

Best Practice Recommendations For Skin Health and Wound Management 2025

CHAPTER 6



Prevention and Management of Skin Tears

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INTRODUCTION

This best practice recommendation chapter is intended to aid teams in their ability to identify risk for, and differentiate, the types of skin tears and to become familiar with strategies to prevent and manage skin tears. As well, it is intended to guide researchers in planning future projects.

What are Skin Tears?

The International Skin Tear Advisory Panel (ISTAP) defines a skin tear as, “a traumatic wound caused by mechanical forces, including removal of adhesives.”¹ Severity may vary by depth (not extending through the subcutaneous layer).¹ “A skin tear can be partial-thickness (separation of the epidermis from the dermis) or full-thickness (separation of both the epidermis and dermis from underlying structures).”² Skin tears have been reported to occur in the extremes of age (neonates and the elderly), as well as critically and chronically ill persons.^{2,3} Skin tears can be found on all areas of the body but are particularly common on the extremities, such as the upper and lower limbs⁴ or the dorsal aspects of the hands.⁵ While some skin tears are unavoidable, most are preventable.¹

Impact of Skin Tears

Individuals with hard-to-heal or stalled skin tears are vulnerable to prolonged pain, emotional distress, embarrassment, infection and decreased quality of life.^{1,5} Qualitative studies to examine the patient experiences and human burden from the impact of skin tears on physical, psychological and social functioning are recommended. Skin tears can result in extensive health-care costs related to material and labour, increased workload and increased length of stay in health-care facilities.^{1,6}

For adults, skin is at greater risk of skin tears as ageing occurs. When comparing normal outer epidermis and aged outer epidermis one can identify multiple factors that affect promotion of skin health and prevention of skin tears. ISTAP identifies the following changes in ageing skin:

- “Thinning of the epidermis and flattening of the epidermal junction
- Loss of collagen, elastin and glycosaminoglycans
- Atrophy and contraction of the dermis (causing appearance of wrinkles and folds)
- Decreased activity of sweat glands and sebaceous glands, causing the skin to dry out
- Thinning of blood vessel walls and a reduction of blood supply to the extremities
- Increased dermal LEP (low-echogenic pixels), including solar elastosis, may represent a risk factor for skin tears; this indicates that skin tear risk factors might not only represent chronological ageing but also photoageing.”¹

ISTAP discusses changes experienced by patients’ skin integrity, from infant to fully developed adult skin and aging skin.¹ Multiple factors contribute to increased risk of skin tears. Although skin tears may occur in all populations, the highest risk of skin tears is common in older adults with particularly fragile and aged skin.⁷

Prevalence of Skin Tears

Skin tears are found in various clinical settings and are highly prevalent yet preventable.⁷⁻⁹ Skin tears have a wide prevalence range that varies in care settings. The prevalence of skin tears has been reported to be 4.1-12.2% in hospital;^{7,10,11} 10.5%-20-8% in long-term care centres;^{12,13} 14.5% in intensive care units¹⁴ and 6.5% in patients living with cancer.¹⁵

It is important for clinicians to recognize that skin tears are adverse and reportable events that require reporting through patient safety systems.¹⁶ Consistent documentation is required to aid in tracking and monitoring the prevalence of these wounds. Skin tears are frequently compared to pressure injuries in the literature because:

- they are both found in the frail elderly and the very young, as well as in those who are critically or chronically ill¹⁷ and
- pressure injury burdens have long been used to benchmark quality of care, a function that could be applied to skin tears as well.¹⁸⁻²⁰

Despite their impact, skin tears are often unrecognized and under-reported in clinical practice, resulting in suboptimal prevention and delayed or inappropriate treatment.²¹ The paucity of published studies and the lack of standardized assessment makes the benchmarking of skin tears difficult. This is especially important for care of patients with dark skin tones.²² Skin tears are generally more common among the long-term care (LTC) population, with prevalence

rates ranging from 10 to 54% across different countries.^{20,23–27} The high prevalence of skin tears highlights the need for standardized tools to assess risk and prevent skin tears and to educate clinicians on classifying and treating skin tears effectively.²⁸

In recent years, researchers have begun to monitor the prevalence and incidence of skin tears and have established a common definition and universally acceptable classification system to identify risk factors and examine prevention strategies. While health-care professionals and care partners should place a primary focus on risk assessment and implementation of prevention strategies to limit the prevalence of skin tears, they must also be equipped to manage these wounds when they do occur.

Best practice includes early and accurate identification, classification, documentation and the application of an evidence-based treatment protocol.^{21,29} By recognizing which patients are at risk for skin tears, preventing skin injuries and using the appropriate skin tear treatment protocols, health-care professionals can ensure that patient outcomes are improved, unnecessary pain is avoided, system efficiencies are enhanced and costs are reduced.²⁰ A systematic review highlights the connection between skin care bundles and the reduction of the number of skin tears.³⁰ Current treatment of skin tears may vary based on available—but not always appropriate—options. In fact, skin tears are often left untreated without any dressing.²⁶ There continues to be a need for increased awareness and common terminology. The current version of the World Health Organization’s International Classification of Diseases does not include separate coding for skin tears.³¹ There is a suggestion that this current lack of coding contributes to skin tears being perceived as insignificant injuries⁸ and that separate coding is needed.¹

The interprofessional team of authors of this chapter engaged in synchronous and asynchronous collaboration using a variety of online tools. This collaborative process fostered rich discussion of the literature and its applicability to practice at the bedside. The depth of these discussions is reflected throughout this paper. This document is written with the intent to encompass the quintuple aim for health-care improvement. This is to enhance the patient experience, reduce costs, improve population health, improve the clinician experience and enhance equity. This equity piece is particularly important for patients living with skin issues, wounds and, specifically, skin tears (See Table 1). Ensuring all patients receive care, supplies and ongoing preventative strategies needs to be recognized and communicated to policy makers.³²

