**Skin Tear Pathway**



**Preventing Skin Tears**

Skin tears are avoidable harm caused by trauma and mechanical forces including adhesives. Ensure patients are protected from skin tears, inform them of risks and help them make decisions to protect their skin. A number of co-morbidities impact upon skin integrity including: heart disease, renal failure and CVE. Long term steroid use and aging also cause skin thinning

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| **Preventing Skin Tears** |
| **Risk Factors** | Patients are at risk if they have:* Reduced cognitive or sensory perception
* Medications that thin the skin – steroids
* Reduced mobility
* Visual impairment
* Friction and shear
* Equipment for transferring
* Dry, oedematous or friable skin
* Ecchymosis – skin stained by leakage of blood into it’s layers
* Previous history of skin tears
* Adhesives on at risk skin
 | * Position furniture, equipment and rugs carefully
* Ensure lighting is adequate
* Cover sharp edges of beds, chairs and equipment
* When using manual handling equipment pay close attention to the skin
* Always use a slide sheet for repositioning on the bed and ensure patients do not drag their skin when moving
* Use protective clothing or tubular bandages on at risk limbs
* Avoid adhesive dressings
* Take care with cannula positioning
* Use protective rehydrating emollients
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| **Nursing Care Plan****All skin tears should be reported and documentation completed** | **Holistic Assessment** | **Skin Tear Assessment / Wound Assessment** |
| * Assess the environment for possible causes of skin tears
* Encourage the patient to wear good fitting shoes and keep nails short
* Consider underlying pathology
* Assess and encourage mobility
* Identify factors delaying healing
* Nutrition
* Medications
* Factors contributing to skin tear development
* Factors potentially contributing to delayed healing
 | When a skin tear occurs assess:* Cause of skin tear
* Position of skin tear
* Date and time the skin tear occurred,
* Date and time of assessment
* Dimension of the skin tear
* Category of skin tear
* Appearance of the wound bed
* Presence/absence of haematoma or necrosis
* Sensitivity to dressings
* Potential to heal within 21 days
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Developed by Julie Bateman, Rachael Vincent and Kerry Grimshaw. Printed and supported by HARTMANN. References: Stephen-Haynes J Carville K (2011) Skin tears made easy Wounds International Vol 2 No 4; All Wales Tissue Viability Forum (2011) Best Practice Statement: The Assessment and Management of Skin Tears MA Healthcare Ltd: London; Bianchi J (2012) Preventing, assessing and managing skin tears Nursing Times Vol 108 no 13 pp 12 – 16; Beldon P (2011) Haematoma: assessment, treatment and management Wound Essentials Vol 6 pp 36 – 39; Megson M (2011) Traumatic subcutaneous haematoma causing skin necrosis BMJ Case Reports Wounds International (2018) Best Practice recommendations for the prevention and management of skin tears in aged skin Best Practice Document 18 [www.woundsinternational.com](http://www.woundsinternational.com) With thanks to J Steven-Haynes for consent to use images.

**Management of Skin Tears**

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| **Skin Tear Classification**  |
| **Category** | **1A** | **1B** | **2A** | **2B** | **3** | **Haematoma – may need secondary referral** |
| **Appearance** | Image result for skin tear images | Related image |  |  |  |  |
| **Description** | The edges of the skin tear can be fully realigned to the normal position without over stretching and the skin or flap is not pale, dusky or darkened | The edges of the skin tear can be realigned to the normal position without over stretching and the skin flap is pale, dusky or darkened | The edges cannot be realigned to the normal position and the skin or flap is not pale, dusky or darkened | The edges cannot be realigned to the normal position and the skin is pale, dusky or darkened | The flap is completely absent | A collection of blood leaked from the vessels into the tissues below the skin. This may be seen as a dark red collection causing a tightening of the skin. In a large haematoma a hard mass may be present |

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| **Treatment Pathway** |
| Control bleeding – elevate the limb (if bleeding does not stop in 10 minutes get medical assistance) | Complete assessment – see guidance above | For lacerations extending into fascia, muscle, tendon or bone or haematomas obtain medical or tissue viability advice | Cleanse with warm saline – Do NOT use adhesive strips | If the skin flap is viable gently easy back in place with a sterile gloved finger or forceps. If it is not viable rehydrate with a moist gauze swab for 5 minutes & ease back in place | Apply a wound contact layer and suitable secondary dressing in the direction of the flap so that it holds the flap in place | Mark the dressing with an arrow indicating the direction off the skin flap. Always remove dressings in the direction of the arrow to ensure the flap is not disturbed | Review category 1A and 2A after 7 days or as dictated by exudate. Review category 1B or 2B after 2 days |

**Managing Old or Chronic Skin Tears**

New skin tears should be dressed as outlined above, a wound contact layer or foam dressing can be used with a light or tubular bandage to secure. When the patient presents with an old wound or chronic skin tear, where you cannot replace the flap it is important the dressing used meets the clinical need. Use the chart below to support your dressing selection

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| **Tissue – Non -Viable****Slough or Necrosis** | **Infection / Inflammation**  | **Moisture Imbalance**  | **Edge of Wound not Progressing** | **Surrounding Skin** |
| HydrogelSheet hydrogelHydro Responsive Wound Dressing | Antibacterial dressing | Superabsorbent dressing | Reassess and consider current practice | Use an emollient to rehydrate dry friable skinConsider skin protection socks or tubular bandages |