

Skin Tear Management Flow Chart

Assessment

- All clients should have a risk assessment for skin tears on admission
- Assess and document skin tears using a recognised assessment and classification system e.g. STAR¹
- Assess the surrounding skin for swelling, discolouration or bruising

If skin flap is pale, dusky or darkened:

- Reassess in 24-48 hours or at the first dressing change
- * *Assessment should only be undertaken by trained staff*

¹ Carville et al. 2007

Management

- Control bleeding
- Cleanse the wound gently with warm water or normal saline, pat dry
- Realign edges if possible
 - do not stretch the skin
 - use a moist cotton-tip to roll skin into place
- Apply a low adherent, soft-silicone dressing to wound, overlapping the wound by at least 2 cm
- Draw arrows on the dressing to indicate the direction of dressing removal
- Mark the date on the dressing
- Apply limb protector

Prevention

- Assess skin regularly and implement a prevention protocol for those at risk
- Use soap-free bathing products
- Apply moisturiser twice daily
- Use correct lifting and positioning techniques
- Avoid wearing rings that may snag the skin
- When repositioning use assistive devices such as slide sheets
- Protect fragile skin with either limb protectors or long sleeves or pants
- Pad or cushion equipment and furniture
- Avoid using tapes or adhesives, use tubular retention bandages to secure dressings

Document

- Level of risk and risk factors present
- Prevention strategies
- Management strategies
- Category of skin tear/s, size, location, tissue type, exudate, surrounding skin
- Progress and outcome of interventions

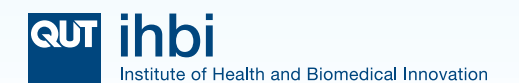
Risk factors for a Skin Tear

History of previous skin tears	Multiple or high risk medications e.g. steroids, anticoagulants
Bruising, discoloured, thin or fragile skin	Impaired mobility
Cognitive impairment / dementia	Poor nutritional status
Impaired sensory perception	Dry skin / dehydration
Dependency	Presence of friction, shearing and/or pressure



References:

Ayello E, Sibbald R, *Preventing pressure ulcers and skin tears, in Evidence-based geriatric nursing protocols for best practice*, E Capezuti, et al., Eds. 2008, Springer: New York. • LeBlanc K, Baranoski S, *Skin tears: Adv Skin Wound Care*, 2011. 24(9S): 2-15 • Rattliff C, Fletcher K, *Skin Tears: Ostomy Wound Management*, 2007. 53(3) <http://www.o-wm.com/article/6968> • Carville K et al., *STAR: A consensus for skin tear classification. Primary Intention*, 2007. 15(1): 18-28 • Joanna Briggs Institute, *Topical skin care in aged care facilities. Best Practice*, 2007. 11(3) • Wounds UK. *Best Practice Statement: Care of the Older Person's Skin Wounds UK 2012*, 2nd ed.



CRICOS No. 00213J

STAR classification system



Category 1a

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 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** pale, dusky or darkened.



Category 2a

A skin tear where the edges can not 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 can not 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.