Developed by the BC Provincial Nursing Skin and Wound Committee in collaboration with Wound Clinicians from:

Title	**Guideline: Assessment, Prevention and Treatment of Skin Tears**
Practice Level	• Nurses in accordance with agency/health authority policy. • Clients (see definition) with skin tears require an interprofessional approach to provide comprehensive, evidence-based assessment and treatment. This clinical practice guideline focuses solely on the nurses' role, as one member of the interprofessional team providing care.
Background	• Skin tears are acute traumatic healable wounds that usually occur on the arms and hands (80%) or shins of older adults and are largely preventable.[3] When they are on the lower extremity of a client with arterial insufficiency, healing may be impaired. • Compared with more complex wounds, such as pressure injuries or diabetic ulcers, skin tears are often seen as minor, inconsequential wounds. However, these wounds occur frequently and can be painful, unsightly and disturbing for clients and families and can lead to complications if not treated appropriately. • Most skin tears occur when the client is receiving personal care or when the client is transferred, falls, bumps into objects or is in contact with or using assistive equipment e.g., a wheelchair. Medical tape injuries can also cause skin tears in clients (young or old) who have fragile skin. Approximately 40-50 % of tears have no observable cause.[20,25,36] • Risk factors for skin tears include advanced age, stiffness and spasticity, poor balance and gait, xerosis (dry skin), dehydration, limited mobility and/or inability to reposition self, activities of daily living (ADL) dependency, poor nutrition, impaired vision, multiple medications, use of assistive devices such as wheelchairs, the presence of bruising or senile purpura on the hands and arms, use of steroid medications (see page 2 for complete list) • Older adults are at greater risk for skin tears due to age-related changes to the skin including thinning of the epidermal, dermal and subcutaneous layers, flattening of the basal cell layer which compromises cohesion between the epidermal and dermal layers, and impaired circulation. • Skin tears are categorized in terms of the amount of tissue loss. This guideline uses the *International Skin Tear Advisory Panel - Skin Tears Classification* (ISTAP, 2015).[21,22] • Prevention is the primary focus for managing skin tears. Interventions to prevent skin tears focus on creating a safe environment, providing adequate hydration and nutrition, moisturizing and protecting the skin and protecting the client from trauma during mobilization and care. • Studies have shown a significant decrease in the incidence and prevalence of skin tears after implementation of no-rinse or soap-free cleansers and routine moisturizer use, strategies to modify the environment and protect the client's extremities. As well, staff education on safer ways to care for and transfer clients assists in reducing skin tear injuries.[2,7,44]
Indications	• For use with clients who have skin tears or who are at risk for sustaining skin tears.
Contra-indications	• Staples and sutures are not appropriate closure methods for skin tears due to skin fragility.
Definitions	**ADLs** - Activities of Daily Living which include eating, bathing, dressing, toileting, walking/transferring. **Aseptic Technique** - Technique used to limit the transfer of microorganisms from one person to another by minimizing the microbe count and preventing cross contamination; includes sterile, no-touch and clean technique. The technique chosen is based on the clinical condition of the client, etiology of the wound, location of the wound, invasiveness of the procedure, goal of care, and agency policy. • Sterile Technique - the use of sterile gloves, a sterile field, sterile tray, sterile instruments, sterile solution and sterile dressings; only sterile gloved hands or sterile instruments are used for direct contact with the wound. • No-Touch Technique - the use of clean gloves and a sterile field, sterile tray, sterile instruments, sterile solution and sterile dressings or dressings appropriately saved using no-touch technique; only sterile instruments are used for direct contact with the wound. • Clean Technique - the use of clean gloves (single client use, non-sterile), a clean field, a clean or sterile dressing tray, clean instruments (single client use), clean solution (single client use), clean dressings or dressings appropriately saved using clean technique; clean gloved hands or instruments are used for direct contact with the wound.

