Team Name: Wound Care Team Lead: Regional Director of Acute Care Approved by: Executive Director - Mid	Reference Number: CLI.4110.SG.003 Program Area: Across Care Areas Policy Section: General
Issue Date: August 19 2015 Review Date: Revision Date: May 15 2017	Subject: Skin Tear Treatment Guideline

STANDARD GUIDELINE SUBJECT:
Skin Tear Treatment Guideline

PURPOSE:
- To prevent the development of skin tears by early identification of at risk clients.
- To encourage a multidisciplinary approach to reduce the prevalence and incidence of skin tears.
- To accelerate healing of skin tears by minimizing risk factors, providing an optimum environment for wound healing and addressing the cause of the wound.

Background:
Healthcare professionals need to be cognizant of which patient/residents are at risk for developing skin tears, how to prevent these wounds, and how to treat them once they occur. Prevention of skin tears is the primary focus, however if the skin tear does occur, appropriate management is very important. By recognizing which patients are at risk for skin tears, preventing skin injuries, and using appropriate non-adherent dressings patients/residents can be spared undue pain and suffering. This Skin Tear Guideline was developed utilizing current literature, expert opinion and the recommendations presented by the International Skin Tear Advisory Panel (ISTAP)

DEFINITIONS:

Pressure Ulcer:	A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.
Dermis:	The lower or inner layer of the main two layers that make up the skin. Consists of a bed of vascular connective tissue and contains nerves, organs of sensation, hair roots, and sebaceous and sweat glands.
Epidermis:	The outermost layer of the skin.
ISTAP:	International Skin Tear Advisory Panel.
Partial-thickness skin loss:	Skin- damage that involves the epidermis and can penetrate into but not through the dermis.
Full-thickness skin loss:	Ulceration that extends through the dermis to involve subcutaneous tissue.

Braden Scale: A universally accepted tool to help professionals identify individual clients who may be at risk for developing pressure ulcers. This tool has been tested for reliability and validity

PROCEDURE:

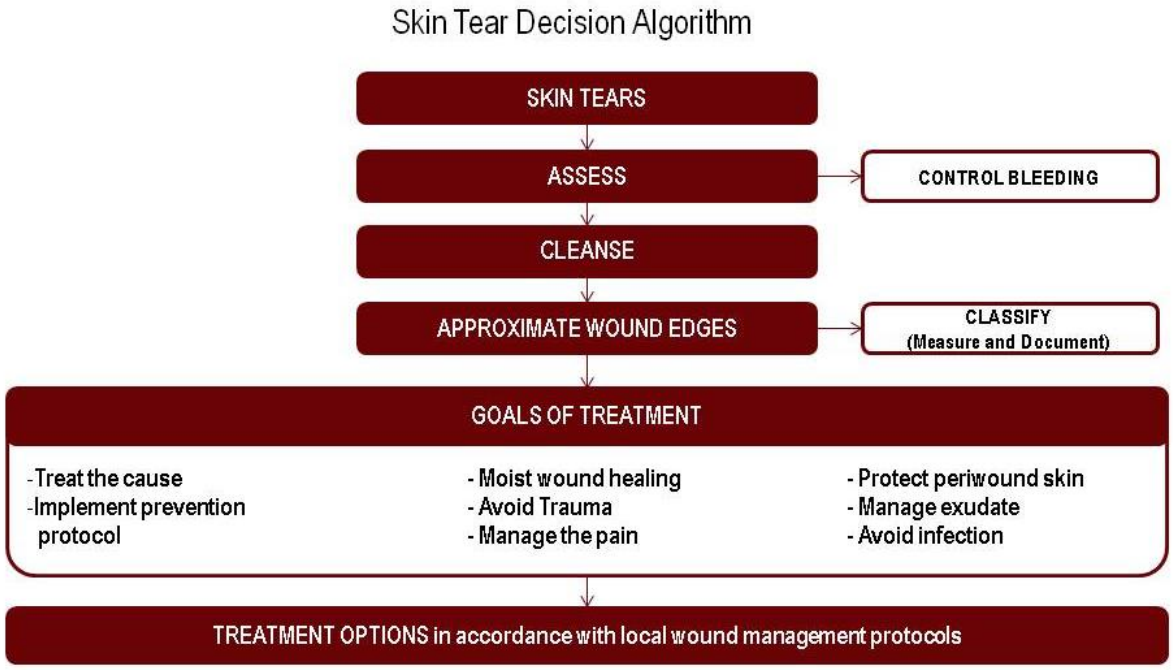
1. Skin Assessment
   A comprehensive head to toe skin assessment must be carried out with all clients at admission, and daily thereafter for those indentified at risk for skin breakdown. Particular attention should be paid to risk factors for skin tears.
   If any changes in skin are noted:
   - Identify the likely cause;
   - Document findings on the Wound Assessment and Treatment Form (CLI.4110.SG.002.FORM.07)
   - If identified as a skin tear, categorize (Table 2) according to the International Skin Tear Advisory Panel (ISTAP);
   - Report findings to the interdisciplinary team as appropriate;
   - Document on:
     - Integrated Progress Notes (IPN) in the chart,
     - Care Plan (Kardex).
2. Risk Assessment & Prevention Strategies
   The client's risk for skin tear development may be determined by utilizing the ISTAP Risk Reduction Program (Table 1), which is a quick reference guide that briefly outlines some prevention strategies for the individual, caregiver/provider and the healthcare setting. Rationale follows for each of the risk factor categories.

