Public – To be published on the Trust external website

Skin Tear Prevention and Management

Ref: CLIN-0072-002-v3

Status: Approved
Document type: Procedure
Overarching Policy: Tissue Viability Policy

Contents

1 Introduction

Wound assessment is an important process that allows clinicians, patients and carers to monitor wound healing or identify any presence of complications and measure the effectiveness of treatment.

A skin tear is defined as a traumatic wound caused by mechanical forces, including the removal of adhesives. Classification is based on the severity of the 'skin flap' loss. A skin flap is defined as a portion of skin (epidermis / dermis) that is unintentionally separated (partially / fully) from its original place due to shear, friction, and /or blunt force' (LeBlanc et al, 2018). Partial thickness occurs when the epidermis is separated from the dermis or full thickness when both the epidermis and the dermis separate from underlying structures (full thickness wound) (LeBlanc et al, 2011).

Skin tears can occur on any part of the body, but are most often found on the extremities, such as upper or lower limbs or the dorsal aspect of the hands (LeBlanc et al, 2011). They can be painful wounds, affecting the individual's quality of life, increasing risk of hospitalisation or increasing hospitalisation time (LeBlanc et al, 2018). In a review of patient and skin characteristics associated with skin tears, the most common patient characteristics were found to be a history of skin tears, impaired mobility and impaired cognition, while the skin characteristics associated with skin tears included senile purpura (recurrent bruising in forearms associated with age), ecchymosis (bruising) and oedema (Rayner et al, 2015; Strazzieri-Pulido et al, 2017).

Older people are at a higher risk of developing skin tears due to the fragility of ageing skin, which is a result of the flattening of the basal cell layer and impaired circulation. Whilst preventing skin tears occurring is the main focus, by recognising those who are at risk, preventing skin injuries and treating skin tears appropriately, we can decrease the pain and suffering patients endure as a result of skin tears. Prevention of these wounds is the primary aim. However, healthcare professionals must be aware of the classification and treatment recommendations for skin tears.

Majority of skin tears are thought to be unavoidable however the true prevalence is unknown, the available evidence demonstrates that they occur in all healthcare settings (LeBlanc et al, 2019).The International Skin Tear Advisory Panel (ISTAP) consensus statement number 11 (2013) identifies that many patients will develop multiple skin tears regardless of preventative strategies and suggest that those individuals with multiple organ failure, existing co morbidities and certain mental health illness including dementia where self-inflicted injuries and non-compliance will contribute to unavoidable skin tear development.

Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust provides care to a diverse range of service users across several specialties and localities, all of whom require varying degrees of need and support. As reiterated by NHS England, 2019 [online], care provision is variable, with some groups of people continuing to experience inequalities. TEWV NHS Foundation Trust is therefore fully committed to ensuring that patients receive care that is individualised, holistic and evidence based, and that fair and equal treatment is offered to all. No one should have a poorer service or a

lesser experience because of their differences. It is in keeping with this principle that this procedure has been written.

This procedure reflects the Trust's strategic direction of travel, Our Journey to Change, by supporting its values and goals. Living our values is integral to the care we deliver. We will show respect to patients by actively listening to their concerns and acting upon them. We will ensure we are always compassionate, kind and supportive. We will be open and honest in our conversations, always receptive (listening) to how much information a person may want, and in what kind of format.

This procedure also supports the Trust's strategic goals. It is important that we work closely with the person so that the experience can be as good as it possibly can be, working to ensure the person has as much choice and control as possible. We will work closely with our Trust colleagues, so they feel supported in working with the person.

2 Purpose

Following this procedure will help the Trust to:

- Support clinical staff in the prevention and management of skin tears.
- Help reduce the risk to patients by recognising those at risk of developing skin tears and implementing appropriate management where necessary.

This includes all nursing and health care staff and members of the multidisciplinary team who care for any patient of any age.

3 Who this procedure applies to

This procedure applies to all registered healthcare professionals and nursing support staff working within TEWV NHS Foundation Trust who have a responsibility to assess, treat and manage wounds.

