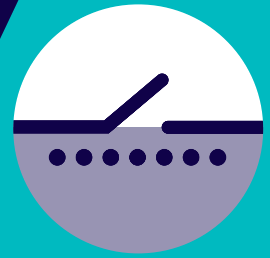
Skin tears

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 prevention and management of skin tears is important

Older people have a higher risk of skin tears due to skin fragility caused by ageing and comorbidity.

Skin tears are acute wounds that can be painful and can lead to complications such as infection and delayed wound healing if not treated correctly. They are the most common wound in older adults but are largely preventable.

Definitions

Acute wound: 'a disruption in the integrity of the skin and underlying tissues that progresses through the healing process in a timely and uncomplicated manner.' These are characteristically surgical and traumatic wounds. (Bates-Jensen & Woolfolk 2012, p. 215).

Debridement: the removal of dead, nonviable or devitalised tissue, infected or foreign material from the wound bed and surrounding skin (Wounds UK 2013).

Skin tear: 'a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers. A skin tear can be partial-thickness (separation of the epidermis from the dermis) or full-thickness (separation of both the epidermis and dermis from underlying structures)' (LeBlanc & Baranoski 2011, p. 3).

Team

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

Acknowledgement

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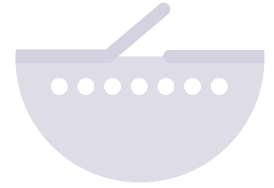


Brief standardised care process

Recognition and assessment

Complete a comprehensive skin tear risk assessment on admission and whenever the resident's condition changes.

On presentation of a skin tear:

- assess the wound and categorise the skin tear using the STAR 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.
- Manage oedemas and haematomas.
- Clean the wound to remove any residual debris or clotted blood.
- Dry the wound.
- Where viable, realign the skin flap (as recommended by the STAR tool).
- Debridement is indicated if the skin flap is non-viable.
- 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

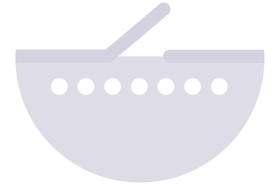
- The frequency of dressing change is guided by the wound's condition.
- Exercise caution on removing the dressing.
- Observe the wound for signs of infection.
- Monitor overall skin health and the incidence of any new skin tears.
- Refer to an appropriate specialist if there is no improvement.

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

Conduct a comprehensive skin tear risk assessment on admission and whenever the resident's condition changes.

Assessment

Skin tear risk assessment

A comprehensive assessment of risk factors should include:

- a skin inspection for dryness and discolouration (ecchymosis)
- previous history of skin tears
- advanced age
- level of dependency, mobility and associated use of assistive devices
- history or risk of falls
- limb stiffness (joint stiffness/contractures) and spasticity
- comorbidities that compromise vascularity and skin status
- the presence of cognitive and sensory impairments
- nutrition and hydration status
- medicines that affect skin health or increase the risk of falls
- prosthetics and other peripheral access devices that have contact with the skin
- factors that prolong skin contact with moisture (incontinence and sweating).

Skin tear assessment

When a skin tear wound has been identified assess the degree of tissue loss and categorise the skin tear using the Skin Tear Audit Research (STAR) classification system.

A skin tear assessment should include:

- its anatomical location
- the dimensions (length, width, depth) of the skin tear and digital wound imaging
- the characteristics of the wound bed:
  - tissue colour
  - 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 or haematoma
- the condition of the surrounding skin for fragility, 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 (STAR 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.

Establish the cause of the injury (when, where and how acquired).

Identify the intrinsic and extrinsic factors that may affect the healing environment (comorbidities that compromise vascularity, 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.

Interventions

Skin tear management

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.

Control the bleeding.

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 povidone iodine (if the resident is not allergic to it) then rinse off after three minutes.

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 (STAR category 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.
- 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.

Debridement is indicated for non-viable and necrotic flaps and should be carried out by nurses who are knowledgeable and skilled in wound care.

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 or to manage infection
- be applied easily
- be worn over an extended period of time
- 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 their application and removal
- carefully removing dressings and any residue
- using a silicone-based adhesive remover where required
- using a warm cleansing solution to irrigate the wound
- minimising the frequency of dressing changes where possible.

Manage oedema (to reduce exudate) and haematoma (where present) by:

- applying gentle compression – one- or two-layer bandaging (tubular elastic) can help dissipate the haematoma
- elevating the limb.

Skin tear prevention

Prevent future skin tears. An individualised prevention plan should be instigated for residents who have, or are at risk of, skin tears. This should consider:

- ensuring a safe environment with adequate lighting, removing trip hazards and excess furniture, and applying padding to equipment and furniture
- protecting fragile skin on the limbs with protective garments
- correcting manual handling techniques when moving or transferring residents and during routine care
- reducing staff factors that contribute to injury (such as nail length and jewellery)
- introducing a good skin care regimen based on the condition of the skin:
  - use of a skin-friendly (soapless or pH-neutral) cleanser
  - gentle application of preservative-free, non-aqueous-based skin moisturisers twice daily (this should be an ointment if the skin condition is good or a lotion if the skin is fragile)
- maintaining optimal nutrition and hydration status
- regularly reviewing medications
- controlling moisture from incontinence and other sources
- appropriately positioning prosthetics and other peripheral access devices that have contact with the skin.

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.
- 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.

- 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 five days to avoid disturbing the flap.
- Where the skin or flap is pale, dusky or darkened in colour, reassess the wound within 24–48 hours.
- Increase the frequency of dressing changes if signs of exudate or infection are present.

Exercise caution on 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.

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:

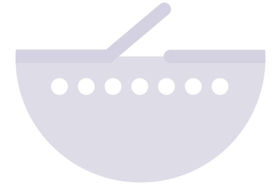
- deterioration of the skin flap
- evidence of local infection.

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.



Evidence base for this standardised care process

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Important note: This SCP is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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