SKIN TEAR PREVENTION

Skin tears are associated with falls, blunt force trauma, poor manual handling and equipment injuries. Skin tears can occur on any part of the body but are often sustained on the extremities, particularly in the elderly. In neonates, skin tears are often more associated with device trauma or use of adhesives. In neonates, the dermis is still developing. Even at full term the skin is only 60% of adult thickness.

Predisposing Risk Factors

History of previous skin tears	Fragile dry or thin skin	Compromised status	Medications	Dependency
Previous injury reduces tensile strength Recurrent skin tears show individuals increased risk	Extremes of age (neonates and elderly) = thin skin, decreased tensile strength and elasticity	Cognitive impairment Dehydration Poor nutrition Altered mobility with history of falls Decreased sensation Poor vision	Long term corticosteroid therapy Anticoagulant therapy	Requires help with activities of daily living.

Reducing The Risk (S.E.E the Risk)

S skin

- Carry out a skin assessment; Document general condition, existing wounds, marks and bruises etc. mark on a body map/chart
- Assess risk; including changes in skin integrity, medications and mobility
- Skin care- Use pH neutral skin cleansers. Pat dry don't rub, moisturise (at least daily) apply in direction of hair growth
- Ensure MUST score is assessed and encourage/monitor fluid intake to prevent dehydration
- Reduce risk of skin trauma from dressing products by using none or low adhesive products. Utilise barrier creams to prevent skin stripping and have available adhesive removal products

E environment

- Complete a falls assessment
- Assess Walsall score and implement pressure prevention as per policy
- Consider surroundings- Ensure there is adequate lighting, and position furniture to reduce risk of injury.
- Manual handling – ensure correct equipment is available and used correctly to reduce friction and shearing.
- Ensure staffs handling patients comply with uniform policy and do not have jewellery or long nails that can cause skin damage when handling patients.
- Encourage use of long sleeves and trousers to protect skin
- Encourage exercise to maintain mobility
- Ensure sensible well-fitting shoes are worn
- Assess potential skin damage from pets

E education

- Provide patient and carer with information on how to reduce risk of skin tears
- Ensure patient and carers understand the prevention strategies discussed
- Actively involve patient and carer in decisions and plans
- A collaborative multidisciplinary approach should be utilised to prevent and manage e.g. carers, Community nurses, GP, Occupational and physiotherapists, dietician
- Refer to appropriate specialist if impaired sensory issues e.g. optician, diabetes, neurology

EVALUATE

REASSESS

Skin tear risk should be re assessed and recorded if the patients' condition changes

SKIN TEAR MANAGEMENT PATHWAY

Patient presents with a skin tear

Carer/family member → Perform first aid as appropriate and refer to minor injuries unit or A&E. Inform GP of incident

Control Bleeding
Apply pressure/elevate the limb

Perform wound assessment and categorise skin tear

Document findings

Include – Classification, wound size, exudate level, colour and condition of skin flap

Approximate the wound edge
If able, gently ease the skin back into position using sterile gloves and saline. Do not attempt to pull/force the skin edges back together. Do not use wound closure strips as this encourages stretching of the wound edges /skin flap

Apply Dressing
Select appropriate dressing based on exudate levels. This should ideally be left in place for 5-6 days to enable the skin flap to reattach.
e.g. Moist wound - Biatain silicon.
Wet wound- Biatain silicon.
Saturated wound - Atrauman covered with Kliniderm superabsorbent pad
Draw an arrow on surface of Biatain dressings to advise following carers which direction to remove the dressing

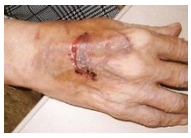
Protect peri wound skin with a barrier film

Set treatment goals
- Avoid further trauma
- Protect periwound skin
- Manage exudate
- Prevent infection
- Minimise pain
- Reassess prevention plans

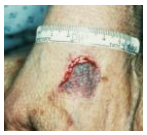
Review and reassess
Monitor the wound for changes and revise treatment plan according to progress

Star Classification of skin tears

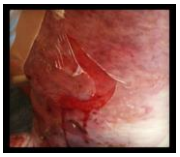
1a - no skin loss, skin flap is not discoloured and can be realigned



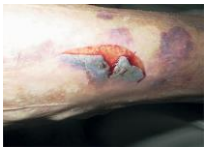
1b – as above, flap may be realigned but skin flap is dusky/darkened



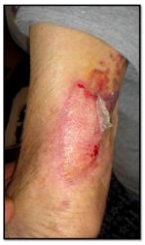
2a - Skin edges can **not** be realigned to the normal position but skin flap is pink



2b – As 2a but flap is dusky /darkened



3 – Skin flap is completely abscent



Skin flaps that are dusky or dark in colour are likely to become non-viable and may require debridement at a later date. This will require referral to TVN or GP