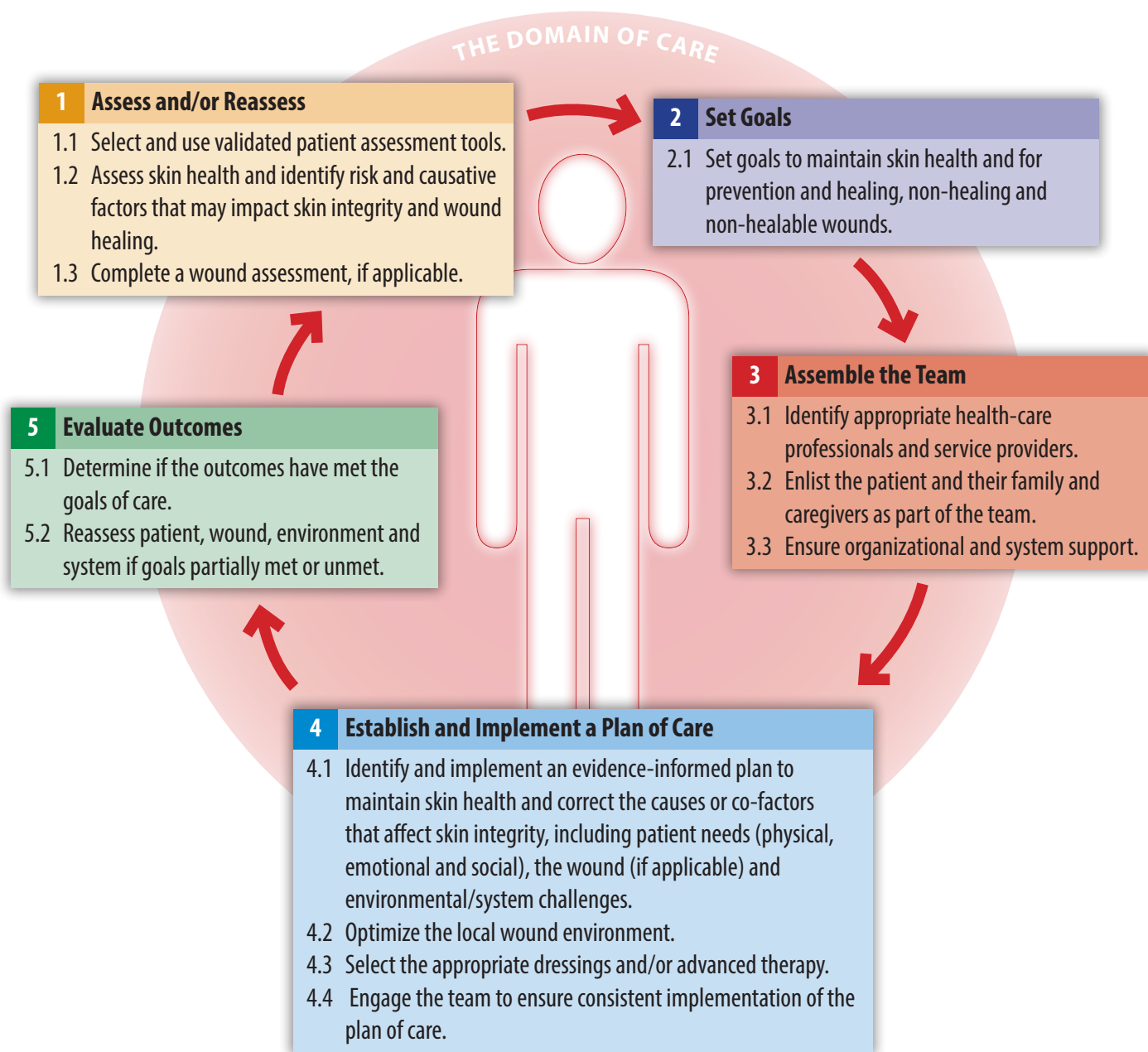
Table 1: Quintuple Aim and Management of Skin Tears

5 Components	Applied to Skin Tears
Improving population health	Through prevention, education and self-management strategies
Reducing costs	Application of best practice to ensure most effective treatment and appropriate use of resources – examples: risk screening, skin tear prevention, lotions, dressings
Advancing health equity	Application of principles to all those at risk for, and affected by, skin tears
Care team well-being	Providing clinically usable information for front line clinicians
Enhancing the patient experience	Providing a supportive process of care for all those with a skin tear

THE WOUND PREVENTION AND MANAGEMENT CYCLE

This chapter offers a practical, easy-to-follow guide that incorporates the best available evidence. It outlines a process, or series of consecutive steps, that supports patient-centred care using the Wound Prevention and Management Cycle (See Figure 1), which guides the clinician through a logical and systematic method for developing a customized plan for the prevention and management of wounds, from the initial assessment to a sustainable plan targeting self-management for the patient.

Figure 1: Wound Prevention and Management Cycle



The recommendations in this chapter are based on the best available evidence and are intended to support the clinician, the patient, care partners, their family and the health-care team in planning and delivering the best clinical practice. Two foundational chapters supplement this chapter with additional evidence-informed information and recommendations that are general to all wound types: Chapter 3: Skin: Anatomy, Physiology and Wound Healing,³³ and Chapter 4: Best Practice Recommendations for the Prevention and Management of Wounds An Overview.³⁴

There are three guiding principles within the best practice recommendation papers (BPRs) that support effective prevention and management of skin breakdown:

1. the use of the Wound Prevention and Management Cycle, regardless of the specifics, to prevent and manage skin breakdown,
2. the constant, accurate and multidirectional flow of meaningful information within the team and across all care settings, and
3. the patient as the core of all decision making.

Step 1: Assess and/or reassess

Recommendations

1.1 Select and use validated patient screening and risk assessment tools

Discussion: Health-care professionals have developed and validated risk assessment tools for various wound types but, unfortunately, a validated risk assessment tool for skin tears does not yet exist. This lack of a tool complicates identifying who is most at risk and why. Few studies address skin tear risk factors in general, and the majority of the skin tear prevention literature is based on expert opinion only.²⁰

The International Skin Tear Advisory Panel (ISTAP) conducted a review of skin tear risk factors and expanded on search criteria.³⁵ Using a Delphi process, the panel subsequently developed a risk assessment pathway. The ISTAP risk assessment pathway is composed of three categories:

1. General health (chronic and critical disease, polypharmacy, cognitive, sensory, visual and auditory impairment and nutritional status),
2. Mobility (history of falls, impaired mobility, dependence for activities of daily living [ADLs] and mechanical trauma) and
3. Skin (extremes of age – neonates, children, older adults – fragile skin and previous skin tears).^{36–38}

The pathway aids in identifying both modifiable and non-modifiable risk factors and predicts an increased risk among those with deficits in any of the categories.^{1,21}

In addition to the risk factors identified by ISTAP, new evidence suggests that aggressive behaviour³⁵ and an increased risk of pressure injuries^{26,39} may also be relevant to skin tear risk. Given these more recent findings, additional studies are required to include these factors in the ISTAP risk assessment pathway and to test its validity and predictive ability.³⁹ It is recognized that the ISTAP risk assessment tool is limited in that it focuses primarily on elderly populations and does not address the chronically ill or pediatric populations.⁴⁰ More research is needed to focus on persons living with dementia.⁴¹ See ISTAP risk assessment pathway for more details.¹

1.2 Identify risk and causative factors that may impact skin integrity and wound healing

1.2.1 Patient: Physical, emotional and lifestyle

Discussion: Skin tears can occur anywhere on the body so prevention strategies and screening should include the entire body.⁹

An early, complete and holistic assessment of patients should be performed and documented, including baseline information pertaining to their knowledge, beliefs, health status and perceived learning needs, to address the risk factors as identified below (See Table 2).^{1,35} Cultural and psychological variables must also be considered.^{1,2,36,42}

This is important as skin tear causes are poorly documented.^{20,43} Documentation may be improved by using electronic incident records at the bedside, on admission or first visit and whenever the patient's health status changes.⁴² Document the patient's baseline skin tone. The Skin Tone Tool helps clinicians identify the patient's baseline skin tone by assessing the patient's inner arm.⁴⁴ Skin changes associated with ageing, such as ecchymosis and senile purpura, are risk factors for skin tear development.¹² In patients with dark skin tones, identification of these factors is challenging. It is important that clinicians assess for other indicators of injury in patients with dark skin tones by using both visual and tactile cues (e.g., purple/blue/grey discolouration and change in temperature). Use of the senses, especially touch and hearing (listening to the patient story), is valuable in the assessment regardless of the tone of their skin. Ask the patient about their skin and listen to their perspectives about what they consider to be an issue (e.g, tightness, changes

in feeling/sensation and pain, discomfort or numbness over the affected area).²² Ongoing daily inspection, documentation and communication of assessment and preventative education with the team should be performed to identify any changes in health status or skin.^{1,45}

