LIVE

**WEDNESDAY 15TH FEBRUARY,** 7:30PM

# Best Practice in **Skin Tear Management**


**HEIDI SANDOZ**

Tissue Viability Services Lead, Hertfordshire Community NHS Trust;
Independent Tissue Viability Consultant, Ferita Consultancy Services



Journal of Community Nursing JCN

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# LIVE Q&A

*SEND IN YOUR QUESTIONS BY COMMENTING ON THE VIDEO*

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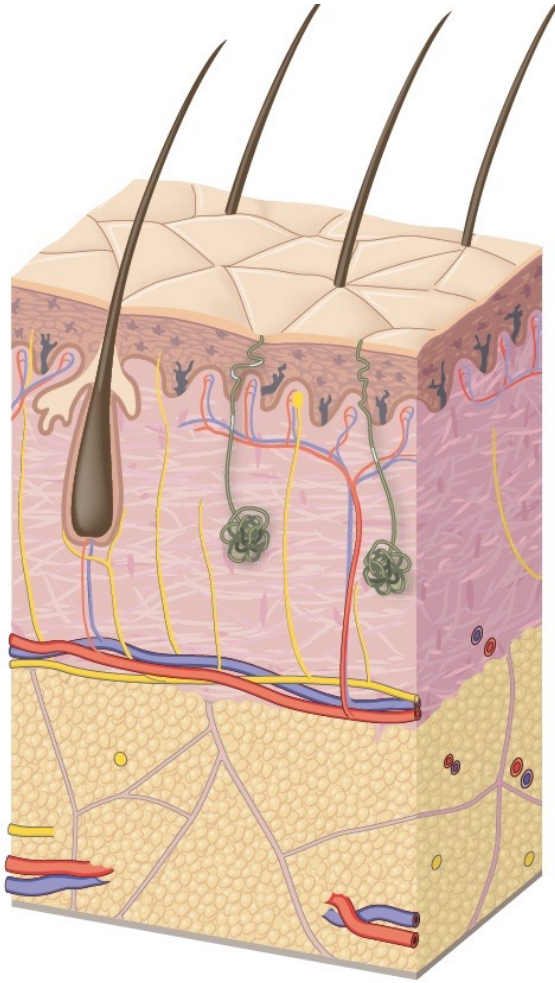
# LEARNING OBJECTIVES

- Skin anatomy — refresher
- Changes in aging skin
- What is a skin tear
- Risk factors for skin tear development
- Prevention of skin tears
- Classifying skin tears and assessment
- Management and treatment of skin tears

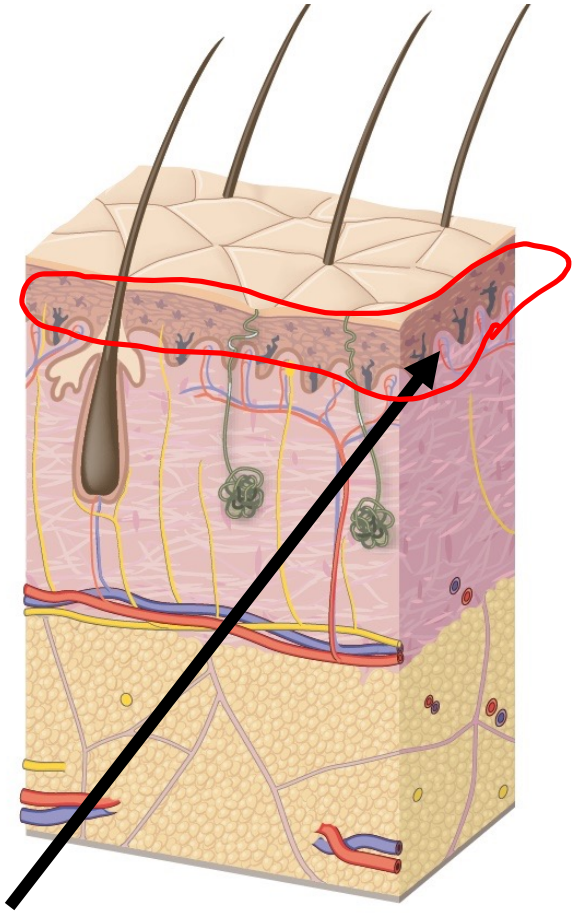
# SKIN LAYERS[1]