Consideration has also been given to those who may be affected by this guideline to ensure that the document content aligns to the Trust's values, so that people who may be affected are treated with compassion, respect and responsibility.

4 Related documents

This procedure describes what you need to do to implement the policy section of the Tissue Viability Policy.

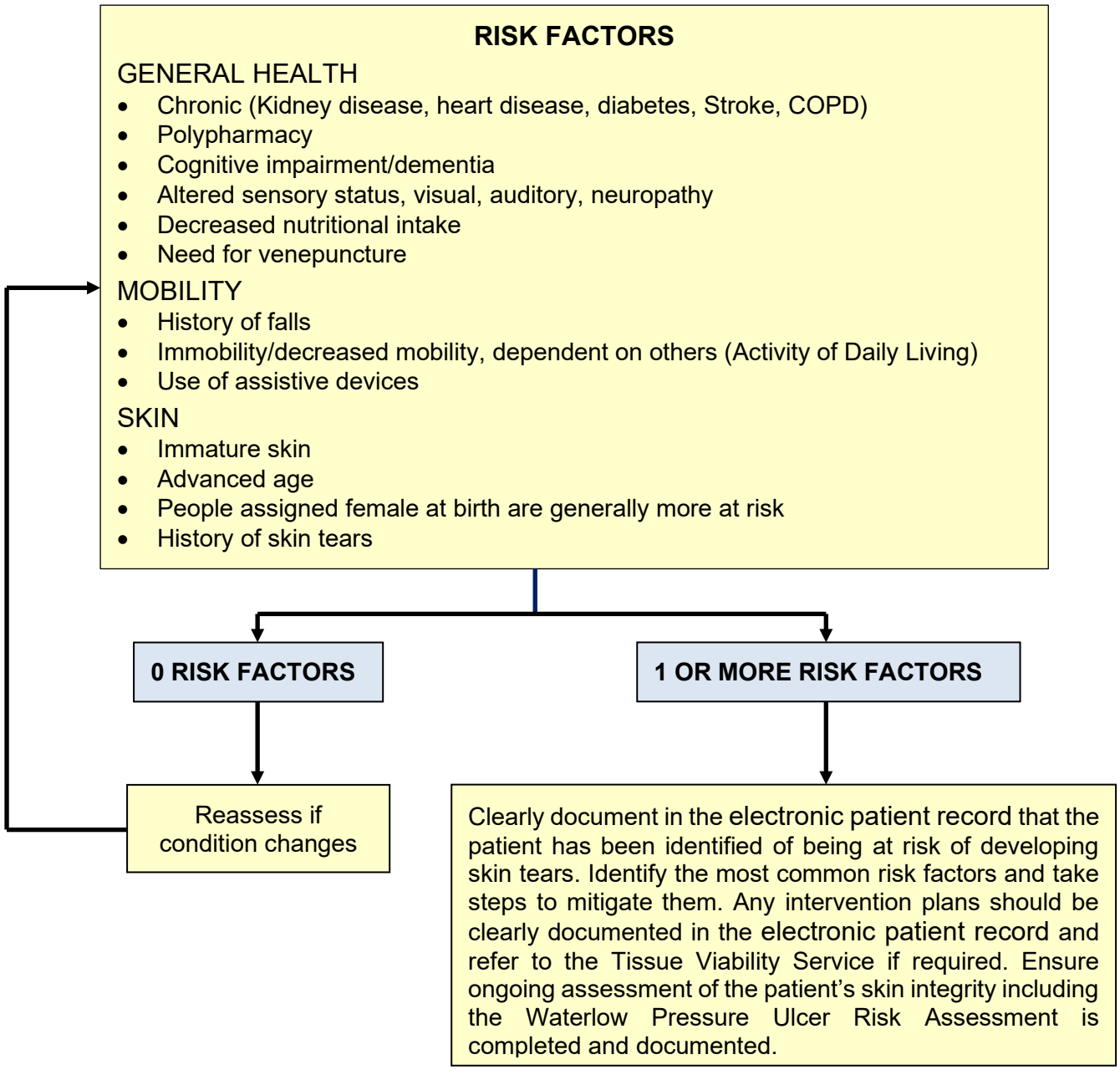
The Tissue Viability Policy defines the roles, responsibilities and interventions which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:

- Aseptic Non-Touch Technique Procedure
- Assessment, Prevention and Management of Pressure Ulcers Procedure
- Consent to Examination or Treatment Policy
- Digital Wound Photography Procedure
- Dress Code Procedure
- Privacy and Dignity Policy
- Safeguarding Adults Policy
- Standard Infection Prevention and Control Precautions Procedure
- Tissue Viability Policy

5 Skin Tear Risk Assessment Pathway

Identify those at risk from developing skin tears. Complete a patient history that includes the general health status and identify any risk factors from the pathway below.



In order to identify a person who is at risk, it is imperative the assessor has an understanding of the skin changes associated with ageing.

5.1 Prevention Advice

By identifying those at risk, appropriate interventions can be implemented before tissue damage occurs. Always assess/recognise fragile, thin, vulnerable skin.

Implement appropriate interventions plans to minimise the possibility of a patient developing a skin tear by using the identified risk factors and the prevention advice in the table below (adapted from the ISTAP guide for preventing skin tears, Le Blanc et al, 2018). All associated interventions plans should be clearly documented on the electronic patient record.

Risk Factor	Prevention
General Health	▪ Self-management approach (if cognitive function not impaired) ▪ Educate the patient on skin tear prevention and promote active involvement in treatment decisions. ▪ Optimise nutrition and hydration. ▪ Safe patient environment ▪ Protect from self-harm. ▪ Dietetic referral if indicated-extra caution with extremes of BMI. ▪ Review polypharmacy for medication reduction / optimisation. ▪ Medical review of comorbidities for improved management. ▪ Educate the patient on medicine induced skin fragility. ▪ Communicate to the MDT re the importance of gentle patient handling, skin fragility with extremes of age and medicine induced skin fragility. ▪ Adequate lighting in patient environment. ▪ Adequate temperature in patient environment.
Mobility	▪ Encourage active patient involvement if physical/ cognitive function is not impaired. ▪ Appropriate selection and use of assistive devices. ▪ Daily skin assessment and monitoring of skin tears. ▪ Ensure safe patient handling techniques. ▪ Ensure safe transferring / repositioning. ▪ Initiate falls and /or frailty assessment where necessary. ▪ Remove unnecessary obstructions/clutter from patient environment.

	▪ Appropriate foot wear. ▪ Consider using appropriate clothing (long sleeve tops, long socks, long trousers etc). ▪ Adequate lighting in patient environment.
Skin	▪ Awareness of medication induced skin fragility. ▪ Consider using appropriate clothing (long sleeve tops, long socks, long trousers etc). ▪ Moisturise skin twice daily (use hydromol or equivalent) ▪ Keep fingernails short. ▪ Skin hygiene – wash in warm tepid, but not hot water, soap-less or pH-neutral cleansers. ▪ Avoid long episodes of bathing- excessive bathing washing away the natural oils in the skin (increases risk of rubbing/ friction). ▪ Avoid strong adhesives, dressings and tapes. ▪ Control oedema. ▪ Adequate temperature in patient environment. ▪ Avoid using talcum powder as this dries out the skin (increases risk of rubbing/friction). ▪ Place, fix and remove subcutaneous cannulas with extreme caution (if insitu).

Should a skin tear occur, this should be treated accordingly and clearly documented on the electronic patient record.

The patient should also have a body map skin integrity/assessment completed which identifies the anatomical location of the skin tear (see appendix 3).

6 Skin Tear Decision Algorithm

SKIN TEARS

↓

ASSESS ← **CONTROL BLEEDING**

↓

CLEANSE

↓

APPROXIMATE WOUND EDGES
If skin is viable, ease the skin flap into position using an aseptic technique. → **CLASSIFY (MEASURE & DOCUMENT)**

↓

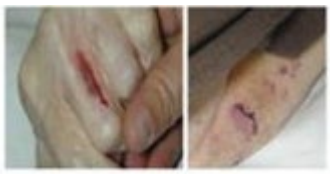
GOALS OF TREATMENT

- Treat the cause.
- Implement an appropriate intervention plan.
- Moist wound healing.
- Avoid further trauma.
- Protect peri wound skin.
- Manage exudate.
- Avoid infection.
- Pain control.
- Refer to the tissue Viability Service if required.

