Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Skin Tear Prevention and Management

Ref: CLIN-0072-002-v2

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

Contents

1 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.

2 Related documents

This procedure describes what you need to do to implement section 3.7 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:-

- ✓ Safeguarding Adults Procedure
- ✓ Digital Wound Photography Procedure
- ✓ Procedure for the Assessment, Prevention and Management of Pressure Ulcers
- ✓ Tissue Viability Policy
- ✓ Consent to Examination or Treatment
- ✓ Privacy and Dignity Policy
- ✓ Standard (Universal) Infection Prevention and Control Precautions
- ✓ Aseptic Technique Procedure (Royal Marsden Manual Online)
- ✓ Dress Code Procedure

3 Introduction

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).

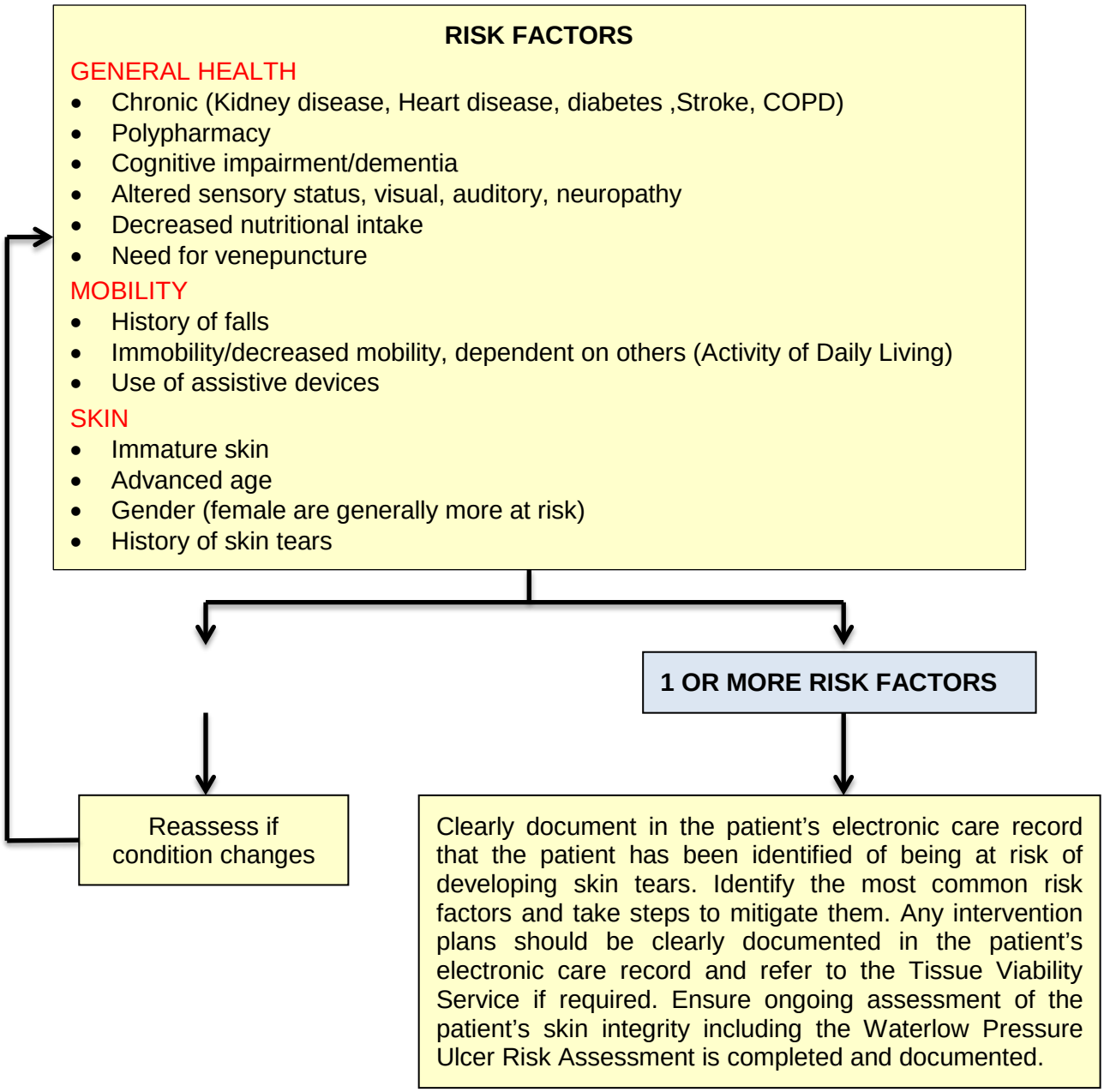
The elderly are at a higher risk of developing skin tears due to the fragility of ageing skin, which is a result of the flattening of the basal cell layer and impaired circulation. Whilst preventing skin tears occurring is the main focus, by recognising those who are at risk, preventing skin injuries 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.

