NUTRICIA CARE
LIFE-TRANSFORMING NUTRITION

SKIN TEARS

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)[1]. Literature suggests that skin tears may be more common than pressure ulcers[2]. Skin tears that heal within 4 weeks are defined as uncomplicated and those that do not heal within this time can be defined as complicated[1].

SECTION 1: PREVENTION OF SKIN TEARS

PREVENTION OF SKIN TEARS INCLUDES

Risk assessment - Complete a risk assessment for individuals deemed at risk for development of skin tears. See ISTAP[1] risk assessment pathway for more details: skintears.org/education/tools/risk-assessment-pathway

Those at increased risk of skin tears include:

- Older persons - as we age the skin becomes drier, looser, and thinner.
- Those who rely on others for assistance with personal care or mobility.
- Those with impaired mobility, vision, or a history of falls.
- Those with cognitive or sensory impairment.
- Those with poor nutritional intake.
- Those who have had previous skin tears.

NUTRITION

- Assess patient's nutritional risk using a validated screening tool such as the Malnutrition Universal Screening Tool (MUST) and/or the Malnutrition Screening Tool (MST)[2].
- Refer patients at risk of malnutrition to the dietitian or implement an appropriate nutrition care plan in line with your local policy.

SKIN CARE FOR THE PREVENTION OF SKIN TEARS

- When assisting with hygiene needs use a soap substitute such as Silcocks Base and avoid excessive washing. Pat skin dry.
- Moisturise the skin at least once daily using appropriate products like Silcocks Base or emulsifying ointment.
- Ensure the residents and healthcare workers have clean and short fingernails.
- Ensure healthcare workers remove jewellery in line with local policy.
- Consider removing personal jewellery for an at-risk person.
- The back of the hands and arms are areas most at risk for skin tear development.
- Cover skin with appropriate clothing in those at risk by wearing long sleeved tops, longer skirts, and trousers.
- Use mobility aids when required to reduce friction and shear during mobilising and repositioning.
- Choose adhesive dressings carefully being mindful of the individuals skin type, the location and frequency at which the dressing may be renewed.
- Remove adhesive dressing and tape slowly and carefully. If required wet the dressing or use products that aid with adhesive removal.

References:

1. Beeckman D. & Van Tiggelen H. (2018) International Skin Tear Advisory Panel (ISTAP) Classification System – English version. Skin Integrity Research Group (SKINT), Ghent University. Available to download from www.skintghent.be
2. Health Service Executive, 2018. HSE National Wound Management Guidelines 2018. Dublin: The Office of Nursing and Midwifery Services Director HSE(HSE2018). https://www.hse.ie/eng/about/qavd/incident-management/pressure-ulcers-a-practical-guide-for-review.pdf
3. Wounds UK (2018) Best Practice Statement Maintaining skin integrity. London: Wounds UK. Available to download from: www.wounds-uk.com
4. Wounds UK (2020) Best Practice Statement: Management of lower limb skin tears in adults. Wounds UK, London. Available to download from: www.wounds-uk.com

PLEASE TURN OVER

SECTION 2: THE MANAGEMENT OF SKIN TEARS

STEP 1: INITIAL INJURY

1. Control the bleeding by applying pressure and/or elevating the limb.
2. Cleanse the wound well and remove any debris/clots.
3. If a skin flap is present, approximate the edges. This is to reposition the flap into place to cover the wound.
4. This can be done gently with gloved fingers. Sometimes a warm damp compress can be applied to the flap prior to this to aid movement. However it is important not to over stretch the skin.
5. Measure and classify the skin tear type.
6. Apply an atraumatic wound dressing. A foam or acrylic or non-adherent gauze dressings will be suitable.
7. Monitor the wound for the first 24-48 hours for bleeding, control bleeding as needed.

STEP 2: ASSESSMENT

Skin tears are classified into 3 types using the ISTAP[1] Skin tear classification (see figure 1 below):

Type 1: No skin loss - flap that can cover the wound within 1mm of wound edges.

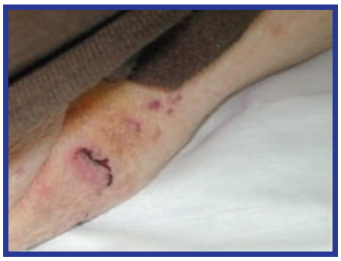
Type 2: Partial skin loss - partial flap that cannot cover the wound bed.

