# CLINICAL GUIDELINE

# Prevention, Assessment and Management of Skin Tears

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

| | |
|---|---|
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**Important Note**:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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## 1. Introduction

This guideline will help staff to identify patients at risk of skin tears and aid in the prevention of skin tears in people with vulnerable skin in Acute and Primary Care settings within NHS Greater Glasgow and Clyde (NHSGGC). For patients who develop skin tears, the guideline will inform staff on assessment and management of these wounds which will be both clinically effective and evidence based.

## 2. Scope

This guideline will be applied to all patients with vulnerable skin and/or acute skin tears irrespective of their ethnicity, disability, religion and beliefs, sexual orientation or age.

This guideline will provide advice and guidance on effective clinical practice for all registered healthcare personnel and care support workers, on prevention strategies, assessment of skin tears at first presentation and on-going management of these wounds.

It is not intended to address specific clinical issues that relate to individual patients.

## 3. Background

*"A skin tear is a traumatic wound caused by mechanical forces, including removal of adhesives. Severity may vary by depth (not extending through the subcutaneous layer)."* International Skin Tears Advisory Panel ISTAP,(Wounds International 2018)

Skin tears are an increasing problem seen by healthcare practitioners. Without appropriate treatment these injuries may become chronic wounds with prolonged healing, subsequently causing unnecessary pain and distress (Baranoski et al, 2015).

Traditional management of skin tears can cause new damage and slow down the healing process (LeBlanc et al., 2018). This type of injury usually occurs in immature skin (neonatal) and in the elderly.

Intrinsic factors such as ageing make the skin more vulnerable to external forces such as trauma. With the ageing process the epidermis and subcutaneous layers become thinner reducing cushioning. The epidermal-dermal junction is also less resistant to friction forces making the skin more likely to tear, making skin tears one of the most prevalent skin complications in the elderly (Vanzi and Toma, 2018).

Neonates and infants are also susceptible to skin tears (Lichterfield et al., 2015). Neonates have underdeveloped skin and children have only 60% epidermal thickness (Baharestani 2007). Neonates also have decreased epidermal to dermal cohesion (Irving 2006). Immunological status and malnutrition, circulation and oxygen intake may also impact on fragility of the skin (Meulenire 2002).

## 4. Roles and Responsibilities

Health Care Practitioners are responsible for:

- Identifying patients with vulnerable skin when carrying out skin inspection on admission to healthcare setting or at first home visit.

- Liaising with carers and the interdisciplinary team to promote/continue prevention strategies.

- Maintaining and updating their knowledge, skills and competence in line with their roles and responsibilities with regards to assessment and management of skin tears. Further information and educational resources on skin tears can be found in Appendix 1.

- Documenting assessment of the skin tear and recommended plan of care in a recommended wound chart.

- Seeking the advice from the Tissue Viability Service where appropriate, whilst maintaining ongoing responsibility for the patient's episode of care. Referring wound complications to the Tissue Viability Service.

- All skin tears which develop on children within the hospital setting should be referred to the Paediatric Tissue Viability Nurse via Trakcare

- If the skin tear is extensive or full thickness or if there is significant bleeding or haematoma formation the patient should ordinarlily be assessed within an A&E Department or minor injuries unit where the clinician may consider referral to surgical / plastics team, although other routes for advice may be more appropriate depending on circumstances. For patients already in the acute environment, a member of the medical team should review and consider referral to surgical/plastics team.

## 5. Tissue Viability Service

The Tissue Viability Service will support the implementation and updating of the guideline as required or at review date.

## 6. Best Practice in the Prevention of Skin Tears

Based on available evidence, the consensus statement of an international panel (International Skin Tear Classfication, 2019) suggests the following strategies should be part of prevention:

**Risk Assess** on admission to healthcare service and whenever the individual's condition changes. Discuss the risk assessment findings with the individual and/or carers and involve them in forming the prevention care plan. This should be part of the patient's generic care plan and should address the following:

| Risk Factor | Action |
|---|---|
| **Skin** | Keep skin well moisturised by applying hypoallergenic moisturiser / emollient at least 2 times per day (excluding neonates unless prescribed for dermatologic reasons). Encourage the patient or their carers to apply the moisturiser/emollient Current emollient products available can be found here GGC Medicines: Emollient and barrier preparations |
| **Clothing** | Discuss plan of care with patients at risk of skin tears and advise wearing long sleeves, full length clothing to reduce their risk, whilst still providing person centred care. |
| **Protection** | Provide protection i.e. Padded tubular bandage or long socks, for those individuals who experience repeat skin tears on shins (adult). In acute areas, ensure infection control policy is adhered to e.g. with foam tubing on mobilators. Protect individuals at high risk of trauma during routine care from self-injury. |
| **Moving & Handling** | Educate registered and non registered staff and care givers to ensure proper techniques are used while providing care without causing skin tears. Ensure safe patient handling techniques and equipment/ environment. |
| **Diet** | Where appropriate and with individuals consent, consider referral to dietician to ensure adequate nutrition and hydration. (LeBlanc & Baranoski 2011) |

**Practical advice** on maintaining a safe environment in both the community and hospital setting to reduce the risk of skin tears should include the following guidance:

- Ensure adequate lighting and position furniture/equipment to avoid unnecessary bumps and knocks.
- Use furniture and equipment where sharp corners are encased, padded or covered.
- Use appropriate aids when transferring patients and adopt good manual handling techniques according to NHSGGC policy.
- Never use bed sheets to move patients at risk of skin tears as this can contribute to damage by causing a dragging effect on the skin. Always use lifting devices or sliding sheets.
- Where possible reduce or eliminate pressure, shear and friction using pressure reducing devices/equipment and correct positioning techniques, i.e. 30 degree tilt.
- Extra care should be taken when carrying out venepuncture or cannulation. The risk of skin tears when using a tourniquet can be reduced by clothing or swabs underneath the tourniquet.

**Consider including these points where relevant in the patients care plan**
**N.B. It is recognised that in some cases it is not always possible to prevent or manage some risk factors. Care planning should reflect this.**

## 7. Best Practice in Assessment of Skin Tears

It is important to classify the type of skin tear into Type 1, 2 or 3, as this will determine the severity of the skin tear and aid in planning appropriate treatment.

**The International Skin Tear Advisory Panel tool has been validated and is recommended by the National Association of Tissue Viability Nurses for use throughout Scotland**

### CLASSIFICATION OF SKIN TEARS

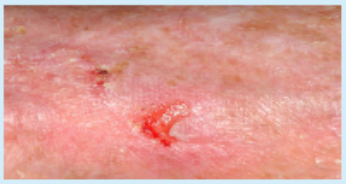
The most important aspect of assessment and management is to minimise further trauma and preserve viable tissue. It is important to classify the type of skin tear as this will determine the severity of the skin tear and aid in planning appropriate treatment. The International Skin Tears Advisory Panel (ISTAP) Classification System is a validated classification tool recommended by the National Association of Tissue Viability Nurse Specialists (Scotland) for use throughout Scotland.

The ISTAP skin tear classification is outlined below:

**TYPE 1: NO SKIN LOSS**

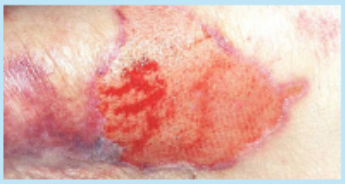
Linear or flap tear which can be repositioned to cover the wound bed

**TYPE 2: PARTIAL FLAP LOSS**



Partial flap loss which cannot be repositioned to cover the wound bed

**TYPE 3: TOTAL FLAP LOSS**



Total flap loss exposing entire wound bed

Images have been provided for inclusion with the kind permission of the Silver Chain Group

# Best Practice in Skin Tear Management

"A skin tear is a traumatic wound caused by mechanical forces, including removal of adhesives". International Skin Tears Advisory Panel ISTAP (Wounds International, 2018).

1. Control bleeding at site. Elevate limb if possible
2. Gently cleanse wound with potable tap water, NaCl 0.9% or wound cleansing solution to remove visible debris
3. Realign skin flap if possible – soak area for 5 -10 mins to help rehydrate flap if difficult to realign

| What type of skin tear does the patient have? | | |
|---|---|---|
| **Type 1** No skin loss<br>Skin can be repositioned to cover the wound bed | **Type 2** Partial flap loss. Skin tear can be realigned to partially cover the wound | **Type 3** Total flap loss, where the entire wound bed is exposed. |
|  |  |  |
| Hydrate, realign and cover with dressing. | Hydrate to help flap be realigned as much as possible, then cover with dressing. | Hydrate then cover with dressing. |

4. Dress wound using **Kliniderm Foam Silicone Border or Kliniderm Silicone Foam. Mark the dressing with an arrow** to indicate direction of removal to reduce risk of flap disturbance.
For neonatal / paediatric patients, use **Kliniderm Silicone Contact Layer only**.
Leave dressing in place for **5 days unless over 70% strike through evident or signs of infection**.
**Document** type of skin tear, wound assessment and management plan on Wound Assessment and Management chart.
5. Review after 5 days, reassess wound, monitor for signs of infection or deterioration.
6. If no improvement refer to tissue viability.