Table 2: Skin Tear Risk Factors

Skin Tear Risk	Causative Factors
Altered sensory, auditory and visual status	Decreased sensory, auditory and visual status that often occurs as an individual ages
Cognitive impairment	An increased risk of skin tear development including: <ul style="list-style-type: none"> • Displaying reactive and or aggressive behaviour • Being cognitively impaired • Having dementia, altered cognition or delirium
Nutritional concerns	Inadequate nutrition and hydration may affect tissue viability ^{46,47} and increase the risk of falls, leading to injury thereby increasing the risk of skin tears Side effects and causes of dehydration including vomiting, diarrhea, impaired kidney function, diuretic use, or input problems, such as not drinking enough water or fluids ^{5,48}
Polypharmacy	Polypharmacy has been indicated to be an independent risk factor for falls; individuals receiving four or more medications are at a greater risk for falls ⁴⁹ Increased risk for falls coupled with the increased risk of confusion reported with persistent polypharmacy in the elderly population ⁵⁰ links polypharmacy to a potentially heightened skin tear risk The chronic use of topical and systemic corticosteroids has been linked to skin tear development. ¹⁶ Corticosteroids are known to regulate the expression of genes encoding collagens, elastin, matrix metalloproteinases (MMPs) and tissue inhibitors of MMPs, among others Medications that may affect skin integrity include: ^{5,51–53} <ul style="list-style-type: none"> • anti-bacterial agents • anti-hypertensives • analgesics • tricyclic antidepressants • antihistamines • antineoplastic agents • neuroleptics • diuretics • hypoglycemic agents • nonsteroidal anti-inflammatory agents • oral contraceptives • steroids • anti-coagulants
Mobility	Factors that increase risk of skin tear development include. ^{54,55} <ul style="list-style-type: none"> • Having an altered level of mobility • Being unable to reposition independently • Having spasticity

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<p>Assistance with activities of daily living (ADLs)</p>	<p>Skin tears are frequently linked to:</p> <ul style="list-style-type: none"> • wheelchair injuries • transfers • blunt trauma from bumping into objects^{2,56} and/or impaired activity • use of assistive devices • dependence on others for care and activities of daily living • lower levels of functional ability
<p>History or risk of falls</p> <p>(See Appendix for additional falls resources)</p>	<p>Falls and associated blunt trauma have been linked to heightened skin tear risk^{2,58,59,60,61}</p> <p>Predisposing factors for falls include:</p> <p>Environmental issues</p> <ul style="list-style-type: none"> • Limited or no lighting • Sun exposure • Loose throw rugs, torn carpeting, or flooring materials, stairs • Slippery tubs and showers • Poorly fitted shoes, slippers, boots • Floor clutter (electrical cords, oxygen tubing) • Beds, chairs, or toilets without handrails/grips • Broken medical equipment <p>General Health</p> <ul style="list-style-type: none"> • Depression and mental health issues • Changes to vision • Unsteady gait, strength and balance (multiple causes) • Chronic diseases, including, kidney disease, heart disease, diabetes mellitus, stroke, chronic obstructive lung disease (COPD) • Urinary / fecal (both) urgency • Pain (anticipatory, procedural) • Cardiovascular changes – stroke, orthostatic hypotension • Lower leg edema (dressings, devices) • Parkinson’s disease (posture, gait) • Osteoporosis, arthritis / Rheumatoid arthritis • Ménière’s disease (balance) • Neurological disorders: epilepsy, brain disorders, seizure activity • Nutrition: dehydration, malnutrition (low vitamin D levels) • Thyroid problems⁶²
<p>Mechanical trauma (not related to mobility aids)</p>	<p>Medical adhesives are common contributors to skin tear development in all at-risk groups. Skin tears that result from adhesives occur when adhesive attachment is stronger than the skin’s tensile strength or when the product is removed. A Medical Adhesive Related Skin Injury (MARSII) is suspected where erythema or other form of skin injury persists for longer than half an hour after skin removal of an adhesive⁶³</p> <p>Handling premature neonates may result in skin breakdown due to the extreme fragility of their skin. Close monitoring of premature neonates requires the use of medical devices that must be frequently removed. Removal of any layers of the neonatal stratum corneum during the process of adhesive removal can further reduce the skin’s barrier function, which significantly compromises fluid balance and homeostasis and increases skin permeability; these disruptions can lead to toxicity and irritation from topically applied substances as well as an increased risk of infection⁶⁴</p>

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Skin, age and critical illness	<p>The underlying mechanism of injury differs between younger and older individuals. The longevity of skin collagen and elastin and the cumulative effects of ageing and UV radiation have shown to progressively degrade the physical architecture of the skin, which alters the biomechanical behaviour and gross clinical appearance of skin with an associated increase in the risk for skin tears^{53,65}</p> <p>Age-related skin conditions are increasingly prevalent. Ageing is associated with anatomical and physiological skin changes, such as flattening of the dermo-epidermal junction, loss of cutaneous collagen, drying and reduction in subcutaneous tissue, rendering the skin more fragile and less elastic³⁶</p> <p>Dermatoporosis (chronic skin frailty), insufficiency fragility syndrome^{66,67}</p> <p>Presence of senile purpura (when small blood vessels leak under the skin) and elastosis (a degenerative change in the dermis layer with increased deposition of elastin material)^{48,68}</p> <p>Skin related risk factors include:</p> <ul style="list-style-type: none"> • Extremes of age (very young and very old) or critically ill • Presenting with skin exhibiting signs and symptoms of aging and/or sun damage • Darker skin tone²² • Having been identified with an increased pressure injury risk^{20,26,35} • Having presence of: <ul style="list-style-type: none"> · ecchymosis (bruises) · senile purpura (benign condition with recurring bruising) · hematoma (a bad bruise where blood pools under the skin) · stellate pseudoscar (Colomb, whitish, slightly depressed area, a condition of senile skin often on the back of hands and arms⁶⁹) · skin atrophy^{8,70} • Having any evidence of previously healed skin tears • Presenting with edema of the extremities • Chronically ill individuals (greater risk for skin breakdown in general and skin tears in particular)^{2,20,40}
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Table 3 outlines an overview of modifiable and non-modifiable factors to consider when promoting patient skin health and prevention of skin tears with the patient and care partners.

Table 3: Modifiable and Non-modifiable Risk Factors¹²⁰

Non-modifiable Risk Factors	<ul style="list-style-type: none"> • Skin changes associated with advanced age • Edema and ecchymosis • Spasticity • Hematoma • Impaired mobility, bedridden • Dependence on others for activities of daily living, such as dressing, feeding and transfers (e.g., operating room, care settings) • Previous skin tears • Increased pressure injury risk, history of falls • Sensory deficits, cognitive impairment, and aggressive behaviour
Modifiable Risk Factors	<ul style="list-style-type: none"> • Hydration (oral) • Protection of skin (e.g., cream and lotions) • Dressing choices: use of adhesives, tape • Assistive devices: orthoses/prostheses, wheelchairs, walkers • Tubes related to care (e.g., urinary, nutrition): type and positioning • Limited or poor nutritional intake • Polypharmacy

Considerations specific to the pediatric population

Discussion: In Canada, pediatrics includes neonates, infants, children, adolescents and young adults.⁷¹ Skin tears occur in greatest numbers in the pediatric population. Unfortunately, limited literature addresses skin tear risk factors in these populations.⁷² Premature neonates are known to have minimal stratum corneum and attenuated rete ridges, giving their skin a red, wrinkled, translucent and gelatinous appearance. They also have less subcutaneous tissue than other populations, meaning that the dermis lies directly over muscle. With less subcutaneous tissue, pediatric patients are at a much higher risk of skin tears caused by medical adhesive removal.⁷²

Researchers have demonstrated that functional maturity of skin is not completed until the second year of life, when increased collagen is found in the tissues. Skin immaturity is considered a risk factor for skin tears in the very young.⁷³ Baharestani reports that all children are at heightened risk of skin tears until the age of three, when the stratum corneum is fully matured, and that all children with acute and chronic illnesses, like their adult counterparts, are at heightened risk for skin tear development.⁷²

Newborns have significantly fewer layers of stratum corneum, fewer collagen and elastic fibres, increased transepidermal water loss (TEWL) and less cohesion between the epidermis and dermis.^{74,75} Because neonatal skin is not fully mature, it is more sensitive and less resistant to mechanical stress, such as friction and shear forces,²⁹ especially for pre-term neonates and children under the age of three.⁷²

Pre-term and newborn infants are particularly susceptible to skin tears. In fact, neonates have under-developed skin, and their decreased epidermal-to-dermal cohesion, deficient stratum corneum, impaired thermoregulation, body surface/weight ratio that is nearly five times greater than an adult and immature immune system place them at an increased risk for skin tears.^{5,72} As well, characteristics of neonatal/infant skin may affect the skin's ability to resist shear, friction and/or blunt force.²

However, while rates are higher in older patients, skin tears affect many different patient groups and are not limited to older patients. Further research around skin tears in neonates and children is required.^{1,53}

1.2.2 Environmental: Socio-economic, care setting, potential for self-management

Discussion: Health-care professionals must have knowledge about the environmental factors that can impact a persons' skin integrity. These factors include socio-economic status, health-care setting and ability to self-manage skin care.⁷⁶ Socio-economic and environmental factors not only affect patients' access to prevention, wound-healing products and technology, but also their ability to adhere to a recommended prevention or wound management protocol. Regional differences in access to supplies, equipment and care may also affect the individual's self-management potential. Even within similar regions, access to supplies, equipment and care may fluctuate depending on the type of environment in which the care is being delivered.