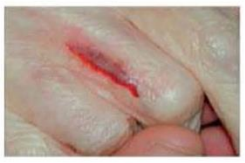
Table 1:

QUICK REFERENCE GUIDE FOR THE ISTAP RISK REDUCTION PROGRAM		
Risk Factor	**Individual**	**Caregiver/Provider**
General Health	➢ Educate patient on skin tear prevention and promote active involvement in treatment decisions (if cognitive function not impaired) ➢ Optimize nutrition and hydration	➢ Safe patient environment ➢ Educate patient/resident +/circle of care/caregivers ➢ Assess cognitive status ➢ Protect from self-harm ➢ Dietary consult if indicated ➢ Promote and monitor nutrition & fluid intake ➢ Extra caution with extremes of body mass index (<20 excessively thin or >30 kg/m2 bariatric) ➢ Review polypharmacy for medication reduction/optimization
Mobility	➢ Encourage active involvement if physical function not impaired ➢ Appropriate selection and use of assistive devices	➢ Ensure safe patient handling techniques/equipment and environment (trauma, ADLs, self-injury) ➢ Proper transferring/repositioning ➢ Implement fall prevention program ➢ Remove clutter in environment ➢ Ensure proper lighting ➢ Pad equipment/furniture (bed rails, wheelchair, etc) ➢ Protective clothing – long sleeves/pants, knee high socks, gloves &/or shin/elbow pads ➢ Keep fingernails and toenails cut short and filed ➢ Assess footwear

Skin	➢ Awareness of medication-induced skin fragility (eg, topical and systemic steroids) ➢ Wear protective clothing (shin guards, long sleeves, etc) ➢ Moisturize skin (lubrication and hydration) ➢ Keep fingernails short	➢ Daily skin assessment and monitor for skin tears ➢ Individualize skin hygiene (warm, tepid, not hot water; soapless or pH-neutral cleaners; moisturize skin) ➢ Moisturize skin after bathing while the skin still damp, not wet ➢ Avoid strong adhesives, dressings, tapes (See dressing recommendations) ➢ Avoid sharp fingernails/jewelry with patient contact
Healthcare Setting ➢ Implement a comprehensive skin tear reduction program ➢ Include skin tears in audit programs ➢ Utilize validated classification system (Table 2) ➢ Develop consultative team (wound care/dietary specialists, rehab/pharmacists)		

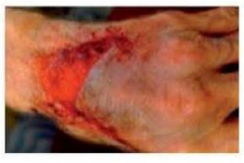
3. Strategies when Skin Tear is Present





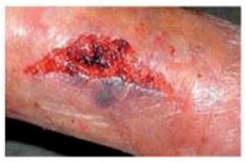
Type 1: No skin loss

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



Type 2: Partial flap loss

Flap cannot be repositioned to cover the wound



Type 3: Total flap loss

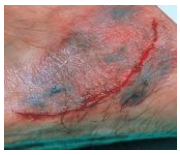
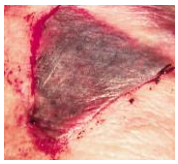
Entire wound bed is exposed

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 2013

- Cleanse the skin tear using non-cytotoxic agents such as normal saline. This can be done by irrigating using a 30ml syringe/18 gauge IV catheter or single use saline bottle (Derma Science) to provide safe pressure of less than 12 psi for granulating tissue but effective to decrease surface slough and debris in the wound. Pat the periwound dry; do not dry the wound bed in order to prevent debris from entering the wound.
- Do not suture or staple due to the fragility of the skin.
- Control bleeding.
- Approximate the skin tear flap/ tissue, if present as closely as possible.
- Best Practice Recommendations for the Prevention and Treatment of Skin Tears indicate that "research supporting the use of adhesive strips is dated, and, while no current research is available to support a change in practice, expert opinion suggests that adhesive strips are not the current treatment option of choice for these wounds." It is suggested that applying wound closure strip will only create more trauma in the end for the individual with the skin tear.