↓

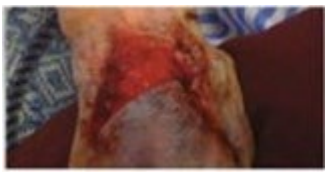
TREATMENT OPTIONS DEPENDENT OF WOUND CONDITION

Type 1: No skin loss



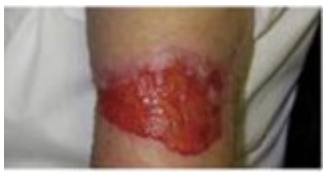
Linear or flap tear that can be repositioned to cover the wound bed.

Type 2: Partial flap loss



Partial flap loss that cannot be repositioned to cover the wound bed.

Type 3: Total Flap Loss



Total flap loss exposing the entire wound bed.

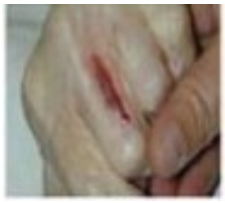
(ISTAP 2024)

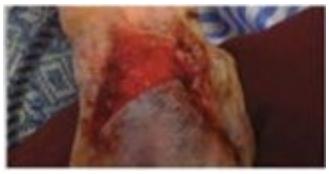
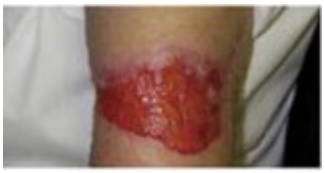
The category of skin tear should be documented in the electronic patient record.

The wound must be monitored for any changes and revise treatment plan according to progress.

All deep and/or significant skin tears should be referred to the Tissue Viability Service (via email: tewv.tissueviability@nhs.net). Alternatively, if there is immediate staff concern, the patient should be transferred to the local Acute Trust emergency department.

6.1 Dressing Selection

Skin Tear Classification		Suggested Skin Tear Treatment	
DO NOT SUTURE OR STAPLE OR STERISTRIP SKIN TEARS			
Type 1: No Skin Loss		Linear Type	Fragile Skin – apply Non-Adherent Mesh Dressing (e.g. Atrauman) cover with an absorbent pad and secure with a light bandage such as K-Band or tubular bandage. Nonfragile skin – apply a Silicone Adhesive Dressing Dressings can be left for several days depending on wound condition and exudate level.
		Flap Type	

Type 2: Partial Skin Loss 	Partial Skin Loss	Apply Non-Adherent Mesh Dressing (e.g. Atrauman) cover with an absorbent pad and secure with a light bandage such as K-Band or tubular bandage. Dressings can be left for seven days depending on wound condition and exudate level.
Type 3: Complete Skin Loss 	Complete Skin Loss	Apply Non-Adherent Mesh Dressing (e.g. Atrauman) cover with an absorbent pad and secure with a light bandage such as K-Band or tubular bandage. Dressings can be left for seven days depending on wound condition and exudate level.

It is important to acknowledge the patients personal preferences and wishes. Wherever possible these preferences need to be taken into account to promote collaborative decision making, privacy and dignity, and also, to prevent the breach of iatrogenic harm.

Further information can be obtained from the Consent to Examination or Treatment Policy and also, the Privacy and Dignity Policy- both of which are available via the Trust intranet.

Do not use adhesive strips on skin tears as this causes skin stripping to the surrounding skin when removed.

7 Definitions

Term	Definition
ISTAP	• International Skin Tear Advisory Panel
TEWV	• Tees, Esk and Wear Valleys NHS Foundation Trust

8 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.
- Each care group/ward will ensure that the staff's training needs are met in accordance with the Trusts Training needs analysis.
- Each registered nurse is responsible for his or her own professional development and individual needs should be addressed through appraisal and training needs analysis.
- An education programme, which incorporates skin tear prevention and management, is available for all healthcare workers. Staff to contact the Tissue Viability Service if required.
- Patients and their relatives/carers who are able and willing should be educated about risk assessment and prevention strategies.