For example, skin tear prevention for a pediatric patient in a critical/intensive care unit may be different from that of an ill child in the home setting, and skin tear prevention for an older person living independently in their home may be different from that of an individual with dementia living in a long-term care facility, yet the underlying preventative, assessment and treatment principles must be adhered to.

With the current trend of individuals with cognitive changes and other co-morbidities remaining longer in a home setting, self-management and prevention will present challenges and more resources will be required to prevent skin tears from occurring. As discussed above, resources such as skin tear checklists and falls prevention programs will be required to enable individuals to safely reside in their homes.

Environments should be assessed to identify factors such as sharp-edged objects like coffee tables, dishwasher doors and loose rugs that may lead to injury and put patients at risk for a skin tear. There may also be ethnic or cultural biases toward or against certain wound care products or practices.⁷⁷⁻⁷⁹ As well, there are inconsistent findings between studies in Japan and those in Western countries, suggesting that different conditions such as ethnicity, environment and medical situation affect skin tear likelihood.⁸⁰

1.2.3 Systems: Health-care support and communication

Discussion: Organizations and health-care professionals are concerned with the prevalence of skin tears and their ultimate burden on the health-care system. To improve care, screening and assessment are required to understand current skin tear prevention practices at a population, health-care professional and organizational level. This assessment is challenging due to the absence of existing skin tear evidence that might inform quality indicators.

Health-care professionals require regular and consistent education about skin tear risk assessment, prevention and treatment.⁸¹ A skin tear knowledge assessment instrument is supported by acceptable psychometric properties and can be applied in nursing education, research and practice to assess knowledge of health-care professionals about skin tears.²¹

Education on risk factors should be provided to patients, care partners and others within their circle of care.^{35,36}

Each health-care setting and agency needs to develop policies and protocols for health professionals to follow to ensure consistency in the assessment of risk and treatment of skin tears.⁴⁵

1.3 Complete a wound assessment, if applicable

Discussion: Wounds should be classified in a systematic and universally accepted manner.^{82,83} To accurately assess, document and treat skin tears, it is important that a common language be used to describe these challenging wounds. Proper documentation is vital to understanding the extent of the problem. Skin tears should not be grouped into pressure injury categories.⁸³

Prior to the initial assessment of the skin tear, the wound should be cleansed, removing all residual hematoma or debris, and the flap re-approximated (See section 4.1). Skin tears should be assessed and documented as per facility protocol. Refer to the ISTAP Skin Tear Classification system for skin tear classification.^{36,57}

Skin Tear Classification

Health-care professionals can more effectively communicate with other health-care professionals, policy makers, researchers, educators and patients/care partners by using common and appropriate descriptors for various types of wounds, including skin tears.⁸³

Step 2: Set goals

“A flap in skin tears is defined as a portion of the skin (epidermis/dermis) that is unintentionally separated (partially or fully) from its original place due to shear, friction, and/or blunt force. This concept is not to be confused with tissue that is intentionally detached from its place of origin for therapeutic use, e.g., surgical skin grafting.”²¹

Table 4: Examples of intact aging skin and skin tears

Descriptor	Examples of skin changes	
<p>Aging skin – intact</p> <p>Note: thinning of skin, sun damage</p>	 	  
	Aging skin, early senile purpura	Aging skin, thinning with sun damage
<i>Permission: Wounds Canada</i>		
<p>Type 1</p> <p>No skin loss. This may be linear or there may be a flap that the clinician can reposition over the wound bed</p>		
	Left forearm, linear type	
<i>Permission: Wounds Canada</i>		

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Type 1:
 Flap not approximated: not yet categorized



Same wound as above, now categorized as Type 1 Skin Tear Sutured (not recommended)



Type 1: Sutured

Permission: Marlene Varga

Type 2
 Partial skin loss, the flap is partially missing and when repositioned does not cover the wound bed



Multiple skin tears on lower leg
Top: Type 3 as no flap present
Bottom: Partial flap present and wound bed exposed

Permission: Rose Raizman NP
 (Scarborough Health Network)



Bruising, skin flap does not cover wound bed

Permission: Mölnlycke



Top: Wound bed dry, with a devitalized flap
Bottom: No flap present

Permission: Rose Raizman NP
 (Scarborough Health Network)



Ecchymosis with skin flap irregular and bruising

Permission: Mölnlycke

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Type 2
Skin Tear with Ecchymosis



Permission: Marlene Varga

Type 3
Full skin loss when the flap is missing and the wound bed is exposed

Skin Tear with clear dressing applied – demonstrates progressive healing



Permission: Wounds Canada

Recommendations

2.1 Set goals for healthy skin, prevention of trauma, management of healing, non-healing and non-healable wounds

Discussion: Even in the presence of skin tears, a primary goal is the promotion of healthy skin and prevention of future skin tears. Goals should be developed using the SMART principle. An example of a multi-part SMART goal may be: within two days the patient and family member will receive educational materials on skin tears, be able to discuss the importance of intact skin and begin to apply lotion to skin twice daily.

2.1.1 Identify goals based on skin health and prevention or healability of wounds

Discussion: It is a priority to promote skin health and prevent skin tears. Protecting intact skin should inform the setting of all goals. Preventative goals could include the implementation of a skin hygiene regimen, hydration of skin with appropriate lotion and promoting oral hydration. Wearing protective clothing, keeping mobile and identifying risk are essential.

If a wound occurs, it is critical that the healability of the skin tear be determined prior to identifying appropriate goals. To prevent situations of misunderstanding due to different assumptions about the healability of the skin tear and the goals of care, it is important that there be discussion, and optimally mutual agreement among health-care professionals, the patient and their family. This discussion allows the health-care team to provide wound care that is directed toward achieving goals that are appropriate for the individual with the wound. For more information, refer to: Chapter 3 Chapter 3: Skin: anatomy, physiology and wound healing³³ and Chapter 4: Best practice recommendations for the prevention and management of wounds: an overview.³⁴

Healing: The skin tear has sufficient vascular supply, underlying causes can be corrected and health can be optimized.

Non-healing: The skin tear has healing potential, but various factors are compromising wound healing at this time (e.g., skin tear on a lower limb with uncontrolled edema).

Non-healable: The skin tear has no ability to heal due to untreatable causes such as terminal disease or end-of-life status.⁸⁵ If the wound is deemed to be non-healable, goals should be set that reflect management strategies for activities that prevent infection and protect the fragile periwound and other skin to prevent further skin tears from occurring.

