, oxygenation or immune function or contribute to chronic oedema
- smoking
- nutritional status
- medicines that affect skin health
- manual handling methods and other factors causing trauma
- skin and wound moisture levels and attempt to reduce their impact.

Document assessment findings and review the skin tear prevention plan.

Interventions

Skin tear prevention plan

An individualised prevention plan should be implemented for residents who have, or are at risk of, skin tears.

Skin

- Protect fragile skin on the limbs with protective garments.
- Reduce staff factors that contribute to injury (such as nail length and jewellery).
- Introduce a good skin care regimen based on the condition of the skin, including:
  - use of a skin-friendly (soapless or pH-neutral) cleanser
  - gentle application of preservative-free, non-aqueous-based skin moisturisers twice daily.
- Control moisture from incontinence and other sources
  - use adhesive removers if required.

Mobility

- Review falls risk assessment and management plan.
- Use correct manual handling techniques when moving or transferring residents and during routine care.
- Appropriately position prosthetics and other peripheral access devices that have contact with the skin.
- Ensure a safe environment with adequate lighting, removing trip hazards and excess furniture, and applying padding to equipment and furniture.

General health

- Maintain optimal nutrition and hydration status.
- Regularly review medications.

Skin tear management plan

Skin tear management should preserve any viable skin flap tissue (where possible) and surrounding tissue, approximate (realign) the edges of the wound, reduce the risk of infection (and further injury) and foster healing.

Initial management:

- Control the bleeding and prevent haematoma formation by applying pressure. Elevate the limb if possible.
- If bleeding is difficult to control, apply a temporary alginate dressing and remove when the bleeding stops. Do not use the alginate product as a primary dressing.
- Assess for pain and provide analgesia as required.
- Clean the wound with a sterile non-woven swab to remove any residual debris or clotted blood (haematoma). Irrigate with warm sterile isotonic saline (sodium chloride 0.9 per cent) or water. If the wound is heavily contaminated use a noncytotoxic antiseptic.
- Dry the area surrounding the wound with a non-woven swab and allow the wound to air dry.

- Where possible, approximate (realign) the skin flap:
  - if viable (ISTAP Type 1 or 2), use the skin flap as a dressing by realigning it
  - gently ease the skin flap into place using a dampened cotton tip, tweezers, a silicone strip or gloved finger
  - ensure the edges are flat and not rolled
  - if the flap is difficult to align, rehydrate the flap by applying a moistened non-woven swab for 5–10 minutes
  - avoid over stretching the flap when realigning it
  - avoid use of skin closure strips or sutures.

If the wound is a tetanus-prone wound, assess the need for tetanus immunoglobulin. If tetanus immunoglobulin is required, ensure it is administered before debridement to prevent the potential release of exotoxin. Any wound other than a clean minor cut Is considered tetanus-prone (ATAGI 2018).

Choose an appropriate non-adherent dressing based on the wound characteristics and classification. The choice of dressing should consider its ability to:

- maintain a moist wound healing environment
- protect the wound and surrounding skin from further trauma caused by shear or from dressing removal
- control or manage exudate
- manage infection
- be applied easily
- be worn over an extended timeframe
- optimise quality of life and cosmetic factors
- be cost-effective.

Apply the dressing and secure it with non-adhesive silicone-interfaced dressing materials such as arm/leg protectors, tubular wraps, or flexible netting to further protect the skin:

- mark the dressing with the date for removal and an arrow to indicate the direction for dressing removal
- protect the site from further injury
- do not use films and tapes on thin, fragile older skin.

Manage wound-related pain by:

- assessing for pain and providing analgesia as required
- choosing dressings that minimise trauma and pain during application and removal
- carefully removing dressings and any residue
- using adhesive remover where required
- using a warm cleansing solution to irrigate the wound
- minimising the frequency of dressing changes where possible.

Manage oedema on limbs to improve healing by:

- elevating the limb as much as possible
- reapply prescribed compression garment/device
- applying gentle compression as per policy. If the skin tear is on the leg, a vascular screen should be conducted.

Referral

- Wound care specialist, physician or wound clinic as surgical interventions may be required for skin tears that are extensive, full thickness, bleeding significantly or forming haematoma, or infected
- Wound care specialist, NP or wound clinic for skin tears that are hard-to-heal, or for advice with compression therapy
- Dietitian to promote adequate nutrition and hydration for healing and prevention of further injury
- Pharmacist to review medicines that affect skin health and increase the risk of falls

Evaluation and reassessment

How frequently the dressing is changed is guided by the wound's characteristics.

- **Check the dressing** daily and change earlier if:
  - the dressing is saturated, leaking, dislodged or crinkled
  - there are signs of infection
  - the dressing product information indicates an earlier maximum wear time.
- The initial dressing should stay in-situ no longer than five days to determine the effectiveness of the dressing.
- Thereafter, where there are no signs of infection or deterioration, the dressing should be left in-situ for approximately seven days to avoid disturbing the flap.
- Where the skin or flap is pale, dusky or darkened in colour, remove the dressing and reassess the wound within 24–48 hours.
- Increase the frequency of dressing changes if signs of exudate or infection are present.

Remove the dressing

- Take care when removing the dressing by working in the direction of the arrow drawn on the dressing (working away from the attached skin flap).
- Minimise trauma to the skin surrounding the wound when removing dressings. Use adhesive remover if required.

Monitor for changes in the wound. This would include checking:

- the viability of the skin flap
- the surrounding skin.

Observe the wound for signs of infection. This may include:

- increased pain
- increased exudate
- reddening of the skin (erythema)
- heat
- malodour
- oedema.

Monitor the resident's overall skin health and the incidence of any new skin tears.

Refer to an appropriate specialist if there is no improvement after four reassessments. Indications of no improvement include:

- deterioration of the skin flap
- evidence of local infection.

Resident involvement

- Provide strategies to prevent skin tears.
- Involve the resident in treatment decisions.

Staff knowledge and education

- Risk factors for skin tear development
- Strategies to prevent skin tears
- Skin hygiene and lubrication
- Assessment of skin tears and management of skin tears
- Appropriate use of wound dressings, adhesives, and non-adhesive products for securing dressings
- Referral options

Evidence base

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