Definitions Cont'd	**Client** - This term includes recipients of care in the acute (patient), community (client) and residential (resident) care settings.
	Client/Family - Family is two or more individuals who come together for mutual aid. Families are self-defined, and family is 'who the client says their family is'; this is individualized.
	Contact layer - A dressing which comes in contact with the actual wound surface; a contact layer requires a cover dressing.
	Cover dressing - A dressing that covers and secures the contact layer in place. Not all cover dressings require a contact dressing.
	Non-adherent dressing - A dressing which does not adhere to the wound bed and does not traumatize the wound or peri-wound skin when it is removed.
	PISheet(s) - Product Information Sheet(s) developed by the Provincial Nursing Skin & Wound Committee - PISheets are found on the British Columbia Patient Safety and Quality Council's Connecting Learners With Knowledge website https://clwk.ca
	Senile purpura - Presents as persistent dark purple ecchymosis usually confined to the extensor surfaces of the hands and forearms. Affects elderly patients as dermal tissues atrophy and blood vessels become fragile. New lesions appear without known trauma and resolve over several days, leaving a brownish discoloration caused by deposits of broken-down red blood cells (hemosiderin) Treatment is not indicated for senile purpura.
	Skin - Skin is the largest organ in the body and is made up of three main layers - epidermis, dermis, and hypodermis. Skin is intended to protect, sense, regulate temperature, secrete sebum, sweat, cerumen and synthesize vitamin D. Skin is the main defence against microorganisms, toxins, trauma, and UV light. Skin also protects the tissues and organs and helps maintain homeostasis. Skin thickness (epidermis) varies in approximately 1-2 mm thick and varies depending on the anatomical site (e.g., eyelids 0.05 mm and palms/soles 1.5 mm).
	Skin Tear - A wound caused by shear/friction (in the absence of pressure) and/or a blunt force resulting in separation of the skin layers. A skin tear wound is either partial- thickness (separation of the epidermis from the dermis) or full- thickness (separation of the epidermis/dermis from underlying structures). There are three types of skin tears: Type 1 no skin loss, Type 2 partial flap loss and Type 3 total flap loss.[21,22]
	• Type 1 Skin Tear - A wound where the linear or flap tear can be repositioned to cover the entire wound bed.
	  ○ Linear skin tear - A wound that occurs in a wrinkle or furrow of skin. Both the epidermis and dermis are pulled apart in a straight line as if an incision has been made, exposing the tissue below.[34]
	  ○ Flap-type skin tear - A wound in which the epidermal flap can be completely approximated, or approximated so that no more than 1 mm of the dermis is exposed.[34]
	• Type 2 Skin Tear - A wound where the partial flap loss cannot be repositioned to cover the entire wound bed.
	• Type 3 Skin Tear - Total or full flap loss exposing the entire wound bed.
	Xerosis – Dry, scaly, cracked and fissured skin characterized by pruritus.

Related Documents	Guideline Summary: Assessment, Prevention and Treatment of Skin Tears Teaching Resource: How to Categorize Skin Tears Guideline: Wound Bed Preparation for Healable and Non-Healable Wounds in Adults & Children Guideline: Assessment and Treatment of Lower Limb Venous, Arterial & Mixed Ulcer in Adults

Assessment and Determination of Treatment Goals

Assessment

1. Assess Client Concerns
    a. Client level of understanding about skin tears, healability and risk factors.
    b. Client and family ability and motivation to understand and participate in the treatment plan.
    c. Impact of the skin tear(s) on client's daily life and body image
    d. Client and family goals for care, preferences for treatment of the skin tear and client's risk factors; acknowledge culture and traditions.

e. Emotional, cognitive, behavioural or mental health concerns and the availability of support systems to address these concerns e.g., dementia, agitation.