2.1.2 Identify quality-of-life and symptom-control goals

Discussion: An important aspect of goal setting includes the customization for each individual. Any plan of care should include the patient's goals of care and cultural considerations, e.g., promotion of healthy skin (nutrition, hydration, lotion use) prevention of future skin tears, pain management and wound healing. Goals should be congruent with the individual's needs, preferences and abilities, risk factors, co-morbidities, pain, quality-of-life issues, support systems and access to care.^{85,86}

Step 3: Assemble the Team

Recommendations

3.1 Identify appropriate health-care professionals and service providers

Discussion: Key team members should be identified and included in any promotion of skin health, skin tear prevention and management program. These team members should include (but are not limited to): individuals at risk and their families and interdisciplinary team members such as: nurses, physicians, pharmacists, registered dietitians, paramedics, physiotherapists, occupational therapists, personal support workers, social workers, psychologists, spiritual care providers, policy makers and other allied health professionals as appropriate.⁸⁷ All health-care providers involved in the care of the patient with skin tears must be willing and able to work together toward positive patient outcomes. This includes teams that focus on falls prevention, delirium watch and care of older adults (geriatric), as they may be key members in promoting skin health and prevention of skin tears.⁸⁸

To be effective team members, unregulated and lay care providers require education and training to prevent skin tears.^{89,90} It is essential that these important members of the integrated team^{34,91} have the knowledge and skills necessary to identify and address risk through hands-on interventions or timely alerts to other members of the team, particularly to reduce the risk of infection and wound complexity.

In addition, education for first-responders and paramedics in skin tears can support and optimize skin care. Hickey and Ayers state that prevention of emergency calls related to slips, trips and falls highlight the opportunity for first responders and paramedics to be educated to provide frontline assessment and management of skin tears.⁹² Education for these professionals can support their understanding of skin tears (for example) and prevent application of outdated practices such as skin closure strips.⁹³ In addition, Jansz and colleagues demonstrated that a first responder skin tear pack reduced overall costs and days with a wound over the study period.⁹⁴

Partnership between ambulance services and other disciplines have yielded successful economic, clinical and patient experience outcomes.⁹²

3.2 Enlist the patient and their family and caregivers as part of the team

Discussion: Current literature supports the promotion of skin health and prevention, assessment and management of skin tears to promote patient health, reduce numbers of skin tears and associated costs.¹ Patients, care partners and health professionals should be provided with health information regarding the promotion of skin health, risks, prevention and treatment of skin tears. In addition, they must be aware of the proper techniques for providing care without causing skin tears (See section 4.1). Information should include the points discussed in section 1.2.1.

Engagement, Communication and Building Trust

Consistent education relevant to the patient and family is essential for promoting healthy skin strategies and engaging the patient and family with safe self management.⁹¹ Wounds Canada, "encourages patients and families to utilize the skin and wound care resources available on its website to assist in their self-management activities."⁴⁴

Given that skin tears are found across the continuum of age and health-care settings and the associated risk factors have yet to be fully explored, engagement of individuals and family/caregivers is crucial to prevention initiatives. By engaging individuals and family/caregivers to participate in the prevention and appropriate treatment of these wounds, it is hoped that fewer skin tears will be found to transition into complex and costly wounds.²

Effective patient and family engagement requires a shift in the role of the health-care team from unidirectional care providers to collaborators. Interactive patient care has emerged as a care-delivery method that effectively engages and

supports patients to manage their health status and improve patient outcomes.⁹⁵ Engaging patients, care partners and families to engage actively in preventative strategies can support self-managed care, enhanced patient experience, improved health prevention and well-being, as well as lowered health-care costs.⁹⁵ Engagement is not ideal for all situations, however. In some instances patients and their families may choose to be disengaged from their care. Should this occur, health professionals must be prepared to adjust their strategies and reassess patient engagement levels on an ongoing basis to encourage individuals based on their desired level of involvement⁹¹ and interest in shared-decision making activities.⁹⁶

3.3 Ensure organizational and system support

Discussion: Organizations are frequently concerned with the burden of wounds on the health-care system. Individuals at risk are more concerned with quality-of-life issues (pain, physical disability, social, spiritual and mental health) and wound healing. This leads to potentially competing priorities among these groups, so close attention is required to identify any knowledge and awareness gaps and address them appropriately to ensure that implementation of skin tear prevention programs are successful.

Given the prevalence of skin tears and their potential to become complex wounds, skin tears should be included in prevalence and incidence studies and benchmarked in order to track their extent within a facility, agency or system.¹

To be successful in reducing the burden of skin tears, health professionals and organizations must be encouraged to conceptualize the outcomes of interventions in terms of the processes of care that have a direct impact on the outcomes. Reduction of skin tear prevalence is one important component to be addressed; however, as not all skin tears are preventable, health-care professionals and organizations should also strive to reduce the number of skin tears that transition to complex and chronic wounds. Outcome measures will dictate the success or failure of implementation strategies and, if success is not met, should be used to adjust the strategies.⁹⁷

A desired outcome for skin tear prevention and management programs includes ensuring health-care professionals, patients, care partners and families have the skills necessary to promote and maintain skin health and prevent skin tears, and to reduce the number of skin tears that transition to complex and chronic wounds.

Step 4: Establish and Implement a Plan of Care

Recommendations

4.1 Identify and implement a personalized, evidence-informed plan to correct the causes or co-factors that affect skin integrity, including patient needs (physical, emotional and social), the wound (if applicable) and environmental/system challenges

Discussion: ISTAP conducted a Delphi consensus study to establish skin tear prevention strategies. See ISTAP prevention strategies for a detailed plan of care.¹

Conducting a home safety assessment is a good starting point (Davis & Davis, 2023)*. These assessments are best conducted with the patient and their care partners and usually include occupational therapy and or physiotherapy. Researchers recommend several checklists to assess for physical safety including falls risks and safety of equipment and furniture. These are conducted with a specific focus on the patient and how they mobilize or function within their home setting.¹²¹

Assess for risk factors and prevention strategies following a systematic approach such as:

- Nutritional status (fluid and nutritional intake, swallowing)
 - Continence status – bladder, bowel status
 - Use of urinary devices (ostomy pouches, urinary catheters, briefs etc)
- Skin conditions (history of issues e.g., eczema, psoriasis, sunburn, pignementation)
 - Location of skin tear
- Cognitive status (e.g., delirium, dementia, depression, anxiety)
 - Vision, hearing, speech changes and adaptative devices)
- Neurological status (e.g., diseases)
 - Mobility and devices uses
 - Footwear (seasonal)

Skin Tear Prevention Strategies^{1,5,35,42,110,120}

Skin tear prevention strategies, for both patients and their care partners, as well as health-care providers and the systems in which they work, are generally categorized within three main risk categories within the risk assessment pathway: general health, skin health and mobility. ISTAP offers a comprehensive resource on the prevention and management of skin tears in aged skin. See: <https://woundsinternational.com/wp-content/uploads/2023/02/085aa82de6f9383340ed14a2d2eda3a1.pdf>.

General Health Strategies

General health strategies require attention to altered sensory, auditory and visual status of the patient. This includes being cognizant of the environment, participating actively in care and ensuring regular vision and hearing screening.

For partners and care providers, strategies should include ensuring a safe environment (perhaps with an occupational therapist or physiotherapist home assessment) and implementing a falls assessment and reduction program. Patient's footwear and sensation should also be assessed, particularly for patients with a history of diabetes and/or chronic diseases. It is also important to assess for clothing that could injure the patient's skin.

Neonates and children in intensive care units (ICUs) should have an occupational therapy consult for positioning, and education is needed on safe patient handling. Caregivers should be instructed on handling premature neonates with 'gentle' care. Information should be provided to patients and their circle of care regarding individual impairment, safety and the risk of skin tears.

In cases of noted or suspected cognitive impairment, the patient's partner and care providers should be counselled on appropriate strategies. These may include consulting an occupational therapist, physician, nurse practitioner, or geriatrician to assess cognitive status. This could include a confusion assessment if the patient is exhibiting signs of delirium. A pharmacist can review the patient's medications to add/increase or stop/decrease medications related to cognition, as well as address the potential for skin changes with certain medications.