Table 2: CATEGORIZATION OF SKIN TEARS & DRESSING SELECTION SPECIFIC TO SKIN TEARS

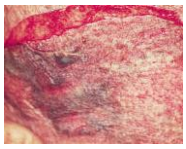
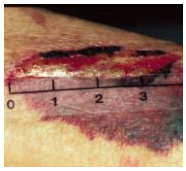
<table>
<tr><th colspan="2">ISTAP</th><th>Skin Tear Care Considerations</th></tr>
<tr><td colspan="3">Do not suture, staple or use wound closure strips due to the fragility of the skin. The use of hydrocolloids or traditional transparent film dressings is not recommended as they may cause skin stripping if not removed properly.</td></tr>
<tr><td>CATEGORY</td><td>CLASSIFICATION</td><td>DRESSING SELECTION</td></tr>
<tr><td>Type 1:

Skin Tears without Tissue Loss</td><td>Linear Type
 
Flap Type
  </td><td>Based on Assessment:

Approximate edges. Cover with silicone or low-tack foam dressing. Use alginate under foam if skin tear is bleeding.*

Or

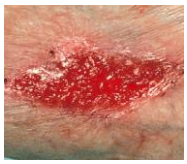
Approximate edges. Control bleeding. Cover with absorbent clear acrylic dressing. Do not remove for 21-28 days. Reassess if signs of infection.**</td></tr>
<tr><td>Type 2:

Skin Tears with Partial Flap Loss</td><td> 
  </td><td>Based on Assessment:

Approximate edges. Cover with silicone or low-tack foam dressing. Use alginate under foam if skin tear is bleeding.*

Or

Approximate edges. Control bleeding. Cover with absorbent clear acrylic dressing. Do not remove for 21-28 days. Reassess if signs of infection.**</td></tr>
</table>

Type 3: Skin Tears with Total Flap Loss		Based on Assessment: Approximate edges. Cover with silicone or low-tack foam dressing. Use alginate under foam if skin tear is bleeding.* *This type of dressing can be left in place for 7 days. Or Approximate edges. Control bleeding. Cover with absorbent clear acrylic dressing. Do not remove for 21-28 days. Reassess if signs of infection.** **Apply acrylic style of dressing once bleeding or amount of exudate decreases as acrylic style dressing do not absorb well. This type of dressing can be left in place for 21- 28 days.

- **Silicone dressing** - Adaptic Touch
- **Low Tack foam** - Allevyn Life
- **Alginate dressing** - Algisite M
- **Clear acrylic dressing** - Tegaderm Absorbent Clear

4. Discharge\Transfer of Care Arrangements
   Provide the following information for clients moving between care settings:
   - Risk factors identified;
   - Details of pressure points and skin condition prior to discharge;
   - Current plan to minimize pressure, friction and shear:
     - Type of bed/mattress
     - Type of seating
     - Current transfer techniques used by the client (bed-chair-commode);
   - History of skin tears, previous treatment, products used and products not effective. This should include:
     - Category, site and size of skin tears
     - Type of dressing currently used and frequency of dressing change
     - Allergies and adverse reactions to wound care products
     - Summary of relevant laboratory results
     - Client and family response/adherence to prevention and treatment plan
     - Requirements for pain management
     - Details of skin tears that are closed; and
     - Need for on-going interprofessional support.
5. Education
   Education will be provided to the multidisciplinary team including clients, family or caregivers as appropriate. It will be updated on a regular basis to incorporate new evidence and technologies.
   This education will include:

   - Etiology and risk factors predisposing to skin tear development,
   - Use of risk assessment tools like the ISTAP risk reduction program,
   - Skin assessment,
   - Categorization skin tears, (table 2)
   - Selection and/or use of skin tear dressings,
   - Development and implementation of an individualized skin care program,
   - Demonstration of positioning/transferring techniques to decrease risk of tissue breakdown,

- Instruction on accurate documentation of pertinent data,
- Roles and responsibilities of team members in relation to skin tear risk assessment and prevention,
- Client/family education and/or client/family involvement in plan of care,
- Ongoing evaluation of education.

SUPPORTING DOCUMENTS:

Integrated Progress Notes (IPN)

Nursing Care Plan/Kardex

CLI.4110.SG.013.FORM.01 Wound Assessment and Treatment Form

REFERENCES:

Barbara Braden (2001). Protocols by level of risk.

Central Region Health Authority (2010). Regional wound care recommendations; derived from Winnipeg Regional Health Authority (2008) WRHA Wound Care Recommendations.

European Pressure Ulcer Advisory Panel & National Pressure Ulcer Advisory Panel (2009), Pressure Ulcer prevention: quick reference guide.

Health Sciences Centre (2005). Pressure ulcers: prevention and treatment, practice guideline.

Leblanc K , Baranoski S, Christensen, Langemo D, Sammon M, Edwards K., Holloway S, Gloeckner M, Williams A, Sibbald G, Regan M, (2013). International Skin Tear Advisory Panel: A Tool Kit to Aid in the Prevention, Assessment, and Treatment of Skin Tears Using a Simplified Classification system.