4 Procedure

4.1 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.

4.2 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 patient's electronic care 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

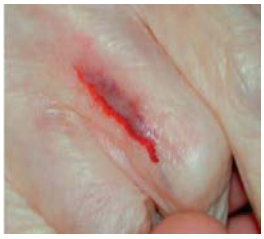
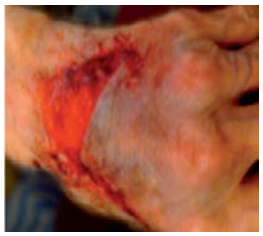
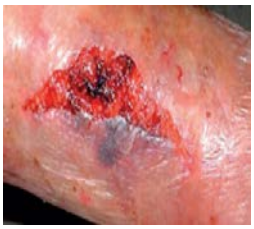
Skin	▪ Awareness of medication induced skin fragility ▪ Consider using appropriate clothing (long sleeve tops, long socks, long trousers etc.) ▪ Moisturise skin twice daily (use hydromol or equivalent) ▪ Keep fingernails short ▪ Skin hygiene – wash in warm tepid, but not hot water, soap-less or pH-neutral 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 patient's electronic care 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).

4.3 Classifying Skin Tears

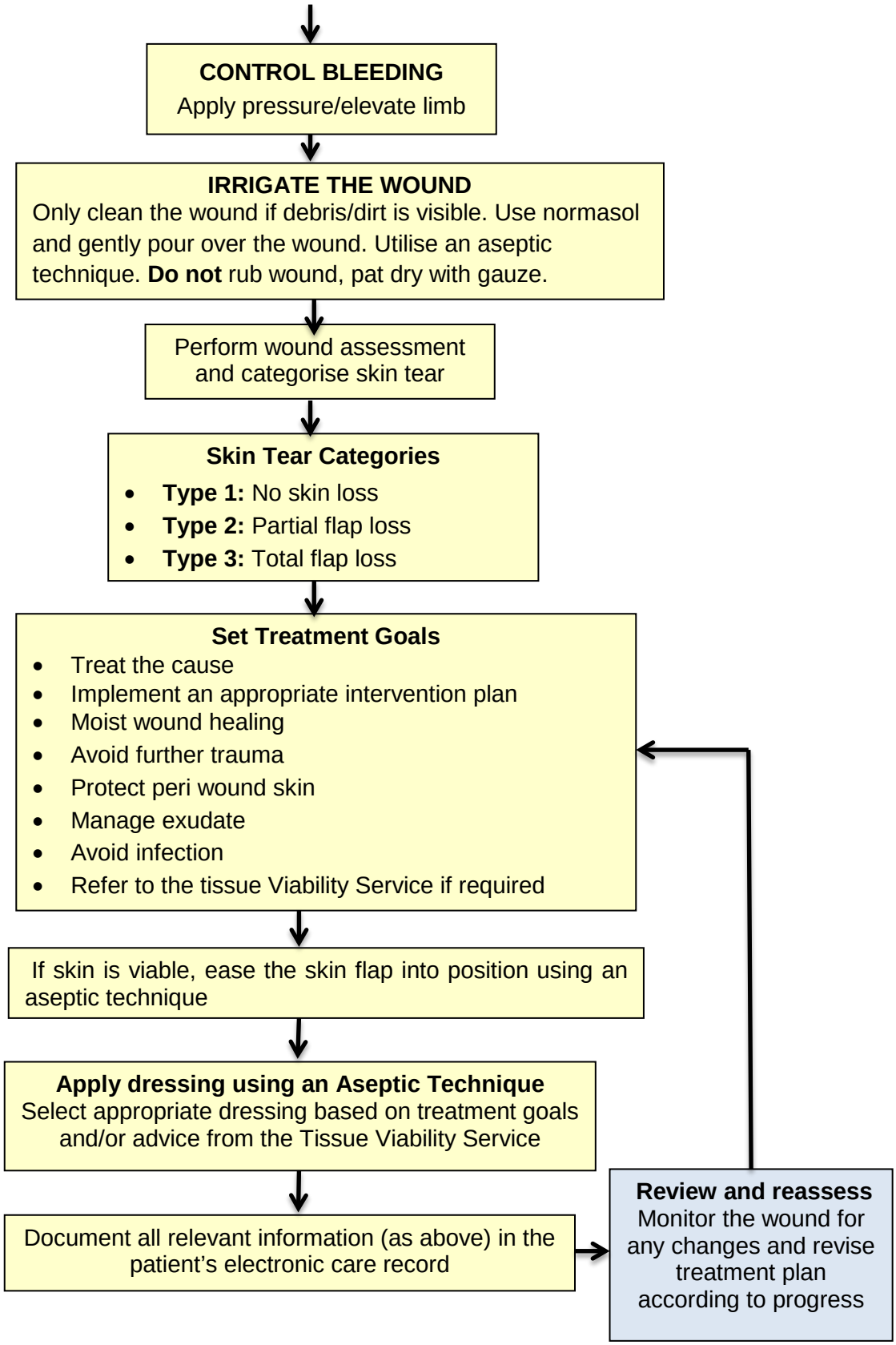
The ISTAP classification system provides an updated and simplified method for assessing skin tears. Skin tears can be categorised as Type 1, Type 2 or Type 3.