**Do not use** steristrips or adhesive dressings as these can cause increased tension on fragile skin and compromise blood supply. **Do not use** iodine based dressings (e.g. inadine) as these dry out wound bed and surrounding skin.

This has been developed to assist in the conservative management of skin tears. However some may require specialist medical and /or surgical interventions. If in doubt, seek medical advice.
Please view the Tissue viability pages on Staffnet for further information on our Skin Tear Guideline.

## Dressings to be avoided

Both film and hydrocolloid dressings contain strong adhesive components and therefore should be avoided in the management of skin tears (or any wound on a patient at risk of skin tears). Iodine based products (e.g. inadine) cause drying out of the wound and peri-wound skin, this is a major risk factor for skin tears and therefore are also not advised (LeBlanc et al. 2016).

If the skin tear is extensive or associated with a full thickness injury, significant and or uncontrolled bleeding or haematoma formation, a surgical/plastic surgery review will be required (Stephens-Hayes & Carville 2011).

Referral to Tissue viability specialists may also be indicated if the wound fails to progress to healing.

All paediatric skin tears should be referred to tissue viability.

If the skin tear is on the lower leg and fails to progress and is over 2 week's duration, consider early referral **to local leg ulcer clinic or vascular nurse specialist** for leg ulcer assessment.

Ongoing wound assessment and management must be holistic, concise, consistent and continuously based on the needs of the patient, as well as the wound. This should be documented on an appropriate wound management chart at each dressing change.

## 1. Best Practice in On-going Management

At each dressing change the dressing should be gently removed in the direction indicated by the arrow. If it does not remove easily, consider the use of saline soaks or silicone-based adhesive removers (Mudge & Orsted 2010).
Potable water or antiseptic solution can be used to cleanse in line with Wound Cleansing Guidelines available on Staffnet via Tissue Viability Homepage.

The wound flap may be friable so care should be taken to prevent disturbing it. The wound should be observed for signs of infection and any changes in the colour of the tissue of the flap which may indicate that it is becoming non-viable (Stephen-Hayes & Carville 2011). Please refer to tissue viability service if wound appears to be deterioriating.

The Tissue Viability Team recommend that clinical areas have a 'Skin Tear Box' containing appropriate dressings for the immediate management of skin tears to reduce the risk of inappropriate dressings being applied. This should include a silicone contact layer or dressing, non adhesive foam and tubular bandage if required. Please see Appendix 1, 2 and 3 for further details.

For an up to date list on appropriate dressings with ordering codes, to be used for acute and in partnerships, please refer to the tissue viability webpages on Intranet.

## 2. Patient Discharged to Primary Care or Other Health Care Setting

**After immediate treatment has been completed and the patient has to be discharged from the acute to community setting, a correspondence letter should be completed for the appropriate Healthcare professional continuing the care**
**Wound products should be provided for 7 days of treatment.**

## 3. Review

This guideline will be reviewed by the Tissue Viability Service every three years.

## 4. References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# Appendix 1

## Acute Adult Skin Tear Box

The following wound dressings are suggested to be in kept in each clinical area in a 'Skin Tear Box' as a go to for staff to for immediate access if a skin tear occurs.

The aim is to reduce the risk of inappropriate dressings being applied.

A copy of the recommendations for management of skin tears flow chart from the guideline should be kept in the box also as a reference point for staff.

