Skin Tear Management Flow Chart

Assessment

- All people should have a comprehensive risk assessment for skin tears on admission and if any change in condition
- Assess and document skin tears using a recognised assessment and classification system e.g. STAR[1] or ISTAP[2]
- Assess cause of any skin tear, pain, the wound characteristics, and 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 be undertaken by those with training and skills in the area

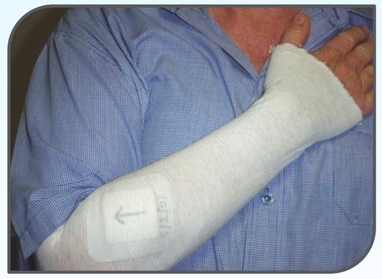
[1] Carville et al. 2007. [2] LaBlanc etal. 2013

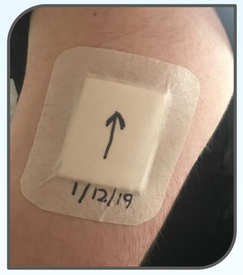
Risk factors for skin tears

- History of previous skin tears
- Bruising, haematoma, oedema, skin changes related to aging or critical illness
- Fragile, dry flaking skin with poor elasticity
- Cognitive impairment
- Impaired sensory perception
- Dependency with repositioning
- Multiple medications
- Impaired mobility or history of falls
- Poor nutritional status and/or dehydration

Management

- Control bleeding and pain
- Cleanse the wound gently with water or normal saline, air/pat dry
- Realign edges or any flap if possible
  - do not stretch the skin
  - use a moist cotton-tip to roll skin into place
- Apply a non-adherent, flexible dressing to wound (e.g. soft silicone), overlapping the wound by at least 2 cm
- Draw arrows on the dressing to indicate the direction of dressing removal
- Mark the date the dressing should be changed
- Avoid use of strong adhesive dressings or tape, film or hydrocolloid dressings, skin closure strips or gauze





Prevention

- Assess skin regularly & implement a prevention protocol for those at risk
- Use soap-free, emollient bathing products
- Apply non-perfumed moisturiser twice daily to dry skin
- Dry skin thoroughly after washing by patting, not rubbing
- Use correct lifting and positioning techniques
- Protect fragile skin with 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
- Minimise falls risk (e.g. good lighting)
- Maintain optimal nutrition and hydration status

Document

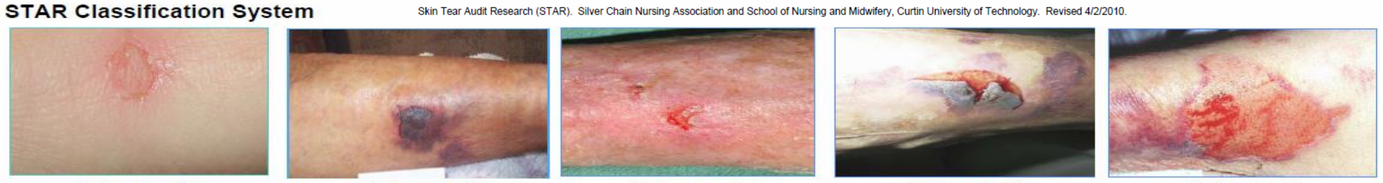
- Level of risk and risk factors present
- Prevention strategies
- Management strategies
- Skin tear category, size, location, tissue type, exudate, surrounding skin
- Progress in healing and outcome of interventions

promoting healthy skin
Champions for Skin Integrity

QUT Queensland University of Technology

STAR Classification System

Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010.



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 **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.

References

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