2. Assess for Risk Factors Impacting the Occurrence and Healability of Skin Tears
    a. Impaired nutritional status
        i. Presence of obesity, low body weight, edema, cachexia, dehydration and prolonged nothing by mouth (NPO).
        ii. Inadequate nutritional intake of protein, calories or fluids as evidenced by percentage (%) of intake at meals or calorie count.
        iii. Dehydration as evidenced by poor skin turgor and/or a decrease in urinary output.
        iv. Possible causes of poor intake e.g., difficulty swallowing, poor dentition, inability to correctly position for eating, inability to feed self, GI symptoms and pain.
    b. Lifestyle factors such as smoking (motivation to quit) and substance use.
    c. Advanced age due to:
        - thinning of the epidermal, dermal and subcutaneous layers,
        - flattening of the basal cell layer which compromises cohesion between the epidermal and dermal layers, and
        - impaired circulation.
    d. Oxygenation status of the skin and underlying tissue e.g., heart failure, anemia, congestive obstructive pulmonary disease (COPD).
    e. Diseases and conditions that affect balance and compromise the skin such as diabetes mellitus, hypotension, motor neuron disease, atrial fibrillation, cardiac or pulmonary problems, cardiovascular accident (CVA), previously radiated skin, areas of scar tissue, uremia, hypothyroidism, autoimmune diseases and peripheral vascular disease.
    f. Edema from organ failure (heart, liver, renal) or venous insufficiency.
    g. Medications that interfere with healing or thin the skin (e.g., NSAIDS, anti-neoplastics, systemic corticosteroids, anticoagulants and vasopressors). A combination of steroids and anticoagulants put the client at a higher risk for skin tears.
    h. Treatment or investigative procedures which require the use of adhesive tapes, transparent dressings e.g., intravenous lines, anchoring devices (electrocardiogram [ECG] leads, tube securement devices, the use of devices such as splints, braces, compression stockings, physical restraints and rigid plastic identification [ID] bracelets).
    i. Client's current environment on the level of risk and on client care e.g., cluttered rooms.
    j. Cognitive impairment, vision, balance and/or mobility issues which put the client at risk for falls. Determine client's risk for falling:
        i. Assess ability to shift position independently when sitting and lying and the need for assistive equipment and/or help to reposition.
        ii. Assistance required to transfer and /or mobilize due to poor balance, unsteady gait, frequent falls etc.; describe assistance needed.
    k. Friction/Shear (in the absences of pressure)
        i. Assess for any limb spasticity.
        ii. Assess for medical devices which could cause friction or shear when being applied/removed e.g., compression stockings.
    l. Skin Assessment
        i. Determine the client's current skin moisturizing schedule.
        ii. Check the hands, forearms and lower legs for thin translucent skin, dry skin/xerosis, bruising, hematomas, senile purpura, erythema, and pruritus.
        iii. Check lower limbs and feet for a change in colour or temperature and for edema.
        iv. Check all extremities for scar tissue and skin tears.
    m. Determine date of last known tetanus vaccine if a new skin tear is present.

3. Assess for Environmental Hazards which could cause Trauma to the Extremities
   For example:
    a. Furniture with sharp angles in the immediate environment.

b. Cluttered environment, scatter rugs.
c. Non-padded bed side rails.
d. Sharp edges or potential contact with wheelchair footrest rigging.
e. Situations which would put the client at a risk for falls (e.g., poor lighting, pets, small children, new/unfamiliar environment.

4. Assess Pain
   a. Assess onset, duration, type, location, frequency and quality of pain in the skin tear and precipitating/alleviating factors.
   b. Impact of pain on function, sleep and mood.
   c. Current pharmaceutical and non-pharmaceutical interventions for pain and their effectiveness.
   d. Pain severity using client self-report, observation of non-verbal cues and/or a pain scale:
      i. Wong Baker FACES Scale,
      ii. Visual Analog Scale,
      iii. Numeric Rating Scale, or the
      iv. Face, Legs, Activity, Cry, Consolability Behavioral Tool (FLACC).

5. Complete Lower Leg Assessment
   Complete a basic lower leg assessment for any skin tear found below the knee. If assessment results are abnormal (signs and symptoms of arterial compromise, venous insufficiency or decreased sensation), complete an advanced lower leg assessment. (Lower Limb Assessment Flow Sheet and Lower Limb Assessment Documentation Guideline)

6. Assess Skin Tear and Determine Skin Tear Category (Wound Assessment & Treatment Flow Sheet and How to Categorize Skin Tears
   a. History of skin tears or evidence of healed skin tears on the face, arms, and legs.
   b. Identify the cause of current skin tear, if able.
   c. Location of skin tear(s).
   d. Measurement of the tear(s).
   e. Condition of skin flap, if present.
   f. Presence of hematoma(s) in the skin tear.
   g. Characteristics/amount of exudate and/or bleeding from the skin tear.
   h. Wound edge appearance.
   i. The integrity of the peri-wound skin.
   j. Categorize tears according to amount of tissue loss.[21,22]
      i. Type 1 - No skin loss; the linear or flap tear can be repositioned to cover the entire wound bed.
      ii. Type 2 - Partial flap loss: there is a partial loss of the flap such that when the flap is repositioned on the wound bed, not all of the wound bed is covered.
      iii. Type 3 - Total flap loss: there is no flap, the entire wound bed is exposed.