Skin Health Strategies

Patient strategies to support skin health include participating actively in care, being cognizant of the environment, being aware of risks for skin tears and practising behaviour that will reduce the incidence of skin tears.

Care partners and health-care professionals need to be aware if the individual is at risk for skin tears and, importantly, how to reduce the risk. It is important to exercise caution when caring for patients with intravenous lines, nasogastric (NG) and other tubes or devices, with specific attention being applied when anchoring catheter tubes and nasal prongs.

Skin should be treated with hypoallergenic moisturizers after bathing, while the skin is still damp, not wet. Warm water – not hot – should be used for bathing. Soapless, no-rinse and/or pH-neutral skin cleansers should be used. See Wounds Canada Skin and Wound Clean-up: <https://www.woundscanada.ca/docman/public/health-care-professional/1307-product-picker-skin-and-wound-clean-ip/file>.

Patients at risk should be provided with education regarding the use of protective clothing, such as long-sleeved tops, long pants, knee-high socks and/or shin/elbow guard pads. Adhesive products should be avoided on frail skin. If dressings or tapes are required, non-traumatic paper/silicone tapes, non-adherent contact layers, non-adherent/silicone foam dressings or other topical dressings specifically formulated for fragile skin should be used. This will avoid skin stripping or tearing on removal. Silicone dressings are preferred when appropriate, however, silicone dressings may not provide enough adhesion to ensure that medical devices remain properly in place. For pediatrics, use thin hydrocolloids as a base when adhesives are needed, while leaving adhesives on site for at least 24 hours.

Avoid the use of patient identification armbands with sharp, hard edges, such as those made from metal or hard plastic. The patient's fingernails and toenails should be cut and maintained to a short length and rough edges filed to prevent self-inflicted skin tears. Similarly, staff and caregivers can keep their own fingernails cut short and avoid wearing rings or other jewelry that could damage the skin.

Mobility Health Strategies

Partners and providers can consider supporting mobility with a physiotherapy consult to learn about stability and ensure safe handling techniques and equipment safety. The use of repositioning slings and sliders for position changes, as well as transfer belts to avoid gripping arms during transitional movements, is recommended to avoid trauma to skin.

Daily skin assessment and monitoring and documentation for skin tears caused by mobility devices is vital. Health-care providers should be aware that extremes of weight require handling with extra care to prevent skin tears. Additional strategies include padding devices and hard objects within the environment. In general, an uncluttered environment should be encouraged. Involving Occupational Therapy in home assessments for persons living in their own home and in providing information to the patient and their caregivers on proper transferring and positioning techniques can have a positive impact.

Strategies to support fall prevention for patients include using assistive devices as prescribed by health-care professionals, working with caregivers to follow falls prevention programs and taking vitamin D and calcium supplements, if appropriate and as prescribed by a physician or nurse practitioner. Medications that increase the risk of falls should be used with caution,

Above all, it is essential that all health-care professionals and caregivers are provided with adequate education on the prevention and treatment of skin tears, and respect and communicate the need for 'gentle care', including to transport services, porters and similar institution or facility departments, such as radiology and dialysis.

4.2 Optimize the local wound environment

Discussion: When treating skin tears, the first step is to control bleeding, cleanse the wound and determine if the wound edges can be re-approximated. It is only then that the skin tear classification should be determined using the ISTAP Skin Tear Classification System.³⁵ See ISTAP prevention strategies for detailed plan of care.¹

The proceeding example demonstrates the steps needed to manage and reapproximate a skin tear. Figure 2 (below) demonstrates how to re-approximate a skin tear and label a dressing. While skin tears represent a specific type of wound, the same principles used to manage other wounds should be employed when treating skin tears.³⁵ Once the skin tear has been properly categorized, local conditions within the wound can be assessed. Bacteria and necrotic tissue must be removed and the appropriate dressing selected to maintain moisture balance.³⁴ Specific to those with and/or those at risk for skin tears, topical dressings should be selected that will not cause additional trauma to the wound bed and any remaining skin flap or cause further skin tear damage to the periwound skin.

If possible, it is best to allow the skin tear to heal without being disturbed; for example, through dressing removal. Therefore, supporting undisturbed wound healing through the use of dressings with an increased wear time should be considered.⁹⁸

Care providers should ideally have access to an appropriate dressing on their formulary and have the confidence to leave it on for an extended period (five days unless there are obvious complications, such as infection).^{1,41,93} Communication with the patient and/or family is key, and the rationale for undisturbed wound healing should be explained to ensure that the patient understands and is happy with their treatment.⁹⁹

4.2.1 Cleansing

Discussion: Uncomplicated skin tears (i.e., those without debris) can be gently cleansed with non-cytotoxic solutions such as clean/potable water, normal saline or nonionic surfactant cleansers at a low pressure of less than 8 psi to protect granulating tissue.³⁵ Congealed and dried blood should be removed gently from the flap.⁵⁷ When removing an existing dressing to evaluate the wound, it is important not to disrupt healing or damage the intact skin surrounding the wound. Special care should be taken to NOT cause further trauma to any remaining fragile skin tear flap (Type 1 or 2 skin tears) or the fragile periwound skin. Skin tears with necrotic debris may require wound debridement (See debridement section chapter 4), and a wound specialist should be consulted when necessary.⁵⁷ If the layer of skin is torn but still attached, the flap should be repositioned over the wound, covering as much of the original surface as possible. If the skin flap is viable, the area should be gently cleansed and the flap rolled back into place with a dampened cotton tip applicator, gloved finger or tweezers (See Figures 7 & 8).^{35,57} If the flap is difficult to align, the clinician should consider the applications of a moistened non-woven gauze compress to the area for five to 10 minutes to rehydrate the flap before repositioning. The

flap should not be disturbed for at least five days to allow for adherence to the cellular structures below.^{35,57} A viable flap may not cover the entire wound bed but should be positioned to cover as much area as possible.

Note: Be cautious cleansing the wound bed if the patient is taking anticoagulants. Calcium alginate dressings may be used to help with drainage.

4.2.2 Debriding

Discussion: Non-viable tissue provides a locus for infection, prolongs inflammatory response, inhibits wound contraction and delays wound healing.⁸⁷ It is important to note that prior to debridement an assessment of tissue perfusion and blood flow, especially on the lower leg or foot, is required.³⁵

Tetanus

Tetanus is an acute, often fatal disease caused by wound contamination with *Clostridium tetani*. Individuals with interruption of skin integrity by a non-surgical mechanism who have not received a tetanus toxoid (Td) inoculation in the past 10 years should be given human tetanus immunoglobulin (TIG) according to institutional policy. TIG neutralizes circulating tetanospasmin and toxin in the wound but not toxin that is already fixed in the nervous system. The TIG should be given before wound debridement because exotoxin may be released during wound manipulation.¹⁰⁰ For pediatric and critically ill populations, determine if TIG is appropriate.