Type 1 — No skin loss 	A Type 1 skin tear is a linear tear where the flap can be repositioned to cover the wound bed.
Type 2 — Partial flap loss 	In a Type 2 skin tear, partial flap loss means that the skin flap cannot be repositioned to cover the whole of the wound bed.
Type 3 — Total flap loss 	A Type 3 skin tear involves total flap loss that exposes the entire wound bed. Please note that deep Type 3 skin tears (i.e. total thickness wounds) will require specialist Intervention.

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

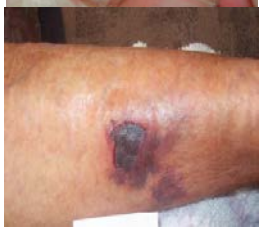
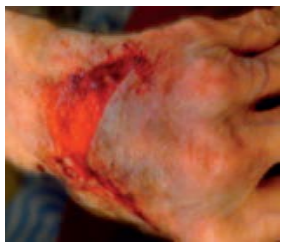
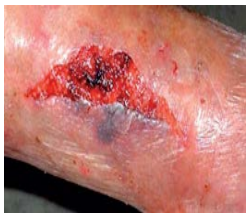
All deep and/or significant skin tears should be referred to the Tissue Viability Service (via email: tewv.tissueviability@nhs.net). Alternatively, if there is immediate staff concern, the patient should be transferred to the local Acute Trust emergency department.

4.4 Skin Tear Decision Algorithm



4.5 Dressing Selection

Dressing selection specific to skin tears

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 Adaptic touch cover with an absorbent pad and secure with a light bandage such as K-Band or tubular bandage. Non fragile skin – apply Cova wound 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 Adaptic touch, cover with 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 Adaptic touch 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.

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

- 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.

5 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 e 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

6 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
No training needs identified			

7 How the implementation of this procedure will be monitored

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	Tissue Viability ad hoc review and spot checks	Tissue Viability Team	IPC/Physical Health Group in absence of Physical Health and Wellbeing Group

8 References

International Skin Tear Advisory Panel (ISTAP) 2013, Skin Tear Classification, ISTAP. Available: http://www.skintears.org/education/tools/istap-skin-tear-classification/

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

9 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	11 January 2021	
Next review date:	11 January 2024	
This document replaces:	Skin Tear Prevention and Management CLIN-0072-002-v1	
This document was approved by:	Name of committee/group	Date
	Virtual meeting of the IPC/Physical Health group	11/01/2021
This document was ratified by:	Name of committee/group	Date
	Virtual meeting of the IPC/Physical Health group	11/01/2021
An equality analysis was completed on this document on:	06/01/2021	
Document type	Public	
FOI Clause (Private documents only)	n/a	

Change record

Version	Date	Amendment details	Status
1	30 Aug 2017	New document	Withdrawn
2	11 Jan 2021	Full Review of Procedure undertaken. Updates and references added.	Approved

Appendix 1 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Nursing and Governance/Tissue Viability Service					
Policy (document/service) name	Skin Tear Prevention and Management Procedure					
Is the area being assessed a…	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance			√	Code of practice	
	Other – Please state					
Geographical area covered	Trust-wide					
Aims and objectives	To support clinical staff in the prevention and management of skin tears.					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	06/01/2021					
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	06/01/2021					

You must contact the EDHR team if you identify a negative impact. Please ring the Equality and Diversity team on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

Trust, staff and patients.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Sex** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Yes – Please describe anticipated negative impact/s

No – Please describe any positive impacts/s

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	√	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

