Skin Tear Guidance for Community Teams

Author(s) & Designation	Julie Dursley, Tissue Viability Nurse
Lead Clinician	Sarah Williams, Tissue Viability Nurse
Ratification Group	

If you require this document in a different format, please contact the Quality and Governance team on 01275 546834

Issue Date	Version	Reviewer	Comments	Review date
June 2018	1	JD	New Guidance	June 2020

Contents

1. Definition 3

2. Classification used for this pathway 3

3. STAR Skin Tear Classification System 3

4. Skin Tear Risk Factors 4

5. Skin Tear Guidance 6

6. References 7

1. Definition

A skin tear is a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers. A skin tear can be partial-thickness (separation of the epidermis from the dermis) or full-thickness (separation of both the epidermis and dermis from underlying structures.)”
(LeBlanc & Baranoski 2011)

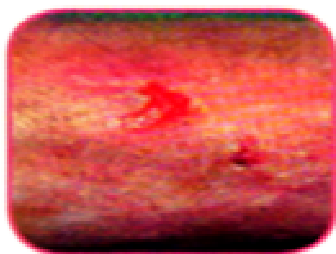
2. Classification used for this pathway

The Skin Tear Audit and Research (STAR) Classification System (Carville et al 2007) comprises three different categories. The development refers to the different levels of epidermal loss and the state of the epidermal tissue. The different level of loss is important and should indicate the care to be provided to preserve the epidermal tissue as much as possible. The state of the epidermal tissue is important as a flap that is pale, dusky or darkened is more likely to break down

3. STAR Skin Tear Classification System

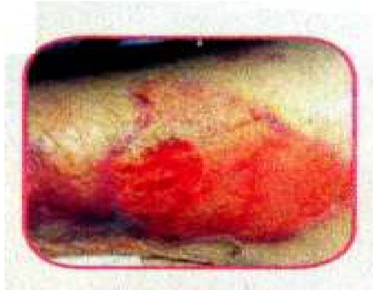
Category 1a, 1b
A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.

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.



4. Skin Tear Risk Factors

RISK FACTORS

Mobility
- Impaired mobility/balance
- Increased manual handling Requirements

General Health
- Extremes of age and the critically ill
- Chronic disease – multiple medication
- Cognitive changes
- Visual impairment
- Poor nutrition/hydration

Skin
- Aging or fragile
- History of skin tears
- Changes in skin condition

Effects of Aging
- Blood supply to the skin is diminished
- Elasticity and strength of the skin is reduced
- Epidermis and Dermis thins
- Loss of subcutaneous fat

- Sebaceous glands atrophy and skin becomes dry
- Epidermis more easily separates from the dermis as the interface between the two flatten

PREVENTION

- Provide a safe environment to prevent trauma
- Cover sharp borders on furniture with soft material
- Provide adequate lighting
- Protect fragile skin with long sleeves/trousers
- Wearing well-fitting shoes to prevent falls
- Maximise nutrition and hydration
- Moisturise the skin

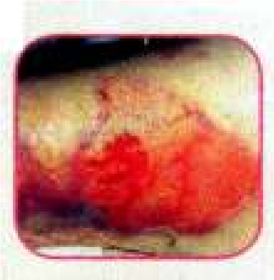
As most skin tears occur during routine patient care activities (Everett and Powell 1994) Caregivers utilise extreme caution and a gentle touch when bathing, dressing and/or transferring individuals who are at risk.

- Have short fingernails or wear gloves when caring for the elderly
- Care when applying compression stockings
- Avoid wearing jewellery that could catch the skin

5. Skin Tear Guidance

SKIN TEAR GUIDANCE

- Head injury
- Unable to control bleeding within 5mins
- Haematoma (a solid swelling of clotted blood within the tissues) which is over 6cm in size.



Cleanse to remove debris if present.

