# BEST PRACTICE FOR THE ASSESSMENT AND MANAGEMENT OF SUPERFICIAL SKIN TEARS

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Skin tears are wounds commonly dealt with by nurses working in either the community or hospital. These wounds are mainly seen on older patients and can cause pain and discomfort in addition to usually being sited on exposed areas of skin, such as the arms, legs and the back of the hands. Prompt action and the application of non-adherent comfortable dressings aids healing. It is also important to discuss prevention of injury with the individual.

Superficial skin tears or lacerations are commonly seen in elderly patients (Malone et al, 1991). This is unsurprising considering the changes which occur within the skin due to ageing. The epidermis flattens due to loss of the papilla, which in younger skin maintains a strong connection between the epidermis and the dermis. Consequently, in older people, the epidermal and dermal layers peel apart more easily and are more prone to damage from friction/shearing forces (Cuzzell, 1990).

Furthermore, in the elderly the dermis reduces in bulk due to cell reduction; the number of dermal capillaries are also reduced, with the effect that less oxygen, nutrients and fluids are delivered to the skin (Shuster et al, 1975). As a consequence the skin becomes drier and more prone to injury.

#### Who is at risk?

In addition to the elderly, skin changes in the following patients make them vulnerable to skin tears:

- Patients with cardiopulmonary disease that results in lowerlimb oedema, in which the skin becomes vulnerable to damage
- ▶ Patients who have taken longterm steroid therapy because of thinning of the skin
- ▶ Patients with malnutrition in whom the skin becomes dry
- Patients who are confused and agitated, who may injure themselves against cot sides.

#### Patient assessment

The patient with a skin tear should have a history taken and the condition of the wound and surrounding skin should be assessed (*Figure 1*).

The skin tear should then be classified and treated with the aims of:

>> Stopping bleeding

- >> Preventing infection
- >> Minimising pain and discomfort
- >> Recovering skin integrity.

#### **Management**

Best practice dictates that skin tears should be managed by providing comfortable, appropriate dressings which optimise the wound environment and do not cause further trauma on removal (Meuleneire, 2002). **WE** 

Cuzzell JZ (1990) Clues: bruised, torn skin. *Am J Nurs* **18:** 16–18

Malone M, Rozario N, Gavinski M, Goodwin J (1991) The epidermiology of skin tears in the institutionalised elderly. *J Am Geriatric Society* **39(6):** 591–5

Meuleneire F (2002) Using a soft siliconecoated net dressing to manage skin tears. *J Wound Care* **11(10):** 365–9

Payne RL, Martin MC (1993) Defining and classifying skin tears: need for a common language. *Ostomy Wound Manage* **39(5):** 16–26

Shuster S, Black MM, McVitie E (1975) The influence of age and sex on skin thickness, skin collagen and density. *Br J Dermatol* **93(6):** 639–43

Figure 1. Assessment, classification and wound management of skin tear wounds.

### If the surrounding skin is fragile avoid adhesive dressings/tapes

#### **Wound Management**

Dependant upon the wound AND condition of the surrounding skin

#### If the surrounding skin is robust:

Thin hydrocolloid: allows wound observation while providing moist environment for re-epithelialisation. Thin foam dressing: allows absorption

# If the surrounding skin is

Soft silicone-coated dressing: allows stabilisation of skin flap without use of adhesive. Apply light padding and retain using bandage

## Clean the wound gently, via irrigation with warm saline or tap water

If there is a viable skin flap gently unroll this and spread over the wound

- DO NOT PULL OR APPLY **TENSION** 

**Apply appropriate dressing** 

#### Assess the patient:

Why has the injury occurred? Previous skin injury? Status of surrounding skin Nutritional status Medication Wound location Size and category of wound

#### Payne-Martin Classification for skin tears (1993):

Category 1. Skin tears without tissue loss

- a) Linear
- b) Flap

Category 2. Skin tears with partial tissue loss

- a) less than 25%
- b) more than 25%

Category 3. Skin tears with entire loss of tissue

## The patient



Category 1a linear tear



If Category 3 refer to **Surgical team** 

If Category 1 or 2 nursing management is appropriate.



Category 1b skin flap



Category 2a tear with less than 25% tissue loss