This is an updated review of a previous procedure that was circulated via the Physical Health and Wellbeing Group. The updated procedure will be reviewed and discussed at the IPC/Physical Health Teams Group prior to approval

No – Please describe future plans that you may have to engage and involve people from different groups

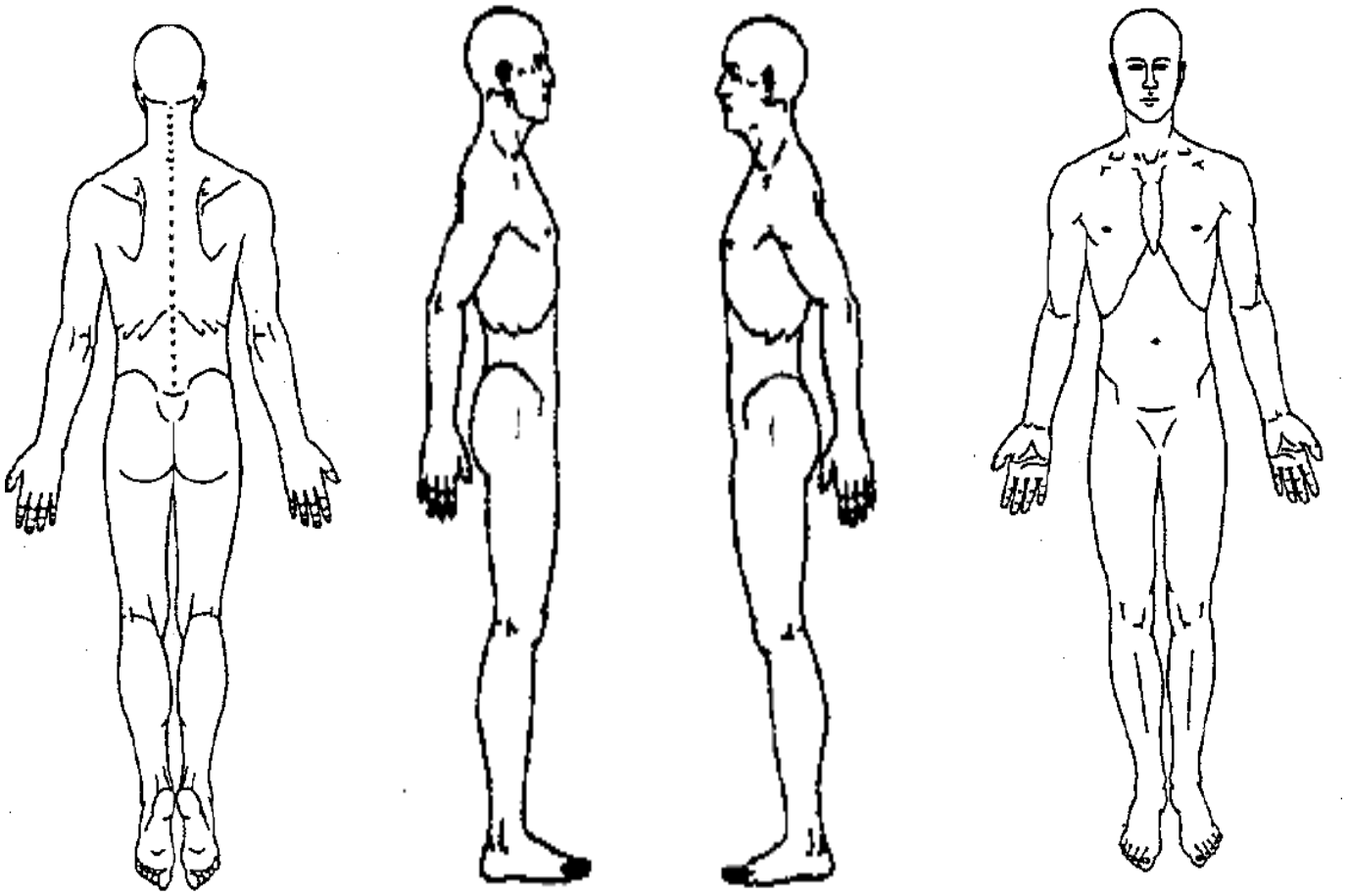
5. As part of this equality analysis have any training needs/service needs been identified?					
Yes	Many staff have completed the WREN programme (which incorporates skin tear prevention and management). If staff require education and training on skin tear prevention and management, this is available by contacting the Tissue Viability Team				
A training need has been identified for;					
Trust staff	See above	Service users	No	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046					

Appendix 2 - 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)