Cover wound with an appropriate sterile dressing

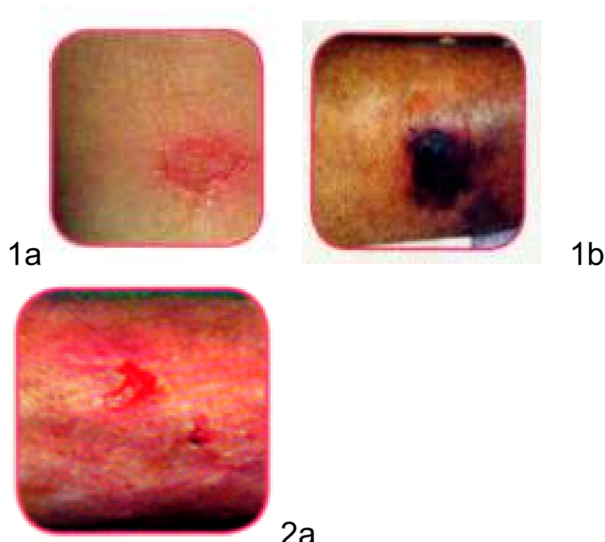
Send patient to A&E Department

- On an oedematous limb (excess of watery fluid collecting in the cavities or tissues of the leg or arms)
- Depth which is full thickness skin loss
- Area of wound above 6cm

Category 2b

Cleanse to remove debris if present

Use a sterile gloved finger moistened with normal saline to align edges of the skin flap



1a 1b

2a

Edges of the skin flap are unable to be realigned.

Cleanse to remove debris if present.

Apply an appropriate dressing.

<u>SKIN TEAR GUIDANCE</u>

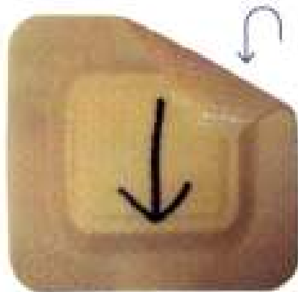
1. **Control bleeding:**
   Use sterile gauze, apply pressure and elevate the limb if appropriate

2. **Remove debris:**
   Gently irrigate the wound using normal saline
   Gently pat the surrounding skin dry with a sterile towel

3. **Document on electronic wound assessment form**
4. **Apply Dressing using the advice below**

<u>Healthy Skin</u>
Apply a non- adherent dressing to cover wound
Apply simple adhesive dressing.

<u>Dry/ Fragile Skin</u>
Cover with a with a silicone bordered dressing
Indicate on the dressing using an arrow the direction of dressing removal.
This will prevent the reopening of the skin tear.



In the event of <u>uncontrollable bleeding</u> apply a pressure bandage

- A non-adherent sterile dressing over the wound
- Cover with a sterile absorbent pad
- Secure with a bandage and transfer to A&E Dept.

6. References

This tool is based on best practice guidelines produced by the International Skin Tear Advisory Panel (2014) Categorising the skin tear using Skin Care Audit Research. Silver chain Nursing association School of Nursing And Midwifery

Carville K **et al**. STAR: ... **Carville** K **et al** STAR: a consensus for skin tear classification. ... January **2007** <http://www.vcp.monash.edu.au>.**STAR: A** consensus for skin tear classification **(PDF ...**
https://www.researchgate.net/publication/44390554_STAR_A_consensus...

Everett and Powell, 1994) are used to ... The management of skin tears Fig 1. A linear category **I** tear; dermis and epidermis are pulled in one layer.. The management of skin tears **-** Nursing Times
https://**www.nursingtimes.net**/Journals/2012/10/04/q/y/m/030204The... · PDF file

LeBlanc, K., & **Baranoski**, S. (**2011**). Skin tears: state of the science: consensus statements for the prevention, prediction, assessment, and treatment of skin tears(c).
NDNQI® | Pressure Injury Training v. 6.0 | Module II
https://members.nursingquality.org/NDNQI**PressureUlcerTraining**/...