(Figure: Baranoski et al, 2020[1])

# AGING SKIN

- Thinning of the epidermis and flattening of the epidermal junction [2]
- Loss of collagen, elastin and glycosaminoglycans (used in the body as a lubricant or shock absorber) [2]
- Atrophy and contraction of the dermis (causing appearance of wrinkles and folds) [2]
- Decreased activity of sweat glands and sebaceous glands, causing the skin to dry out [2]

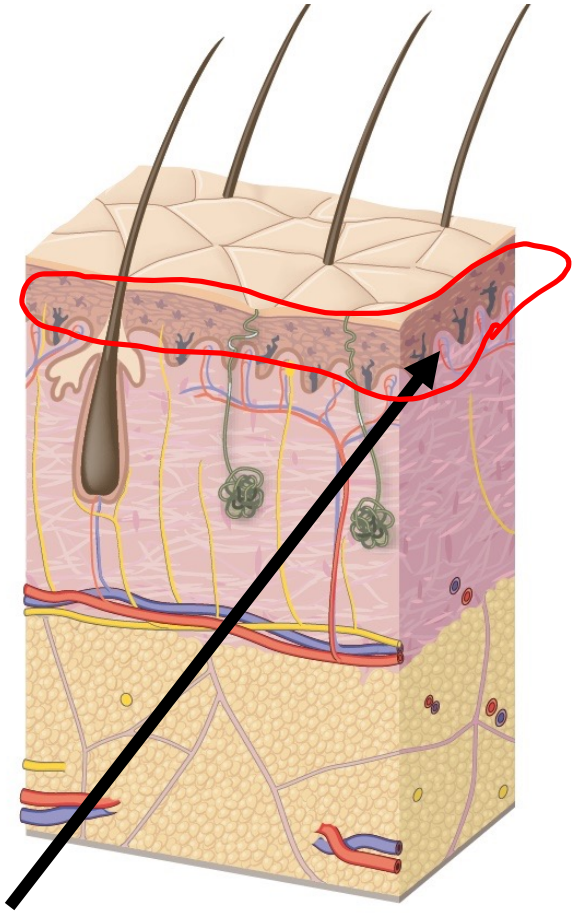


Rete ridges
(epidermal junction)

(Figure: Baranoski et al, 2020[1])

# AGING SKIN

- Thinning of blood vessel walls and a reduction of blood supply to the extremities [2]
- Photoaging [2]



Rete ridges
(epidermal junction)

(Figure: Baranoski et al, 2020[1])