Type 3: Complete skin loss - there is no epidermal flap to cover the wound.

Assess patient's nutritional risk using a validated screening tool such as the Malnutrition Universal Screening Tool (MUST) and/or the Malnutrition Screening Tool (MST)[2].

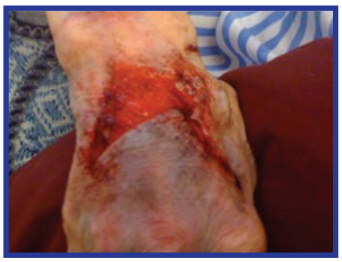
Figure 1: Skin Tear Classification (ISTAP[1] 2018)

Type 1:
NO SKIN LOSS



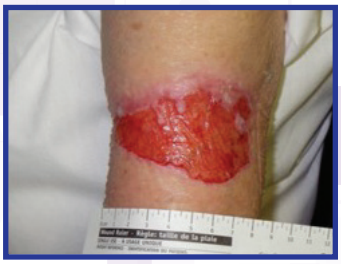
Linear or Flap* Tear which can be repositioned to cover the wound bed

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

** A flap in skin tears is defined as a portion of the skin (epidermis/dermis) that is unintentionally separated (partially or fully) from its original place due to shear, friction, and/or blunt force. This concept is not to be confused with tissue that is intentionally detached from its place of origin for therapeutic use e.g. surgical skin grafting.*

For further information or guidance please contact 1800 923 404 or email TVNreferrals@nutricia.com

STEP 3: WOUND CARE AND DRESSING SELECTION

1. Always remove dressing in the direction of the flap not against it. Please note the direction of removal on the dressing by drawing an arrow - see figure 2 below.
2. Apply a barrier film to the periwound to aid in atraumatic removal of the dressing.
3. It is not advisable to use steri-strips as evidence suggests they are not suitable to aid with flap closure due to the fragility of the skin and possible trauma on removal.
4. Avoid using gauze, iodine-based products, or hydrocolloids for skin tears. These are either too drying or too adhesive and may cause further injury.

Leave dressing undisturbed for up to 7 days for simple skin tears. If the skin tear is complex, then a wound assessment may be indicated sooner.

STEP 4: NUTRITION

1. Encourage intake of key nutrients to meet the needs of wound healing, in particular: protein, energy (calories), Vitamin C, Vitamin A and Zinc[2].
2. Refer patients at risk of malnutrition to the dietitian or implement an appropriate nutrition care plan in line with your local policy.

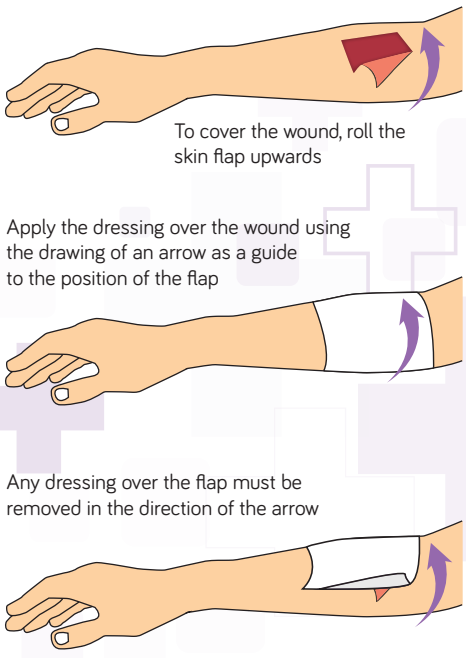
STEP 5: CONSIDER OTHER ASPECTS OF CARE PLAN

1. Document the wound in line with local policy. Documentation should include a wound assessment and management care plan at a minimum.
2. Consider tetanus immunization if clinically indicated.

STEP 6: MONITORING

1. Observe for signs of local or deep tissue infection.
2. Revaluate if the flap becomes necrotic or if wound edge is non advancing. If necessary, seek advice of Tissue Viability.

Figure 2: Skin Tear dressing removal



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