4.2.3 Managing bacterial balance

Discussion: It is important to note that skin tears are acute wounds. Initially these wounds may display increased inflammation to the injured area as the result of the trauma. Prior to treating for infection, it is critical that health-care professionals distinguish between inflammation from trauma and inflammation from wound infection.¹⁰¹

All topical dressings selected for the management of infection must be compatible with fragile skin in order to prevent further trauma (See Section 4.3).³⁵

4.2.4 Managing moisture balance

Discussion: Ensure that all topical dressings for the management of moisture balance are compatible with fragile skin to prevent further trauma.⁵⁷ Dressings should be chosen in accordance with the demands of the wound bed and other patient factors. Generally, skin tears are not heavily exudating wounds; however, in some cases, depending on the location and co-morbidities such as peripheral edema, skin tears may be heavily exudating. Absorbent dressings such as foams, hydrofibres or alginates may be required to manage exudate.⁵⁷

4.3 Select the appropriate dressing and/or advanced therapy

Discussion: The ISTAP established a skin tear product selection guide to identify products currently in the global marketplace that will allow for moist wound healing in accordance with the local wound conditions, while at the same time respecting the fragile nature of the skin of those who have been identified as being at risk for skin tear development.³⁵

ISTAP does NOT recommend dressings be used as preventative measures. Adhesives should be avoided on the skin whenever possible. The list is neither all-inclusive nor all-encompassing. Frequency of dressing changes will be based on local wound conditions. The ISTAP recognized that not all of the products discussed are available in all countries. Some dressing categories were excluded for differing reasons: the strong adhesive nature of hydrocolloid and films dressings, the drying effects of iodine-based dressings, the lack of availability in many countries of non-gauze forms of polyhexamethylene biguanide (PHMB) dressings and an increased risk of periwound maceration with the use of medical honey dressings.³⁵

Special care should be taken with the pediatric population when selecting topical dressings.¹⁰² Ideally, topical wound dressings used in the pediatric population should be able to maintain moisture balance, protect the wound from bacteria and be atraumatic to the wound bed and periwound skin. Non-interactive dressings such as soft silicone foams and wound contact layers are viable choices.¹⁰²

For persons living homeless or experiencing homelessness, skin health and skin tears can occur in relation to nutrition, hygiene, trauma and poor footwear and sleeping conditions.¹⁰³

Special Considerations for Skin Tears in the Pediatric Populations

- Ensure that all products used have been verified for use in the pediatric populations
- Ensure that products do not pose a risk of causing systematic or tissue toxicity when used on immature skin
- Ensure that all products are atraumatic on removal

Special Consideration for People with Skin Tears

Antimicrobial Products	Indications	Skin Tear Type	Considerations
<p>Methylene blue and gentian violet dressings</p> <p>Caution: While the methylene blue primary dressing may be non-traumatic, the secondary topper dressing may cause medical adhesive-related trauma</p> <p>Consider use of products with silicone border</p> <p>The primary dressing requires a moisture retentive topper, and the manufacturer recommends a film dressing</p>	Effective broad-spectrum antimicrobial action, including on antibiotic-resistant organisms	1, 2, 3	<ul style="list-style-type: none"> • Non-traumatic to wound bed use when local or deep tissue infection is suspected or confirmed • Secondary dressing may be required
Ionic silver dressings	Effective broad-spectrum antimicrobial action including on antibiotic-resistant organisms	1, 2, 3	<ul style="list-style-type: none"> • Should not be used indefinitely • Contraindicated in patients with silver allergy • Use when local or deep infection is suspected or confirmed • Use non-adherent products whenever possible to minimize risk of further trauma

Note: This product list is not all-inclusive; there may be additional products applicable for the treatment of skin tears.

Figure 2: This demonstrates the correct way to label a dressing and remove the dressing



Dressings should always be removed in the direction of the skin flap (the pedicle) and not against it, thus maintaining flap viability. Indicate on the dressing the classification, size and shape of the skin tear, as well as the direction for dressing removal. Follow the product monogram instructions for proper dressing removal.

Permission: Mölnlycke

Wound Dressing Resources

Wounds Canada Product Pickers are useful resources on appropriate dressings that can be used for skin tears: <https://www.woundscanada.ca/health-care-professional/resources-health-care-pros/library/183-resources-industry-partner/288-product-picker>.

Wound Dressing Formulary: <https://www.woundscanada.ca/docman/public/health-care-professional/1113-product-picker-2017-formulary/file>.

Change in Practice Related to Skin Closure Strips

Wounds closed by primary intention have been traditionally secured with sutures or staples. With skin tears, closure adhesive strips, sutures and staples are not a recommended option.^{1,2,8,29,45} Consideration for the specific components of each medical wound adhesive should be considered, including risk of developing allergic contact dermatitis.¹⁰⁸

In the pediatric population, Tsai et al. reported that topical skin glue was a faster and less painful method, with increased comfort and better scar management in facial lacerations in children (n=50 children).¹⁰⁹ Tandon et al. reviewed 31 studies of wound cosmesis and incidence of wound complications when comparing tissue adhesives and suturing. They reported no difference in cosmesis and risk of wound infection or dehiscence.¹¹⁰

Additionally, in a review study, the cosmetic results using cyanoacrylates to close skin tears have been shown to be superior or equivalent to sutures for type 1 skin tears in elderly patients.¹¹¹

- A cyanoacrylate liquid can be used as a rapid and effective treatment for injury-related Type 1 skin tears on the arms, legs and faces of elderly patients.
- Skin tear wound edges annealed rapidly, thereby promoting faster skin tear closure and wound healing compared to skin closure strips alone.
- The use of a cyanoacrylate liquid skin protectant decreased the time and costs required for skin tear wound care and reduced the time for wound healing.

More research is needed to understand the role of tissue adhesives in Type 1 skin tears.

Advanced Dressing Considerations Specific for Skin Tears

Skin tears are generally acute wounds; however, in cases where the circumstances or co-morbidities delay wound healing, advanced therapies may be considered. A wound clinician should be consulted to work with the integrated health-care team, the organization and the patients and their care partners and families to ensure that the agreed-upon goals of care are established and that the treatment plan is in accordance with these goals.¹

4.4 Engage the team to ensure consistent implementation of the plan of care

Discussion: Engagement of individuals in their own care occurs when they meaningfully and actively collaborate in the goal setting and management of their care. Skin tear prevention across all age groups and levels of care must include a plan for engaging individuals, families, caregivers, health-care professionals and organizations to ensure that best practices are implemented. All involved must collaborate to ensure that programs are successful and sustainable.

Wounds Canada Resources: Refer the patient to DIY Skin Health Series: Skin Tear

<https://www.woundscanada.ca/patient-or-caregiver/resources/diy-series>

Implementation of a skin tear prevention program should centre on self-management and ways health-care professionals can aid individuals in modifying behaviours where necessary (See Table 6). As one example of how health-care professionals can assist individuals to choose beneficial behaviours, consider the modifiable risk factor of xerosis. Studies have indicated skin tear incidence can be greatly reduced by twice daily application of moisturizers.¹¹² Therefore, individuals who are engaged or who can be motivated to modify their behaviours by applying a skin moisturizer twice daily may have a reduction of skin tears. To achieve this reduction, the individual at risk may need physical assistance or support in the form of regular reminders to apply the moisturizer. Family and care partners may also participate in prevention strategies.

Special Consideration: Control of Peripheral Edema

Lower leg edema is well documented to contribute to delayed wound healing, regardless of wound etiology.¹⁰⁷ When skin tears occur on the lower limb, the risk and cause of potential peripheral edema should be assessed.^{1,37} It is important to control edema and equally important to rule out any significant degree of peripheral vascular disease. This should be done prior to the application of dressings or compression therapy for edema control and can be established through a clinical history and total leg assessment, including the use of Doppler ultrasound to determine the ankle brachial pressure index.³⁹

For additional information on chronic leg edema/lymphedema see [Chapter 13: Best Practice Recommendations for the Prevention and Management of Lymphedema](#).