7. Assess for Wound Infection (see Prevention, Assessment & Treatment of Wound Infections Guideline)
   a. Determine date of last Tetanus booster.
   b. Assess for signs and symptoms of localized, spreading or systemic infection; 2 or more signs of infection require notification of the concern to the Physician/NP and may require a Culture and Susceptibility (C&S) swab to be done. (pending Guideline: Assessment and Treatment of Wound Infections)
      i. Some wounds may be in a state of chronic inflammation as evidenced by erythema, induration, warmth and pain. It is important to determine if there is a change in these indicators, e.g., spreading erythema, which may be indicative of an infection.
      ii. Clients with diabetes mellitus:
         - Diabetes may mute visible evidence of infection due to compromised arterial blood flow, blunting of the inflammatory process, and diminished sensation therefore; for clients with diabetes, 1 or more signs and symptoms of infection,

especially if there is new or increasing pain, is sufficient to warrant notification to the Physician/NP and a C&S swab to be done.
- Uncontrolled blood glucose levels may also indicate an infection.
- **Areas of wet gangrene and deep or systemic infection in diabetic wounds, especially if the wound probes to bone, are potentially limb or life threatening and require immediate medical attention.**

iii. Clients with severe arterial insufficiency:
- Visible evidence of infection may be muted due to compromised arterial blood flow, blunting of the inflammatory process, and diminished sensation therefore; for clients with sever arterial insufficiency, 1 or more signs and symptoms of infection, especially if there is new or increasing pain, is sufficient to warrant notification to the Physician/NP and a C&S swab to be done.
- **Areas of wet gangrene and deep or systemic infection in arterial wounds, especially if the wound probes to bone, are potentially limb or life threatening and require immediate medical attention.**

Determination of Treatment Goals

1. The treatment goals are determined based on:
    a. Client and family willingness and ability to participate in and adhere to the care plan.
    b. The healability of the skin tear.
    c. Overall assessment findings.

Interventions

Develop a plan of care in conjunction with the client/family that incorporates client care, treatment of risk factors, skin tear management, client outcomes, client/family education and discharge plans and implement for clients who are at risk as well as for clients who have a skin tear.

Client Care Management

Address Client Concerns

a. The plan of care should take into account the client and family abilities, concerns, preferences and motivation for treatment.
b. Consult with Social Work, Facility Liaison, Clinical Lead, or Aboriginal Representative if the client has psychosocial concerns and/or requires emotional support or counseling or if there are financial concerns related to the management of the skin tear.
c. Refer the client to the appropriate professionals for input to improve health, such as improved diet or a change in hygiene routines, exercise plans that would improve mobility or creating a safer environment.
d. Address the impact of dementia, agitation and mobility issues on client and family ability and motivation to engage in treatment.

Preventing Skin Tears

1. Routine skin care regimen for all clients with skin tears or at risk for skin tears
    a. Inspect the skin for any new damage each time the client is repositioned, transferred or assisted with ADLs.
    b. For clients at risk for skin tears:
        i. Apply a fragrance-free moisturizer twice daily over the upper and lower extremities.
        ii. Minimize cleansing the skin area which is at risk for skin tears e.g., arms and legs 2-3 three times a week:
            - Gently cleanse the skin with a pH balanced, fragrance-free no-rinse skin cleanse.
            - Gently pat the skin dry.

