SKIN TEAR TREATMENT AND PREVENTION PATHWAY OF CARE

A superficial or deep traumatic tear to the skin resulting in no loss, partial loss or entire loss of skin

Assess the extent of tissue damage

- Skin flap is complete, without skin loss (Skin Tear 1)
- Skin flap edges do not meet, partial skin loss (Skin Tear 2)
- Skin flap is missing, entire loss of tissue (Skin Tear 3)

First line management for all skin tears

- Control bleeding, gentle pressure and elevation
- If visible debris or ‘dirty environment’ cleanse the wound with saline / tap water
- Where practical gently bring skin flap edges as close together as possible.
  **DO NOT** pull the skin flap across in an attempt to join the edges.
  **DO NOT** use wound closure strips
- Provide patient and carers with full explanations of actions at every stage of care
- Measure and record wound for patient records, in line with local guidelines, e.g. Skin Tear 2 (cm x cm)
- Perform local wound assessment and document with actions in patient’s notes
- Before applying dressing, draw arrow on it with a pen, to show direction of removal

Assess the level of leakage from the wound

Dressing choice will be dependent on wound assessment and dressing formulary

Minimal leakage
- Formulary dressings have been selected to be left in place for 7 days or more.
  - Thin hydrocolloid dressing
  - Lipocolloid contact layer with secondary dressing
  - Silicone contact layer with a secondary dressing
  - Absorbent clear acrylic dressing (can be left in place indefinitely)
- Do not remove the dressing unless there is evidence of wound infection (See Page 2) or the dressing is not sticking.

If you need to change the dressing – reassess the wound.

Moderate to heavy leakage
- Formulary dressings have been selected to be left in place for 7 days or more.
  - Foam Dressing
  - Lipocolloid contact layer with secondary dressing
  - Silicone contact layer with a secondary dressing
  - Absorbent clear acrylic dressing (for moderate exudate levels, can be left in place indefinitely)
- Do not remove the dressing unless there is evidence of wound infection (See Page 2) or the dressing is not sticking. Select the dressing according to the level of exudate. If you need to change the dressing – reassess the wound.

If lower leg oedema is present, advise the patient to elevate the limb and request a review by health care professional within seven days

Remember

- Frequent or daily dressings are not required. Dressings should be reviewed and changed if the edge of the dressing has lifted, if there is evidence of wound infection or when the wound has healed.
- Remove the dressing in the direction of the skin flap to avoid accidental removal of the flap and document in the notes
- Other conditions may interfere with wound healing and skin integrity e.g. diabetes, peripheral vascular disease, anaemia and immunosuppression, dementia, skin changes at life’s end (SCALE)
- Some medications may affect the integrity of the skin, e.g. anti-coagulants, steroid therapies and other immunosuppressants
- Assess and manage pain
- If a skin tear on the lower leg is not showing signs of healing after 2 weeks, consider consulting another health care professional for advice

Dressings do not heal wounds but provide the best conditions for healing

In the first few days following injury, inflammation and redness are part of the NORMAL healing response, unless accompanied by a raised temperature. If the condition of the wound becomes worse this may indicate infection. (See page 2 for signs and symptoms)
Is your patient at risk of sustaining a skin tear?

Consider the following:

- Fragile, dry or thin skin
- Long term corticosteroid therapy
- History of previous skin tear
- Dependent, immobile patient
- Bruises easily
- Mental capacity

SEE the risk

S = Skin Care
- Skin inspection and assessment
- Consider using pH neutral skin products
- Apply all emollients in direction of hair growth and at least twice daily (refer to Emollient Guidelines)
- Encourage fluid intake
- Nutritional Assessment and complete MUST
- Consider the use of barrier film products underneath adhesive tapes and dressings
- Non healing wounds consider consulting Tissue Viability Nurse for advice
- Ensure those at risk wear long sleeves or trousers or knee high socks

E = Education
- Provide patient / carer leaflet
- Ensure patients and carers understand risk and prevention strategies

E = Environment
- Falls Assessment
- Where possible, reduce or eliminate pressure, shear & friction using pressure relieving devices & positioning techniques
- Consider surroundings, ensure adequate lighting and position furniture to avoid the risk of injury
- Manual Handling/Equipment – use aids when moving patients ensuring good manual handling techniques

Additional signs
- Delayed healing
- Dark discoloured granulation tissue
- Increased friability (tissue which bleeds easily)
- Painful / altered sensation to the wound site or surrounding skin
- Altered odour
- Wound breakdown
- Pocketing at the base of the wound
- Increased exudate levels
- Pocketing or bridging of skin across a wound

If your patient shows signs of acute infection, refer to antimicrobial algorithm and an appropriate health care professional as soon as possible

SIGNS AND SYMPTOMS OF WOUND INFECTION

In the first few days following injury, inflammation and redness are part of the normal healing response.

Clinical signs
- Raised temperature (Pyrexia)
- Increasing inflammation (redness and heat)
- Oedema
- Increased pain
- Increased exudate or pus present

Additional signs
- Delayed healing
- Dark discoloured granulation tissue
- Increased friability (tissue which bleeds easily)
- Painful / altered sensation to the wound site or surrounding skin
- Altered odour
- Wound breakdown
- Pocketing at the base of the wound
- Increased exudate levels
- Pocketing or bridging of skin across a wound

Bibliography
- Skin Tear 1 image - Biddix, J. Management of skin tears in the elderly with a unique absorbent clear acrylic dressing. Symposium in Advanced Wound Care. San Diego 2008

Produced by Surrey Wound Management Formulary Group in partnership with 3M Critical & Chronic Care Solutions Division, October 2013