8.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered Healthcare Professionals	Face to face as part of WREN programme	60 minutes	Once only (bespoke update training available if required)
Nursing Support Staff	Face to face as part of WREN programme	60 minutes	Once only (bespoke update training available if required)

9 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Clinical Audit of ESR training records for staff who have completed the WREN programme	Frequency =Annually Responsible = Tissue Viability Team	The Fundamental Standards of Holistic Care, Clinical Advisory Group

10 References

International Skin Tear Advisory Panel (ISTAP) 2023, Skin Tear Classification, ISTAP. Available: http://www.skintears.org/resources

LeBlanc K., et al. International Skin Tear Advisory Panel: A Tool Kit to Aid in the Prevention, Assessment, and Treatment of Skin Tears Using a Simplified Classification System. Advances in Skin and Wound Care, 26, pp.459-476.

LeBlanc, K and Woo, K (2018) Best practice recommendations for the prevention and management of skin tears in aged skin: an overview. Wound International 9(3), pp.66-70.

LeBlanc, K., et al (2019) Skin tears: prevention and management. British Journal of Community Nursing , 24, pp. 12-18.

LeBlanc, K., et al. Skin Tears: State of the Science: Consensus Statements for the Prevention, Prediction, Assessment, and Treatment of Skin Tears. Advances in Skin and Wound Care, 24(9), pp.2-15.

Rayner, R., et al (2015) A review of patients and skin characteristics associated with skin tears. Journal of Wound Care, 24(9), pp.406-14.

Strazzieri K, Picolo G, Gonçalves T, Gouveia Santos VL (2017) Incidence of skin tears and risk factors: A systematic literature review. Journal of Wound Ostomy Continence Nursing, 44(1), pp. 29-33.

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	02 April 2024
Next review date	02 April 2027
This document replaces	CLIN-0072-002-v2 Skin Tear Prevention and Management
This document was approved by	The Fundamental Standards of Holistic Care Clinical Advisory Group
This document was approved	02 April 2024
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	18 March 2024
Document type	Public

Change record

Version	Date	Amendment details	Status
3	02 Apr 2024	Full review of Procedure undertaken. Update of references, section 6 ‘Skin Tear Decision Algorithm’, removal of section 5.2 ‘Classifying skin tears’ and ‘related documents’ section.	Approved

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance/ Tissue Viability Service
Title	Skin Tear Prevention and Management Procedure
Type	Procedure/guidance
Geographical area covered	Trust-wide
Aims and objectives	• Support clinical staff in the prevention and management of skin tears. • Help reduce the risk to patients by recognising those at risk of developing skin tears and implementing appropriate management where necessary.
Start date of Equality Analysis Screening	18 March 2024
End date of Equality Analysis Screening	18 March 2024

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Trust staff and patients
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller)**NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	This procedure will not negatively impact upon any of the protected characteristic groups.
Describe any positive impacts / Human Rights Implications	Service users receive safe, effective and appropriate wound care and interventions

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See appendix 9 for references used within document
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	This procedure has been discussed with the Fundamental Standards of Holistic Care Clinical Advisory Group who support patients from a range of protected characteristics on a daily basis.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	N/A

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Registered healthcare professionals and nursing support staff must undertake wound care training which will incorporate skin tear prevention and management
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	
Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	

