F. PRINCIPLES OF TREATMENT BASED ON ETIOLOGY (TREAT THE CAUSE)

F.4 SKIN TEARS

BACKGROUND AND EXTENT OF ETIOLOGY; INSTRUCTIONS FOR USE OF OTHER SECTIONS

4.1 Introduction: A skin tear is defined as a traumatic injury caused by friction, or a combination of shear and friction forces strong enough to separate the epidermis from the dermis (partial thickness wound) or separate both the epidermis and the dermis from underlying structures (full thickness wound). Many are preventable with adequate skin hydration and protective devices.

The resources in this section will help the health care provider:

- to identify the risk factors and individuals
- to document and classify the skin tear according to the degree of trauma
- to provide safe environment for individuals at high risk
- to maintain nutrition and hydration

4.2 Algorithm

This algorithm is based on the Wound Bed Preparation Algorithm but incorporates specific client-centered care considerations, is from the LeBlanc et al. 2008 article, and is used with permission.

4.3 Skin Tears Classification & Risk Assessment Tool

Skin Tear Classification

Instructions for use:

Page 1: Classify skin tears according to degree of trauma using the Payne-Martin Classification for Skin Tears:

<table>
<thead>
<tr>
<th>Category and Description</th>
<th>Photograph</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong> – Skin tears without tissue loss: Linear (full thickness or flap partial thickness). Photograph courtesy of Kim LeBlanc, Dawn Christensen and Wound Care Canada. Used with permission.</td>
<td><img src="image1.jpg" alt="Photograph" /></td>
</tr>
</tbody>
</table>

Flap type (partial thickness): epidermis and dermis are separated. Flap can be completely approximated or approximated to expose no more than 1mm of the dermis. Photograph courtesy of Kim LeBlanc, Dawn Christensen and Wound Care Canada. Used with permission. | ![Photograph](image2.jpg) |
**Category 2** – Skin tears with partial tissue loss (scant tissue loss type or moderate to large loss)

“Scant Category II skin tear” - 25% or less of the epidermal flap is lost.
Photograph courtesy of Kim LeBlanc, Dawn Christensen and Wound Care Canada. Used with permission.

**Category 3** – Skin tears with complete tissue loss (absent epidermal flap)

“Moderate Category II skin tear” - more than 25% is lost.
Photograph courtesy of Kim LeBlanc, Dawn Christensen and Wound Care Canada. Used with permission.

**Risk Assessment**

These tools can be used to assess individuals who have developed skin tears or for those who have fragile skin and are at suspected risk. The risk assessment portion will help to document those risks and to formulate a plan of care to prevent occurrence/recurrent of skin tears. Obtain a patients history that includes general health status and identifies risk factors that may put the patient at risk for skin tears and factors that may affect the healing of existing skin tears. Identify persons at high risk for skin tears.

Scoring: automatic placement in risk reduction program requires the following

- 1 item is Group I
- 4 items in Group II
- 5 or more items in Group III
- 3 items in Group II and 3 items in Group III
Page 2: Care Plan Tool
Support the prevention of skin tears through skin hygiene and hydration, responsible bathing, good nutrition, appropriate clothing, the removal of environmental risk factors and correct turning, positioning and transferring. This does NOT outline the clinical interventions for wound care of an actual skin tear. Please see section 4.5 for options.

4.4 Client/Patient Teaching and Learning Resources
This explains some of the reasons that aging skin becomes vulnerable to skin tears, and outlines steps to avoid trauma and improve skin integrity. It is meant for individuals who are at risk, and their families and care providers.

4.5 Evidence-Based Clinical Interventions (From SWCCAC Wound Management Program March 2011):

Determine client’s goals:

☐ Healing Service Plan
  • Stabilize skin flap if still present
  • Choose dressing that will not cause further skin damage
  • Teach prevention methods to decrease risk of recurrence

☐ Maintenance Service Plan
  • Prevent deterioration
  • Teach prevention methods to decrease risk of recurrence

Wound Assessment:
  • Use a validated and reliable wound assessment tool and categorize the severity of the skin tear (see above)

Other:
  • Human tetanus immunoglobulin (TIG) should be given to all individuals with skin tears who have not received a tetanus toxoide (Td) inoculation in the past 10 years. The TIG should be given before wound debridement because exotoxin may be released (LeBlanc et al 2008)

Wound Bed Prep:
  • Debridement of non-viable skin only after TIG (above), skin flaps should be preserved and approximated to allow autograft if possible.

CAWC Best Practice Recommendations Choice of Dressings:
  • Absorbent, clear acrylic semi-permeable dressings are recommended for Category I to III skin tears with low to moderate exudate. These are meant to be left in place for up to 21 days, and should not be changed unless exudate is leaking beyond the edge.
  • For Category I and II skin tears with less than 25 per cent epidermal flap loss a physician or nurse practitioner may choose to approximate of the edges of the skin tear/flap tissue with 2-octylcyanoacrylate topical bandage (skin glue).
  • Other dressing choices include silicone-based mesh or foam products, clear meshed contact layer (non-petrolatum), calcium alginate dressings if bleeding is present or other foam dressing with a contact layer that would prevent sticking.
• Zinc-impregnated gauze (normally used for Unna’s boot) can be fan-folded to 6-8 thicknesses and placed over the area- cover with secondary dressing and change q 3-5 days (commonly used with good effect but no literature found to support this).
• The use of hydrocolloids or transparent film dressings is NOT recommended as they may cause skin stripping or lifting of the skin flap if not removed properly, and paraffin gauze (tulle gauze) based products are no longer recommended - they can cause disruption of the skin flap, are not moisture-retentive and require frequent dressing changes.

There is also a new protocol for a product currently in the SWCCAC Medical supply catalogue a combination hydrofiber/ semi-occlusive dressing (Codes 1604 and 1606): Choose & apply appropriate shape and size of non-adhesive product to be anchored with Kling wrap. If there is a skin flap under the dressing, use a waterproof marker to draw an arrow on the dressing, pointing away from the attached end of the skin flap. This indicates in which direction the dressing should be removed. A removal date can also be written.

Dressing to remain in place for 5 days, depending on client’s condition. Assess wound & re-apply 2nd dressing (Codes 1604 and 1606). Leave undisturbed for an additional 5 days depending on client’s condition. Re-epithelialization should be complete within 14-21 days (Convatec Canada Protocol for Versiva XC).

4.6 Resources

References