- Apply a fragrance-free moisturizer within 2-3 minutes following cleansing or tub/ shower bathing.

c. All skin care products should be used according to the manufacturer's instructions or PISheets. (Product Information Sheets)

3. Protect the Extremities from Trauma:
   a. Avoid using tape on the skin, but if it must be used use tape specifically designed for fragile skin; e.g., silicone tape. If such tape is not available, then apply a skin barrier under tape being used. A hydrocolloid may be used as a 'landing pad' for non-silicone tapes.
   b. Remove tape by stabilizing the surrounding skin and gently rolling it off the skin or use an adhesive remover.
   c. Have clients wear long sleeves, long pants or knee high socks and/or consider the use of specific protective wear e.g., shin-guards.
   d. Consult with OT/PT and/or the Wound Clinician regarding protective devices such as elbow pads, limb sleeves or appropriately sized cotton tubular bandage, tubular sleeves or tubular netting bandage over the forearms and lower legs. Be aware that limbs, especially lower limbs, may swell over the course of the day.
   e. Support dangling arms and legs with pillows or blankets.
   f. Pad bedrails and wheelchair arm/legs, pad edges of furniture and other equipment.
   g. Remove leg rests/foot pedals from wheelchair when transferring clients.
   h. Remove environmental risk factors, such as clutter, to reduce the incidence of trauma
   i. For ambulatory clients, ensure that rooms are well-lighted and free of obstacles.
   j. For clients who develop skin tears related to compression stockings - donning and doffing, consider use of a donning and doffing device (slider or skin sleeve).
   k. Educate caregivers regarding the need for short fingernails and not wearing jewellery which could cause a skin tear.
   l. Client's finger and toe nails should be kept short and filed.
   m. Reassess client's risk status when the client's condition changes or according to agency policy.

4. Reduce Friction/Shear Forces
   Protect the skin during positioning, transferring and turning to reduce friction and shear forces:
   a. Use a lift or transfer sheet to minimize friction/shear when repositioning; do not drag the client.
   b. Use transfer belts or lifts when transferring the client from bed to chair.
   c. Develop appropriate strategies for transferring and mobilizing the client that protect the extremities from skin tears.
   d. Consult with OT/PT to develop appropriate strategies for transferring and mobilizing the client, if required.

5. Treat Risk Factors for Skin Tear Healability
   a. Consult with a Physician/NP if changes in pre-existing conditions occur, such as stroke, peripheral vascular disease, renal disease, or cardiac disease.
   b. Encourage client to take medication(s) as prescribed. For those clients who are taking both an anticoagulant and steroids, minimize the risks as much as possible and protect the extremities from friction, shear, and trauma.
   c. Support client to stop smoking and discuss referral to a smoking cessation program. Consult with harm reduction/substance use management, if available and the client consents.
   d. Nutritional Care:
      i. Consult with the Dietitian, if available, if the client has one or more of the following:
         - Nutritional risk factors such as weight loss, dehydration, obesity, poor intake, poor glycemic control, total parenteral nutrition (TPN)/tube feed.
         - The client has recurrent skin tears or the skin tear is not healing.
      ii. Maximize the client's nutritional status through adequate protein and calorie intake unless contraindicated. Clients with chronic wounds should receive 35 kcal/kg of energy dense

foods per day including 1.5 g of protein/kg.[27] Assess renal function if increased protein intake is indicated.

iii. Reassess the need for protein supplements and additional fluids as the client's condition changes.

iv. Encourage 1500–2000 ml of fluid daily or 30 ml or more per kg of body weight. Assess for renal or liver dysfunction and heart failure if increased fluid intake is indicated. Offer fluids every 2 hours (q2h) for adult clients with dehydration, fever, vomiting, profuse sweating, diarrhea or heavily draining wounds, unless contraindicated, e.g., organ failure.

v. Consult with the appropriate professional if the client has difficulty swallowing, poor dentition or other problems chewing or digesting food.

Treatment of Skin Tears

1. General Principles for Skin Tear Management
    a. As best possible, approximate the skin flap wound edges to their normal anatomical position without applying tension to the flap.
    b. Staples and sutures are not appropriate to approximate wound edges because of the fragility of the skin, consult the Wound Clinician or Physician/NP if sutures or staples are in place and the wound is not healing or appears infected.
    c. Apply moisturizer twice daily to the surrounding skin (see above).
    d. Consult with Physician/NP regarding the client's need for a tetanus booster.