Table 5: Engagement Strategies for Skin Tear Management¹¹³

Level	Skin Tear Management Strategies
Direct care	<ul style="list-style-type: none">• Integration of individual's (including family and care partners) beliefs around skin health into the plan of care• Introduction of the individual, family and care partners and their health-care providers to strategies for screening, prediction, prevention, assessment and management of skin tears through education and training• Open dialogue between the individual, family/caregivers and health-care providers to discuss and implement plan of care• Provide education related to skin tears to patient, care partners and health-care providers
Organizational	<ul style="list-style-type: none">• Integration of the health-care providers and the individual, family/caregivers into the design and governance of an overarching skin tear management program• Including individual, family and care partners in continuous quality improvement teams and strategies to maintain resources over time• Provide education on skin tear prevention and management to health care providers• Partner with stakeholders and researchers to develop quality improvement measures and outcomes
Policy Making	<ul style="list-style-type: none">• Engagement focused on developing, implementing and evaluating skin tear management programs• Partnerships between individual, family and care partners, health-care providers and organization to set priorities and make policies required to support skin tear management program• Partner with stakeholders and policy makers to develop policy to support prevention, assessment, treatment and measurement of quality outcomes

Step 5: Evaluate Outcomes

5.1 Determine if the outcomes have met the goals of care

Discussion: Literature supports primary prevention as the best skin tear management strategy.^{42,114,115} By controlling modifiable risk factors, skin health can be maintained and injury avoided. If skin tears occur they are traditionally categorized as acute wounds as they are reported to be traumatic wounds and are, therefore, expected to heal in a timely trajectory (7 to 21 days). Yet many reports indicate that skin tears fail to meet the expected wound healing milestones. Skin tears that do not follow an expected healing trajectory may evolve into complex wounds without appropriate care.^{17,35,36,52} It is hypothesized that this transition to slow or non-healing status is related to the co-morbidities and complications often associated with the frail elderly, the very young and those who are critically or chronically ill, all of whom are deemed to be at greater risk for skin tear development in the first place.³⁹

Skin tears can be further defined as 'uncomplicated' or 'complicated.' An uncomplicated skin tear is a wound that will go on to heal within four weeks. A complicated skin tear is more complex, particularly if it is on the lower

extremities and/or on a patient with multiple comorbidities.¹ Skin tears can turn into complex or complicated wounds in cases of total flap loss¹, or when not immediately assessed and cared for.^{4,116}

Some considerations:

- Monitor wound edge/closure:
 - Skin tears typically proceed to closure within 7–21 days. Re-evaluate if a tear has not closed within this time frame
 - Monitor and address factors that delay wound healing, e.g., diabetes, peripheral edema or nutritional issues
 - Consider compression therapy if the wound is on the lower leg. Perform a full vascular assessment, e.g., ankle brachial pressure index, before applying compression.^{1,52}

5.2 Reassess patient, wound, environment and system if goals are partially met or unmet

Discussion: If skin tears do not close in a timely fashion (7–21 days), barriers to wound healing should be assessed. The individual should be assessed for possible repeated trauma to the area and co-morbidities that might be delaying wound healing.² The local wound environment, the physical environment and the supports from the organization should be reassessed to ensure that best practice is being followed and all modifiable factors are controlled. If any goals are not met, the barriers should be readdressed and modified if applicable. If necessary, new, more realistic goals should be set.

5.3 Ensure sustainability to support prevention and reduce risk of recurrence

Discussion: As with any other wound-related program, implementation and sustainability of a successful skin tear program requires implementation support at both the organizational and clinical level.¹¹⁷

The association between skin tear prevalence and rising wound care costs, coupled with governments’ political agendas emphasizing primary prevention, provides governments with the incentive to promote population-based skin health.²¹ Skin tear prevalence and incidence should be monitored and tracked to allow for benchmarking and program evaluation.^{1,45}

The Registered Nurses’ Association of Ontario (RNAO) developed a toolkit for implementation of best practice guidelines.¹¹⁷ While these guidelines were developed for the implementation of guidelines on a more global level, the principles can be distilled to be applicable to the individual as well as an organization (See Table 7). The RNAO guidelines are based on the ‘knowledge to action’ framework.¹¹⁸

Table 6: Implementation and Sustainability of a Skin Tear Management Plan^{1,20}

Steps of the knowledge-to-action Model	Specific Content	Application Specific to Skin Tears
Identify the problem	Identify gaps in practice Use quality indicators to determine the extent of the problem	Identify the knowledge, attitude and practice around skin tear prediction, prevention, assessment and management
Adapt knowledge to local content	Develop an infrastructure for implementing best practices Critically appraise and adapt best practice to the culture	Identify available resources and attitudes surrounding skin tears Adapt knowledge to the environment (long-term care, community, various age groups)
Involve stakeholders	Ensure stakeholder identification, analysis and engagement to lead the implementation process.	As skin tears occur across the age continuum and across health-care settings, multiple stakeholders may be involved
Identify resources	Identify resources (physical and knowledge-based), including available best practices	Valuable resources for skin tear prevention include positive attitudes and practices by individuals, family/caregivers and health-care providers

cont'd...

Assess facilitators and barriers to implementation	Address or manage potential barriers and maximize facilitators (See section 4.2)	A major barrier to skin tear management is the knowledge, attitudes and practices of individuals, family/caregivers and health-care providers (See section 4.2 for strategies)
Tailor implementation strategies to the individual	Assess education needs based on audits and stakeholder feedback Design implementation strategies to meet the identified needs and to align with organizational policies and needs	Adapt skin tear management plan to the setting and age group
Monitor knowledge use and outcomes	Implement ongoing quality improvement processes, indicator monitoring and ongoing data collection and review. Some considerations: <ul style="list-style-type: none"> • the use of e-health and electronic health records in this process • indicator identification worksheet • structure, process and outcome, evaluation relevant to initial problem and reducing the gaps • evaluation models, logic model 	Ensure consistent documentation of skin tears using a validated classification system Conduct ongoing prevalence and incidence studies to benchmark burden of skin tears and success of management programs
Sustain knowledge and implementation	Embed an evidence-informed practice culture through orientation, position descriptions, performance appraisal and mission, vision and values Leverage key organizational structures in ensuring such a culture is adopted throughout the organization at every level	Engage all levels of stakeholders (individual, family/care partners, health-care providers and organization) in ongoing knowledge production and dissemination and implementation of best practices

Conclusion

There is every reason to believe that well-crafted interventions can be highly effective in improving skin health. Skin tears are preventable acute wounds with a high propensity in certain individuals to develop into chronic wounds and impose health burdens on individuals and care agencies. Although often under-reported, skin tears are hypothesized to be highly prevalent and particularly troublesome for the elderly population. Individuals with skin tears often complain of increased pain that, in addition to biopsychosocial factors associated with wounds such as physical disability, social needs and mental anguish, may negatively impact quality-of-life.

Neonatal and pediatric populations can also be affected by skin tears, but the healing process is usually fast if their health condition is stable. Skin growth rates in infants are higher than in adults. The skin of infants is characterized by a greater ability to restore itself as a barrier.¹¹⁹ It is important to note that skin tears are a source of pain and anxiety for these patients and can create great distress in parents seeing their newborn's skin disrupted.

Prevention of skin tears in all age groups is considered the key to management, so the focus should be on controlling modifiable risk factors so skin health can be maintained and injury avoided.

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Appendix: Skin Tears and Falls

The Registered Nurses' Association of Ontario (RNAO) has published Best Practice Guidelines for Preventing Falls and Reducing Injury from Falls (2017) that may be of value to the clinician. Available at <https://rnao.ca/bpg/guidelines/prevention-falls-and-fall-injuries>

Clinicians are encouraged to review fall-prevention programs and implement the prevention strategies that are best suited to the individual. Examples of several fall prevention program websites include:

- Registered Nurses' Association of Ontario. (RNAO). Long-term Care Best Practices Toolkit (2nd ed.). Falls Prevention and Management. (Tools and Resources available for download and use by clinicians, patients and families). 2023. Available at: <https://ltctoolkit.rnao.ca/clinical-topics/falls-prevention>
- Sinai Health. Healthy Aging and Geriatrics. Preventing Falls at Home: What are the dangers of falls. (Patient resources). 2023. Available at: <https://sinaigeriatrics.ca/patient-resources/preventing-falls-at-home/>
- Centers for Disease Control and Prevention. Clinical resources: STEDI – Stopping Elderly Accidents, Death and Injuries. 2019. Available at: <https://www.cdc.gov/stedi/index.html>