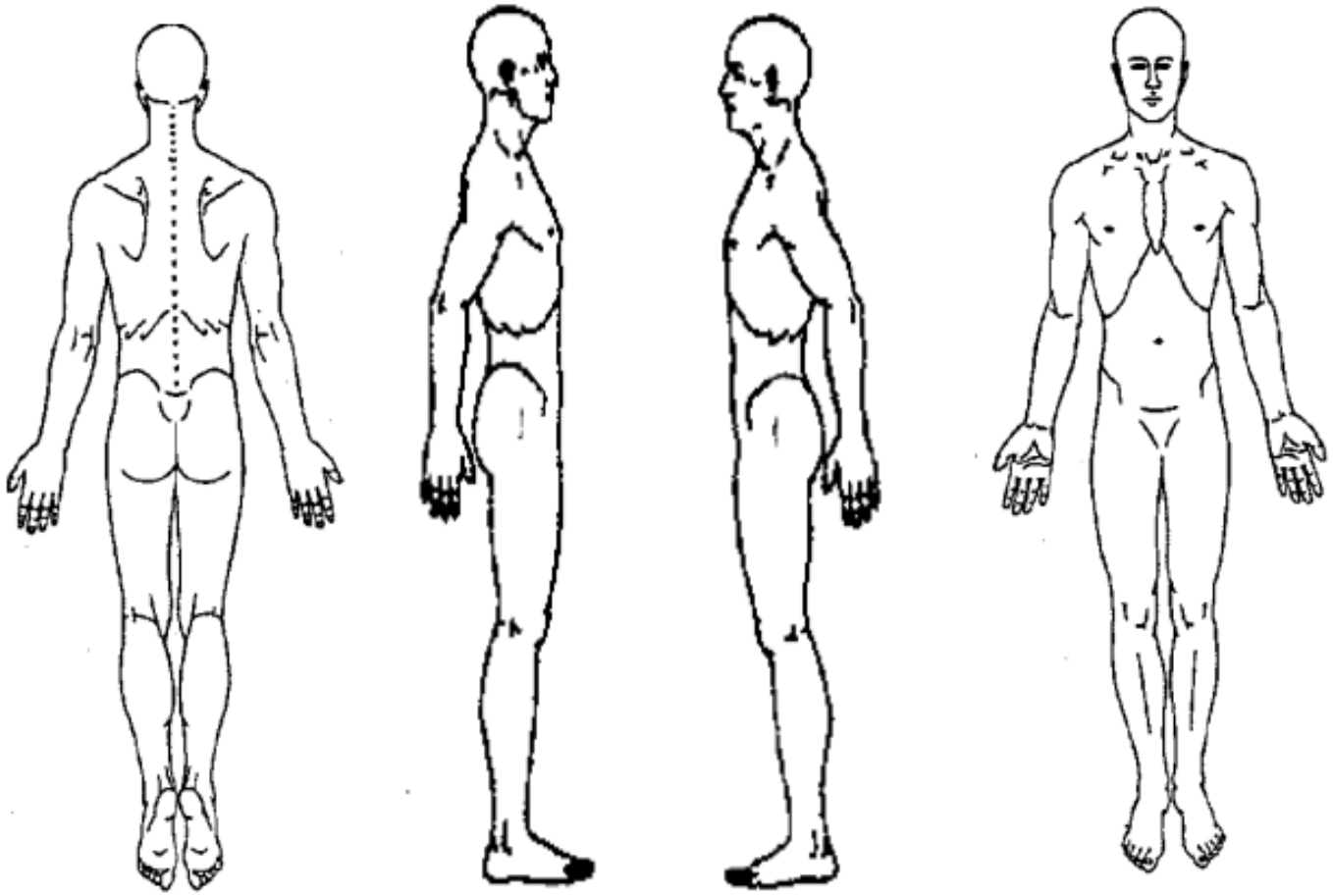
Are supporting documents referenced?	Yes	
6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9. Approval		
Does the document identify which committee/group will approve it?	Yes	The Fundamental Standards of Holistic Care Clinical Advisory Group
10. Publication		
Has the policy been reviewed for harm?	Yes	
Does the document identify whether it is private or public?	Yes	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	

Appendix 3 – Body Map Skin Integrity Assessment Sheet

Body Map Skin Integrity Assessment Sheet

Patient Name:	PARIS ID Number:
Completed by:	Designation:

Please see diagram to illustrate location of any skin damage including pressure ulcers, abrasions, rashes, wounds and red/darkened areas.



The body map skin integrity assessment sheet should be completed in conjunction with the advice and guidance outlined in the relevant policy and/or procedure (Skin Tear Prevention and Management Procedure, Tissue Viability Policy and the Assessment, Prevention and Management of Pressure Ulcers Procedure)