2. Consideration for Lower Limb Skin Tears (Guideline: Assessment and Treatment of Lower Limb Venous, Arterial & Mixed Ulcers in Adults)
    a. If the client has arterial insufficiency and a skin tear on the lower extremity, determine healability of the wound prior to treatment. An ABI of 0.5 or less indicates that the wound may not be healable.
    b. If unable to determine healability consult with a Wound Clinician or Physician/NP

3. Management of Bleeding Skin Tears
   If the skin tear is bleeding, the goal is to stop the bleeding before cleansing and dressing the wound:
    a. Cover the wound with an absorbent pad, elevate the limb and apply pressure to the wound until bleeding is controlled.
    b. If bleeding fails to stop with pressure, apply a hemostatic dressing (calcium alginate dressing or hemostatic agent) to control bleeding (Product Information Sheets)
    c. If bleeding has not stopped within 15 minutes for clients on anticoagulant medication or within 5-7 minutes for those not on anticoagulant medications, contact a Physician/NP.
    d. Once bleeding is controlled, gently cleanse (see #4 below) the clots from the skin tear, approximate the skin flap if present (see #7 below) and re-apply a hemostatic dressing, such as a calcium alginate, to the skin tear and cover with an appropriate cover dressing (see #9 below).
    e. Check the dressing frequently to ensure that bleeding has not restarted. If at home, teach the client or the family to check the dressing. Reinforce handwashing techniques.
    f. Assess the hemostatic dressing 24 hours later, if bleeding is controlled then consider discontinuing the use of the hemostatic dressing and apply appropriate dressing (see #5 below). If there is a risk of further bleeding, then continue with calcium alginate dressing and reassess in 24 hours.

4. Cleansing Skin Tears (Wound Cleansing Procedure DST)
    a. Choose the appropriate aseptic technique (sterile or no-touch) based on the clinical condition of the client, the location of the wound the invasiveness of the dressing procedure, the goal of care and agency policy
    b. For the **first** cleansing of the skin tear when a skin flap is present, cleanse the wound using the following method:
        i. Gently cleanse beneath the skin tear flap to remove surface bacteria, necrotic tissue and blood clots, if present, using at least 100 mls of solution. Use either a squeezable solution

container designed for **wound cleansing** or a 30-35 cc syringe filled with cleansing solution and fitted with either a wound irrigation tip catheter or an 18-19 gauge device.

ii. If some, or all, of the skin tear flap is present, gently position it into place (see #6 below) and then cleanse entire skin tear area again.

c. If there is no skin flap present, and for all subsequent cleansing of a skin tear with a skin flap present, cleanse the wound using one of the following methods:
   i. A 30-100 mls squeezable container designed for **wound cleansing** or a 30-35 cc syringe filled with cleansing solution and fitted with either a wound irrigation tip catheter or an 18-19 gauge device.
   ii. If the wound appears clean, cleanse with a bottle of sterile normal saline or sterile water by gently pouring the cleansing solution over the tear.

d. Do not rub or wipe the skin tear as this may disturb the approximated skin flap, damage fragile tissue or cause the wound to bleed.

e. Gently pat dry before applying the dressing.

5. Treatment for Type 1 Skin Tears - No Skin Loss
   The goal is to heal by primary intention as the skin tear edges can be fully approximated.
   a. Prompt treatment is needed to ensure that the flap remains viable.
   b. As soon as possible after the injury, cleanse the wound beneath the skin tear flap (see #4 above), preserve the skin flap by rolling it back over the wound bed using either a moistened, sterile, cotton-tipped applicator, or a sterile gloved hand or a moistened sterile gauze.
   c. Approximate the skin flap wound edges to their normal anatomical position without applying tension to the flap; do not remove or damage the skin flap.
   d. Cleanse the skin tear area and apply a non-adherent dressing. Place an arrow on the cover dressing indicating the direction in which it is to be removed (see #9 below).
   e. Skin glues, where available, may be used within 24 hours of the injury for those skin tears where there is at least 75% of a viable skin flap present and under the direction of a Wound Clinician or Physician/NP.
   f. The use of steri-strips may be used to secure the skin flap if the periwound skin is intact, but must be placed to allow for drainage of exudate and must be left in place until the strip itself falls off (Steri-Strips for Type 1 Skin Tears PISheet)
   g. **Staples and sutures are not appropriate to approximate wound edges** because of the fragility of the skin.

