

Skin tears

assessment and management

What are skin tears?

Skin tears are traumatic wounds that occur mainly on the extremities of the elderly, and result in a 'peeling back' of the skin.

Skin tears can be as a result of friction alone or shearing and friction forces together. These forces can separate the epidermis from the dermis, (partial thickness wounds) or separate both the epidermis and dermis from underlying structures (full thickness wounds).

Who is at risk?

Individuals with:

- Fragile, thin, vulnerable skin
- Previous history of skin tears
- Poor nutrition and/or hydration
- Multiple medications (including steroids)
- Dependency on others
- Memory or sensory impairment



How can skin tears be avoided?

- Staff should use extreme caution and gentle touch when bathing, dressing and/or transferring individuals at risk
- Do not wear 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 or a long-sleeved top or long pants
- Follow the recommendations for washing and moisturising skin and first-aid treatment of skin tears, noted in the 'Skin care and you' brochure
- Optimise nutrition and hydration
- Implement strategies that prevent falls and other traumas (for example, cushioning equipment, uncluttered environment and walking aids)
- Consider occupational therapist review / modify equipment and transfers
- Consider a review of medications **in consultation with the individual's doctor** to reduce (if possible) those that alter skin integrity (for example, corticosteroids)
- Educate the individual and their carer about information preventing skin tears and the first-aid treatment of them
- Traditional adhesives should always be avoided when the individual has been assessed to be at risk

If adhesives are used:

- Apply tape/dressing without tension
- Use porous tapes to allow evaporation
- Remove tape/dressings with extreme caution
- Slowly peel tape away from stabilised skin
- Consider using adhesive remover wipes or sodium chloride to loosen the bond

How do I assess skin tears?

STAR Skin Tear Classification System



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.



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.



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.



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.



Category 3:

A skin tear where the skin flap is completely absent.

How do I treat them?

Stop bleeding and clean

- Control the bleeding (consider pressure, elevation and/or alginate)
- Cleanse the wound bed using irrigation with sterile water or normal saline
- Cleanse under the flap if dirt or blood remains post haemostasis. Blood between the flap and wound bed can delay healing

Tissue alignment

- If the skin flap is viable, roll back into place using a moistened cotton tip
- **Do not** stretch any remaining skin flap in order to approximate the flap edges. Gently lie the remaining skin flap over the wound bed

Assess and dress

- Assess the degree of tissue loss and flap colour using the STAR classification system
- Assess the individual, their wound, the mode of injury and the healing environment
- Use a dressing which has silicone over its entire wound contact surface, as this will secure the flap
- 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 to allow for wound drainage
- 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
- Assess and address further factors which delay healing:
 - If the skin tear is on an oedematous leg or a leg with venous disease, assess suitability for compression
 - Full thickness flaps (where fat, muscle or other underlying tissues are seen), OR those with large haematomas, should be reviewed by medical staff as soon as possible

Review and re-assess

- If the skin flap is pale, dusky or darkened, reassess in 24–48 hours to ensure that the flap is viable (attached and pink colour). If the skin flap is not viable, remove the nonviable tissue with sterile scissors or Conservative Sharp Wound Debridement (CSWD) if competent
- Unless there are clinical signs of infection, leave the primary dressing intact for 7 days
- The secondary dressing should be changed earlier if indicated, for example:
 - strikethrough
 - leakage
 - signs of infection
 - dislodgement
- Document assessment, intervention and future plan

Tips to remember

- 1 **Never pull against the direction of the skin flap when removing the dressing**
- 2 **Understand that sutures are not required for partial thickness skin tears and may delay healing**
- 3 **Obtain medical assessment urgently if surgical intervention is required**
- 4 **Discuss and address the issues related to risk with the individual (for example, nutrition, hydration, falls risk)**

References

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Disclaimer

This health care guide is part of the 'Connected Wound Care' program, which provides important information about wound care. All care has been taken to ensure information is current and best-practice, however always consult your healthcare professional if you have any concerns or queries.

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