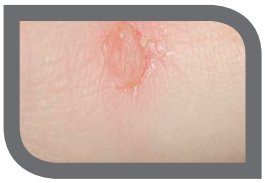
Skin Integrity
Classification System

promoting healthy skin
Champions for Skin Integrity

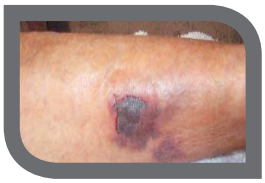
STAR - Skin Tear Classification System Guidelines

1. Control bleeding and clean the wound according to protocol.
2. Realign (if possible) any skin or flap.
3. Assess degree of tissue loss and skin or flap colour using the STAR Classification System.
4. Assess the surrounding skin condition for fragility, swelling, discolouration or bruising.
5. Assess the person, their wound and their healing environment as per protocol.
6. If skin or flap colour is pale, dusky or darkened reassess in 24-48 hours or at the first dressing change.

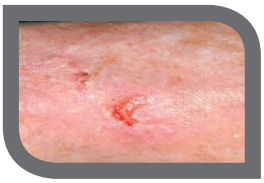
STAR classification System



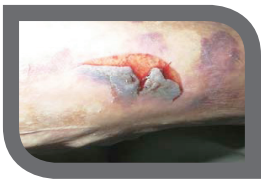
Category 1a
A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is not** pale, dusky or darkened.



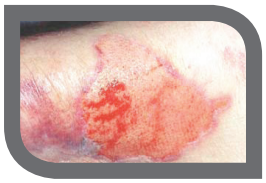
Category 1b
A skin tear where the edges **can** be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is** pale, dusky or darkened.



Category 2a
A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is not** pale, dusky or darkened.



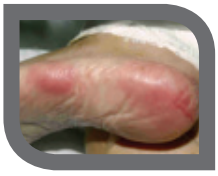
Category 2b
A skin tear where the edges **cannot** be realigned to the normal anatomical position and the skin or flap colour **is** pale, dusky or darkened.



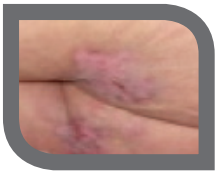
Category 3
A skin tear where the skin flap is completely absent.

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

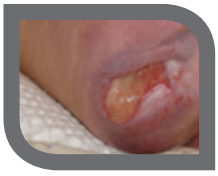
Pressure Injury or Ulcer Staging



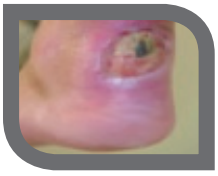
Stage 1
Persistent redness in lightly pigmented skin. In darker skin the ulcer may appear with persistent red, blue or purple hues.



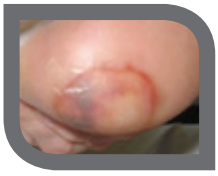
Stage 2
Skin loss involving epidermis and/or dermis. The ulcer is superficial in appearance.



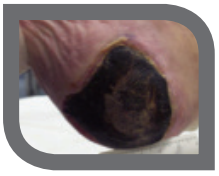
Stage 3
Involves damage or necrosis of subcutaneous tissue that may extend down to but not through the underlying fascia.



Stage 4
Full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often undermining or tunnelling.



Suspected Deep Tissue Injury
Purple or maroon localised area of discoloured or intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.



Unstageable
Full thickness tissue loss in which the actual depth of the ulcer is completely obscured by slough and/or eschar in the bed.

EPUAP & NPUAP (2009)

GLOSSARY

Chronic venous insufficiency is a medical condition where, due to damaged or "incompetent" valves the veins cannot pump blood effectively back to the heart resulting in elevated ambulatory venous pressure (venous hypertension). Characteristics of chronic venous insufficiency may include oedema, skin staining, varicose veins, itchy legs and ulceration.

Peripheral Vascular Disease is caused by obstruction of the large arteries, especially in the extremities most commonly due to atherosclerosis. Characteristics of peripheral vascular disease include: claudication, rest pain, trophic changes, e.g. hair loss on the lower limb, thin shiny skin on the calves or feet, thickened toenails, purple colour of the limb in the dependent position, cool skin on palpation, mummified or dry and black toes, devitalized soft tissue with a wet or dry crust.

References

Carville, K. et al. (2007). STAR: A consensus for skin tear classification. *Primary Intention*, 15(1), 18-28. • Dardik, A. et al. (2008) Guidelines for the prevention of lower extremity arterial ulcers, *Wound Repair and Regeneration*, 16, 175-188. • European Pressure Ulcer Advisory Panel and NPUAP. (2009) Prevention and treatment of pressure ulcers. Washington DC: NPUAP. • Robson, M. et al. (2006) Guidelines for the treatment of venous leg ulcers, *Wound Rep Regen*, 14, 649-662

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Skin Integrity
Survey Form

promoting healthy skin
Champions for Skin Integrity

Date ☐☐/☐☐/☐☐ MRN ☐☐☐☐☐☐☐☐☐☐

List all wounds detected on examination				Wound type
	Wound present	Left	Right	List wound type (e.g. venous or arterial leg ulcer, diabetic foot ulcer, pressure injury, skin tear), category/stage of wound and location of wound e.g. Category 2a skin tear outer aspect of R calf
Head	☐	☐	☐	
Arm	☐	☐	☐	
Hip/iliac crest	☐	☐	☐	
Sacrum/buttocks	☐	☐	☐	
Back	☐	☐	☐	
Leg	☐	☐	☐	
Foot/toes	☐	☐	☐	
Other	☐	Specify other		
Total wounds present at examination:				

1. There is evidence of:

- ☐ Skin cancers
- ☐ Chronic venous insufficiency
- ☐ Peripheral vascular disease
- ☐ Previous leg ulcers
- ☐ Previous pressure injuries
- ☐ Lower limb amputation
- ☐ Previous skin tears

2. The following pressure reducing/relieving device(s) are present:

- ☐ None
- ☐ Speciality bed or chair
- ☐ Comfort/adjunct devices
- ☐ Replacement mattresses (static, dynamic)
- ☐ Cushions/overlays (static/dynamic)
- ☐ Other (specify) .....

3. The following preventative interventions or strategies are in place:

- ☐ None
- ☐ Compression hosiery
- ☐ Protective clothing
- ☐ Specialised orthotic footwear
- ☐ Foot and ankle exercises
- ☐ Elevates limbs above heart level
- ☐ Moisturising
- ☐ Compression hosiery applicator device
- ☐ Lighting
- ☐ Turning schedule
- ☐ Padded wheelchair foot plates, leg rests, bed rails
- ☐ Other (specify) .....

4. Documentation within the last 5 days related to the management of any CURRENT wound(s):

- ☐ None
- ☐ Wound tracing
- ☐ Wound assessment
- ☐ Wound photography
- ☐ Risk assessment
- ☐ Dressings
- ☐ Turning regimes
- ☐ Compression bandaging (specify) .....
- ☐ Pressure off-loading (specify) .....
- ☐ Referral (specify) .....
- ☐ Organisation protocol (specify) .....
- ☐ Investigations (specify) .....
- ☐ Other (specify) .....

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