6. Treatment for Type 2 Skin Tears - Partial Flap Loss
   The goal is to heal by secondary intention (moist wound healing) as the skin tear edges cannot be completely approximated.
   a. Prompt treatment is needed to ensure whatever flap is present remains viable.
   b. As soon as possible following the injury, cleanse the wound beneath the skin tear flap (see #4 above), preserve what skin flap is present by rolling it back over the wound bed using either a moistened, sterile, cotton-tipped applicator, or a sterile gloved hand, or a moistened, sterile gauze.
   c. As much as possible, approximate the remaining skin flap wound edges to their normal anatomical position without applying tension to the flap; do not remove or damage the skin flap.
   d. Cleanse the skin tear area and apply a non-adherent dressing; place an arrow on the cover dressing indicating the direction in which it should be removed (see #9 below).
   e. **Do not use steri-strips** to secure the flap for Type 2 Skin Tears.

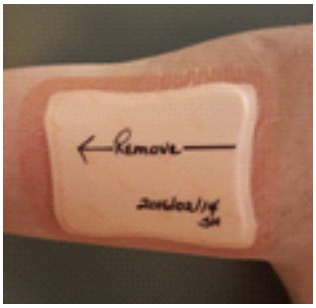
7. Treatment for Type 3 Skin Tears – Full Flap Loss
   The goal is to heal by secondary intention (moist wound healing) as there is no skin flap.
   a. Once the bleeding is controlled, cleanse the wound and apply appropriate wound dressing (see #9 below) to promote moist wound healing.

8. Consideration for Dressing Products
   a. The dressing should:

- not adhere to the wound bed;
- manage the wound exudate without macerating the peri-wound skin;
- be appropriate for fragile peri-wound skin; and/or
- not require frequent dressing changes, if frequent dressing changes are required then ensure minimal disturbance to the skin tear

Examples of dressings are a silicone contact layer with an absorbent cover dressing, silicone foam dressing, an absorbent clear acrylic dressing, paraffin or petrolatum impregnated gauze with an absorptive cover dressing.

b. **Do not use** occlusive, adhesive dressings such as transparent films and hydrocolloids as they can cause maceration and damage to the peri-wound skin; and may damage the skin flap itself upon removal of the dressing.
c. **Do not use** a telfa-like dressing or gauze as these dressings will adhere to the wound.
d. If moderate to large amount of exudate is expected, apply a contact layer over the skin tear and then apply a cover dressing; this dressing combination allows for the cover dressing to be changed as needed without removing the contact layer to ensure minimal disturbance to the skin tear during the cover dressing change.
e. If using a non-bordered dressing, ensure that the dressing is properly secured in place with a gauze wrap and an appropriately sized cotton tubular bandage, tubular sleeve or tubular netting bandage. Ensure that the tape to hold the gauze wrap together does not come in contact with the skin. Monitor for slippage of the securement device.
f. Avoid using tape on the skin but if it must be used, use tape specifically designed for fragile skin; e.g., silicone tape. If such tape is not available, then apply a skin barrier under tape being used. A hydrocolloid may be used as a 'securement platform' for non-silicone tapes.
g. Remove tape by rolling it gently off the skin rather than pulling it off or use an adhesive remover.
h. Write the date that the dressing is to be changed on the dressing itself to minimize unnecessary dressing changes (see #10 below).
i. Place an arrow on the dressing noting the direction for removal of the dressing. The dressing must be removed without peeling, lifting or damaging the flap.



Label dressing with an arrow and date, so that the arrow drawn on the cover dressing always indicates the direction of how the skin flap was laid back down. The dressing is removed in the direction of the arrow.

9. Consideration for Dressing Change Frequency
    a. If profuse bleeding had occurred, the hemostatic dressing should be checked frequently to assess if bleeding has restarted. Remove the hemostatic dressing at 24hrs and if bleeding is resolved then apply appropriate dressing.
    b. For Type 1 and Type 2 Skin Tears, minimize dressing changes to allow the skin flap to 'take'. Dressings can be left on for 5-7 days if there is no bleeding or infection and if the dressing can manage the exudate for this period of time.
    For Type 3 Skin Tears should be changed as needed based on the condition of the wound.
    c. For skin tears with moderate to large amounts of exudate, change the cover dressing as needed taking care not to disturb the contact layer and skin tear flap.
    d. Absorbent clear acrylic dressings may be used for skin tears with minimal exudate.
    e. All dressings should be checked daily to ensure that they remain intact and to assess for strikethrough. Teach the client or family to check the dressing daily if in the home.

f. Once the skin tear is healed, moisturize area twice daily and protect the area (See Preventing Skin Tears above).

