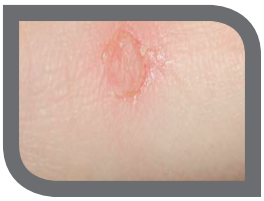
Skin Tear
Assessment Tool

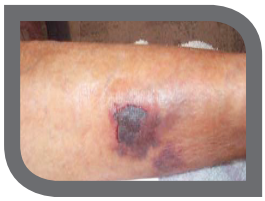
Affix patient Label

Date	
Location of Skin Tear:	
Skin Tear Category: (tick box)	☐ Category 1a ☐ Category 1b – check within 24-48hrs ☐ Category 2a ☐ Category 2b – check within 24-48hrs ☐ Category 3



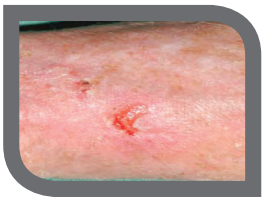
Category 1a

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.



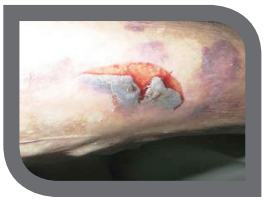
Category 1b

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.



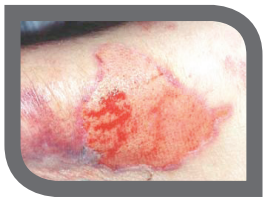
Category 2a

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.

Week 1

Date	Treatment	Date For Next Dressing Change	Initials

Week 2

Date	Treatment	Date For Next Dressing Change	Initials

Week 3

Date	Treatment	Date For Next Dressing Change	Initials

Week 4

Date	Treatment	Date For Next Dressing Change	Initials

If skin tear not healed within four weeks refer for specialist assessment

Note: Dressings should stay insitu for 5-7 days or unless strikethrough 75%

Skin Tear
Prevention Guide

Affix patient Label

Definition

A skin tear is a traumatic wound as a result of friction alone or shearing and friction which separates the epidermis from the dermis (partial-thickness wound), or separates both the epidermis and dermis from underlying structures (full-thickness wound).

Risk factors for skin tears:

- ☐ History of previous skin tears
- ☐ Presence of bruising or discoloured skin
- ☐ Advanced age
- ☐ Poor nutritional status
- ☐ Cognitive impairment/dementia
- ☐ Dependency
- ☐ Multiple medications
- ☐ Impaired mobility
- ☐ Dry skin/dehydration
- ☐ Presence of friction, shearing, pressure
- ☐ Impaired sensory perception
- ☐ Disease processes (renal failure, heart disease, stroke)

Prevention Strategies:

- ☐ Assess/recognize fragile, thin, vulnerable skin
- ☐ Use soap-free bathing products to avoid drying the skin
- ☐ Apply moisturiser to the skin twice daily
- ☐ Use proper lifting, positioning and transfer techniques
- ☐ Use caution when bathing and dressing
- ☐ Avoid wearing rings that may snag the skin
- ☐ Keep fingernails trimmed
- ☐ Avoid direct contact that will pull the skin. Use assistive devices such as slide sheets
- ☐ Protect fragile skin – use limb protectors and/or use clothing that has long sleeves or pants
- ☐ Consider padding or cushioning equipment and furniture. For example, bed rails and wheelchairs to reduce risk of injury
- ☐ Use pillows (satin or silk covers help to reduce to the risk of friction and shear) to position people who are less mobile or restricted to bed or chairs
- ☐ Avoid using tapes or adhesives. If dressings or tapes are required, use paper tapes or soft silicone dressings to avoid tearing the skin upon removal
- ☐ Provide a safe environment
- ☐ Optimise nutrition and hydration

References:

Ayello E, Sibbald G. Preventing pressure ulcers and skin tears. In: Capezuti E. et al. (eds) *Evidence-based Geriatric Nursing Protocols for Best Practice*. 3rd ed. New York: Springer Publishing Company 2008. **www.guideline.gov/summary/summary.aspx?doc_id=12262**

Carville K. et al. STAR: A Consensus for skin tear classification. *Primary Intention* 2007. 15(1): 18–28

Payne R. Martin M. Defining and classifying skin tears: need for common language. *Ostomy Wound Management* 1993. 39(5): 16

promoting healthy skin
Champions for Skin Integrity

QUT ihbi
Institute of Health and Biomedical Innovation

Skin Tear Alert sticker
for progress notes

SKIN TEAR ALERT

Resident name: Date Time

Location of skin tear:

Skin Tear Category: (tick box)

Category 1a	Category 1b	Category 2a	Category 2b	Category 3
☐	☐	☐	☐	☐

Treatment:

Incident report Completed: (tick box) ☐ Yes ☐ No

Date of review **Signature:**

Skin Tear
Management Guidelines

1. Control bleeding
2. Clean wound with warm normal saline, warm water or in shower. Pat dry

3. Realign (if possible) any skin or flap using a moist cotton-tip
4. Assess and document the skin tear using the Skin Tear Assessment Tool
5. Assess the surrounding skin for swelling, discolouration or bruising. If flap colour is pale, dusky or darkened reassess in 24-48 hours or at first dressing change

6. Apply a soft-silicone dressing (e.g. Mepilex Border™, Mepitel™ or Allevyn Gentle™) to wound overlapping the wound by at least 2cm
7. Draw arrows on the dressing to indicate the direction the dressing should be removed and date that dressing was applied
8. Apply a limb protector (e.g. Tubifast™) to prevent further injury
9. If you are not the RN notify the RN and document what you have done

10. Leave dressing on for 5 to 7 days or if 75% strike through
11. Remove dressing slowly in direction of arrows, moisten with water for easy release
12. If wound is healed leave open and moisturise
13. If wound has not healed apply a new soft silicone dressing and leaveon for 5 to 7 days

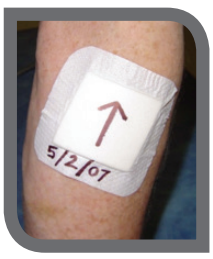


Figure 1: Remove dressing in direction of arrow 5 to 7 days after application or if 75% strikethrough

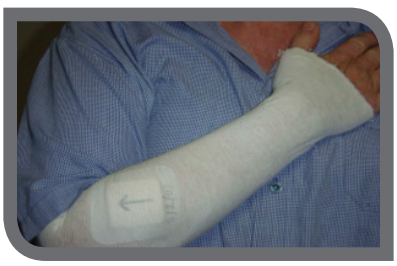


Figure 2: Limb protector to prevent further trauma

References:

Ayello E, Sibbald G. Preventing pressure ulcers and skin tears. In: Capezuti E. et al. (eds) Evidence-based Geriatric Nursing Protocols for Best Practice. 3rd ed. New York: Springer Publishing Company 2008. http://www.guideline.gov/summary/summary.aspx?doc_id=12262

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