# WHAT IS A SKIN TEARS?

## The International Skin Tear Advisory Panel (ISTAP) defines a skin tear as:

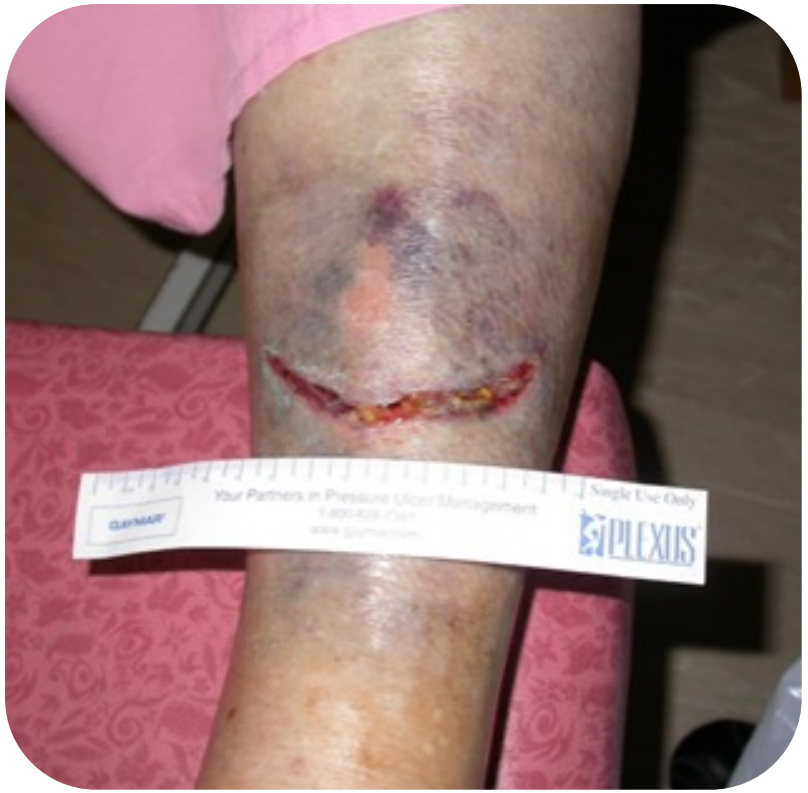
A traumatic wound caused by mechanical forces, including removal of adhesives.

Severity may vary by depth (not extending through the subcutaneous layer)[2].

# WHAT IS A SKIN TEARS?

Skin tears are acute wounds with a high propensity to develop into chronic wounds and impose health burdens on individuals and care agencies[2].

Although skin tears are frequently precipitated by trauma, they are often slow to heal and may become chronic wounds because of co-existing conditions[2].



# HOW BIG A PROBLEM ARE SKIN TEARS?

Skin tears occur across varied patient groups; people with **aged and fragile skin are at an increased risk** of skin tears — aging of the worldwide population means that incidence is increasing[2].

Skin tears result in **increased community visits[2]**.

They can be painful wounds, **affecting quality of life** and **causing distress** to the individual[2].

Skin tears may **increase the likelihood of hospitalisation** and **prolong hospitalisation stay[2]**.

# PLASTICS & PRE-TIBIAL HAEMATOMAS

**83.3**
Years of age (47–96)

**77.8%**
American Society of Anaesthesiologists (ASA) Score[3] (Mohamed, 2011)

**42.1%**
Cancelled once

**30%**
Theatre delayed by 3–9 days

**68.2%**
Female

**17.7%**
Mortality

**21.1%**
Cancelled more than once

**10 DAYS**
Length of stay (LOS) 6–21 days

(Unpublished data, Herts and West Essex ICB, 2017. To access data contact, Heidi Sandoz)

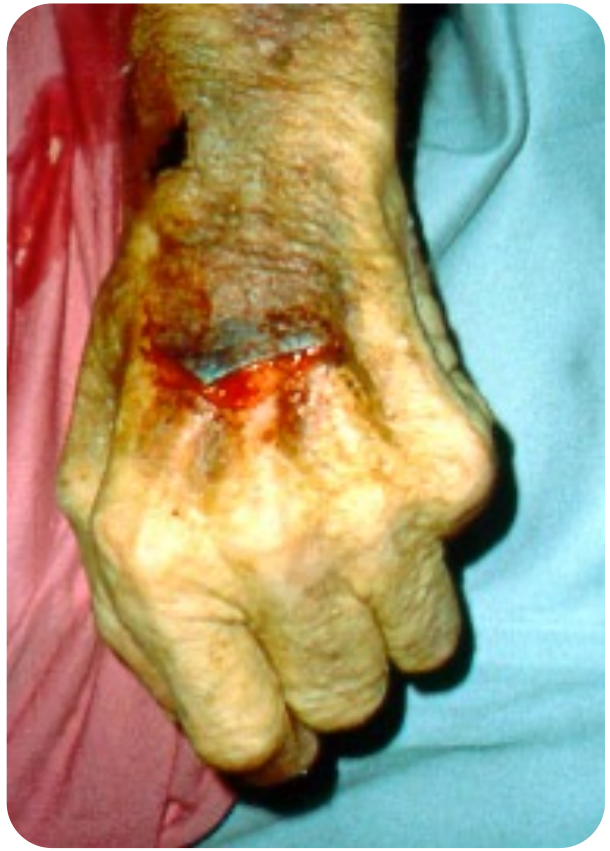
# WHAT'S THE SIZE OF THE PROBLEM?