10. Management of Wound Infection (see Prevention, Assessment and Treatment of Wound Infections Guideline; Swab for C&S for Suspected Wound Infection Procedure)
    a. Consult with Physician/NP regarding the client's need for a Tetanus booster based upon the date of the last booster.
    b. Use an antimicrobial dressing to treat a localized wound infection.
    c. Notify the Physician/NP if signs and symptoms for spreading or systemic wound infection are present; do C&S swab as ordered.
    d. Debride non-viable tissue to minimize the risk of a wound infection
        i. Collaborate with a Wound Clinician or Physician/NP to determine if the non-viable flap should be debrided and if so, which debridement method would be most appropriate.

11. Management of Pain Relief
    a. If the client has wound pain and pain associated with dressing changes, organize care to coordinate with analgesic administration allowing sufficient time for the analgesic to take effect.
    b. Administer analgesic medication regularly and in the appropriate dose to control pain. Consult with a Physican/NP if pain is not well controlled.
    c. Encourage client to request a 'time-out' during a painful procedure.
    d. Use dressings that do not cause pain and trauma on removal, e.g. non adherent dressings, and/or those which require less frequent changes.
    e. Reassess pain at regular intervals and note any increase in severity.

12. Notify a Wound Clinician or Physician/NP if:
    a. The flap is not viable.
    b. There is acute onset of wound pain or increasing wound pain.
    c. Sign and symptoms of wound infection are noted.
    d. The wound deteriorates or there is no evidence of wound healing after 2 weeks.

Client Education

1. Educate clients and family caregivers about:
    a. Strategies for keeping the skin cleansed, well-moisturized and well-hydrated.
    b. Handwashing techniques.
    c. Strategies for keeping the environment as safe as possible.
    d. Strategies for reducing or eliminating friction and shear, especially when repositioning, lifting and transferring.
    e. Strategies for improving nutrition, especially increasing protein and fluid intake.
    f. Monitoring the wound for bleeding, infection or strikethrough.
    g. Wound dressing technique if client / family are doing the dressings and to check the dressing daily.
    h. Signs and symptoms of infection and what to do if present.
    i. The benefits of smoking cessation if client is smoking.

2. Provide written materials that will support/reinforce teaching.

Discharge Planning

1. Discharge planning should be initiated during the initial client encounter and should support timely discharge and optimal client independence.
2. If the client's care is being transferred across sectors (acute care, community care, or residential care), ensure that the receiving site/facility is provided with a care plan that outlines the current client care and skin tear management strategies.

Client Outcomes

1. Intended
    a. Skin tears are prevented.
    b. If a skin tear does occur, then:
        - The skin tear heals.
        - The skin tear is free of infection.
        - The peri-wound skin is clear and intact.
        - The client and family understand and act on their role in preventing and treating skin tears.
2. Unintended
    a. Skin tear does occur.
    b. The skin tear does not heal.
    c. The skin tear shows signs and symptoms of infection.
    d. The surrounding skin becomes reddened or blisters where it is in contact with the dressing.
    e. The skin flap is damaged.
    f. The edges of the skin tear become macerated.
    g. The client and family do not understand or act on their role in preventing and treating skin tears.

Documentation

1. Document initial and ongoing wound assessments as per agency guidelines.
2. Document care plans, clinical outcomes and care plan revisions as per agency guidelines.

Bibilograpy

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Document Creation/Review

This guideline is based on the best information available at the time it was published and relies on evidence and avoids opinion-based statements where possible. It was developed by the Provincial Nursing Skin and Wound Committee and has undergone provincial stakeholder review.

Created By	British Columbia Provincial Nursing Skin and Wound Committee in collaboration with Wound Clinicians from across all Health Authorities
Publication Date	May, 2016
Revision Date(s)	
Review Date (s)	