Assess & Diagnosis Skin Tears

Client Concerns

- Understanding of skin tear healing and risk factors.
- Ability to participate in care plan & treatment.
- Impact on daily life/body image.
- Client environment on level of risk (e.g., cluttered room).
- Psychosocial/ financial / mental health issues & supports.
- Client/family preferences for treatment acknowledging culture and traditions.

Assessment of Risk Factors Impacting the Occurrence and Healability of Skin Tears

- Impaired nutritional status.
- Dehydration, difficulty swallowing, inability to feed self.
- Pain: acute / chronic / surgical / procedural.
- Smoking / impaired O² status / substance use.
- Chronic diseases (comorbidities)
- Medications NSAIDs, systemic steroids, anticoagulants, vasopressors.
- The use adhesive tapes, transparent dressings e.g., for IV lines, ECG pads, anchoring devices, splints, braces, donning & doffing of compression stockings.
- Friction/shear forces (in the absence of pressure) and trauma to the extremities.
- Skin Assessment
 - a. Lack of a daily or twice daily skin moisturizing schedule
 - b. Thin translucent skin, dry skin / xerosis, bruising, senile purpura, & pruritus (itch)
 - c. Confirm and document date of last Tetanus vaccine
- Environmental assessment causing trauma to extremities
 - a. Cluttered environment.
 - b. Equipment e.g., side-rails, wheelchair components.
 - c. Risk for falls lighting, rugs, or equipment.

Skin Tear Assessment & Categorize Skin Tear

- History of skin tears / evidence of healed skin tears on the arms and legs.
- Identify the cause of current skin tear (if able).
- · Location of skin tear(s).
- Measurement of the tear(s).
- Condition of skin flap, if present.
- Presence of hematoma(s) in/surrounding the skin tear.
- Characteristics/amount of exudate and/or bleeding from the skin tear.
- · Wound edge appearance.
- The integrity of the peri-wound skin (e.g., intact, bruised, inflamed)

Categorize Skin Tears according to amount of tissue loss:

Type 1 Skin Tear - No skin loss.

The linear or flap tear can be repositioned to cover the entire wound bed.





Type 2 Skin Tear - 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.



Type 3 Skin Tear - Total flap loss.

There is no flap, the entire wound bed is exposed.



Assessment of Wound Infection

- Date of last tetanus booster
- Onset of new or ↑ pain
- Wound odour after cleansing
- Friable granulation tissue
- Poor wound healing and/or ↑ size
- Induration / erythema 2 cm or greater
- Presence of or ↑ purulent exudate
- Malaise / fever
- Change in blood glucose / elevated WBC levels
- 2 or more S&Ss or 1 or more S&S for a diabetic client warrants notification of Physician or NP.

An ↑ WBC or fever may not be present with an infected skin tear in a client with diabetes due to a blunted inflammatory response; therefore, these are not reliable indicators of wound infection in clients with DM.

Go to: Prevent & Treat Skin Tears