| Generic Group | Indications for Use | Contraindications |
|---|---|---|
| **Foam with silicone contact layer Kliniderm Border**  | Primary contact layer for skin tears. Minimises the risk of further trauma at dressing changes. Absorbs low to moderate levels of exudate, promotes a moist healing environment and allows a pain free dressing change. | Known sensitivity to silicone.<br><br>**PECOS CODES**<br>7.5 x 7.5cm: 216659<br>10 x 10cm : 216604<br>12.5 x 12.5cm: 216673<br>15 x 15cm: 216680<br>10 x 20cm: 216697<br>10 x 30cm: 237388<br>15 x 20cm: 216703 |
| **Kliniderm silicone wound contact layer**  | For larger skin tears, a bordered dressing may not always be appropriate, therefore you can apply a silicone wound contact layer and cover with wound pad or foam (depending on exudate levels) This can be secured with wool and crepe bandage. | **Silicone Contact Layer codes**<br>5 x 7cm : 267767<br>8 x 10cm: 267774<br>12 x 15cm: 267781<br>20 x 30cm: 267798 |
| **Kliniderm foam silicone non border**  | | **Kliniderm Foam Non Bordered**<br>5 x 5cm: 216598<br>10 x 10cm: 216604<br>10 x 20cm: 216611<br>15 x 15cm: 216628<br>20 x 20cm: 216635 |
| **Dressing Pack With Forcep** | Universal sterile procedure Pack | Each: 238392 |
| **Wound Cleansing Fluid – Potable tap water or vials of NaCl 0.9% or Prontosan Solution** | Use for soak to rehydrate skin tear and aid realignment. | Prontosan Solution 350mls: 133895 |

Appendix 2

## Adult Partnerships Skin Tear Box

The following are suggested to be in kept in each clinical area in a 'Skin Tear Box' as a go to for staff to reduce the risk of inappropriate dressings being applied. A copy of the Recommendations for management of skin tears flow chart should be kept in the box also as a reference point for staff.

| Generic Group | Indications for Use | Contraindications |
|---|---|---|
| **Foam with Silicon Contact Layer – Kliniderm Border**  | Primary contact layer for skin tears. Minimises the risk of further trauma at dressing changes. Absorbs low to moderate levels of exudate, promotes a moist healing environment and allows a pain free dressing change. | Known sensitivity to silicone.<br><br>**Ordering sizes& PIP codes**<br><br>7.5 x 7.5cm : 3947231<br>10 x 10cm : 3947249<br>12.5 x 12.5 cm: 3947256 |
| **Foam with Silicon Contact layer – Non bordered – Kliniderm Silicone**  | Primary contact layer for skin tears. Minimises the risk of further trauma at dressing changes. Absorbs low to moderate levels of exudate, promotes a moist healing environment and allows a pain free dressing change. | 10 x 10cm: 3947223<br>15 x 15cm: 3994084<br>10 x 20cm:3994092 |
| **Dressing Pack With measuring tape** | Universal sterile procedure Pack | Ordering name:<br>Dress it |
| **Wound Cleansing Fluid – Potable tap water or vials of NaCl 0.9%** | Use for soak to rehydrate skin tear and aid realignment. | Ordering:<br>Irripods- 20mlx25<br>Stericlens Aerosol- 240mls |

Appendix 3

# Paediatric Skin Tear Box

The following are suggested to be in kept in each clinical area in a 'Skin Tear Box' as a go to for staff to reduce the risk of inappropriate dressings being applied. A copy of the Recommendations for management of skin tears flow chart should be kept in the box also as a reference point for staff.

| Generic Group | Indications for Use | Contraindications |
|---|---|---|
| **Silicone contact Layer – Kliniderm Contact**  | Primary contact layer for skin tears. Minimises the risk of further trauma at dressing changes. Allows exudate to pass through into secondary dressing. | Known sensitivity to silicone.<br><br>**PECOS CODES**<br>5 x 7cm : 267767<br>8 x 10cm: 267774<br>12 x 15cm: 267781<br>20 x 30cm: 267798 |
| **Kliniderm Foam Silicone Lite (Border)**  | Silicone foam dressing absorbs low to moderate levels of exudates. Non-adherent contact layer. Promotes a moist, healing environment and allows pain free dressing change. | Any known allergies to dressing components.<br><br>**PECOS CODES**<br><br>4cm x 5cm :<br>7.5cm x 7.5 cm<br>5cm x 12.5cm |
| **Tubular Bandage – Comfifast**  | Light and breathable fabric bandage made of elasticated viscose helps keep dressings in place without the need for pins or tape. | This dressing is available in a variety of widths. Please ensure appropriate size is used to avoid restriction on the limb. |
| **Dressing Pack With forcep** | Universal sterile procedure Pack | Each: 238392 |
| **Wound Cleansing Fluid – Prontosan liquid**  | Use as soak to rehydrate skin tear and aid realignment. Helps to keep wound bed clean. | None listed.<br><br>**PECOS CODES**<br><br>350mls: 133895 |