- **In long-term care:** 2.23–92%, although estimates vary and may be lower[2]
- **In the community:** 4.5–19.5% in all age groups[2]
- **In acute care:** 6.2–11.1%[2]
- **In palliative care:** 3.3–14.3%[2]
- **In intensive care and operative theatres:** prevalence is unknown[2].

# INTRINSIC RISK FACTORS

## Intrinsic risk factors[2]:

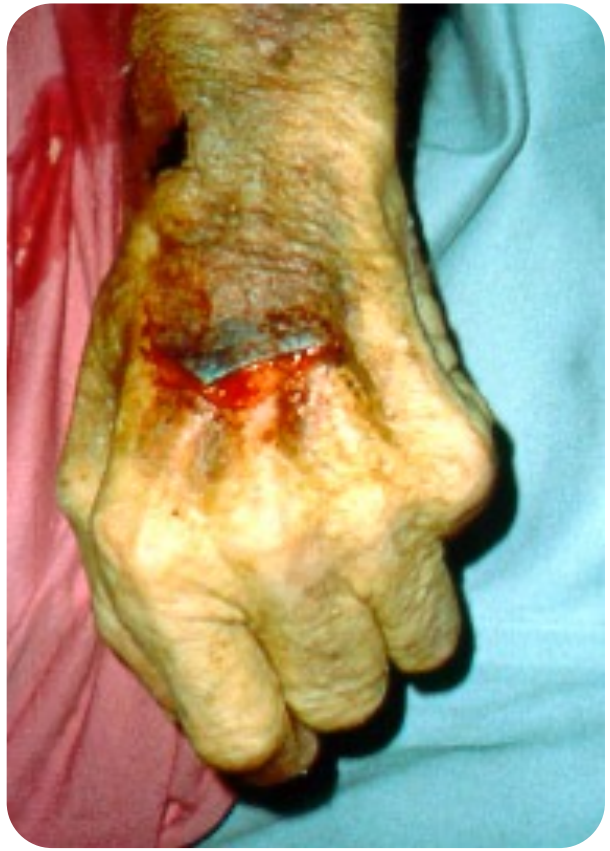
- Co-morbidities
- Immobility
- Female sex
- Visual Impairment
- Extremes of age
- Frailty
- Incontinence/MASD
- Limb stiffness and spasticity
- Cognitive impairment
- Neuropathy
- Altered sensory status
- Presence of ecchymosis



# EXTRINSIC RISK FACTORS

## Extrinsic risk factors[2]:

- Inadequate nutritional intake
- Transfer and falls
- Prosthetic devices
- Skin cleansers
- Blood draws
- Removal of tape or dressings
- Application and removal of stockings
- Using assistive devices
- Polypharmacy



# FRAILTY

## The Rockwood Clinical Frailty Score Guidance

### Very Fit: 1-4

**Red flags to monitor for:**

- Unexpected weight loss
- Poor nutrition and hydration
- Fatigue
- Weakness
- Slowing down
- Deteriorating cognition

### Mildly Frail: 5

**Actions:**

- Keeping as active as possible
- Refer to Community Navigator
- Consider getting involved in a volunteer scheme
- Active Ageing advice and guidance (Age UK)
- Yearly medication/long term condition review
- Falls screen
- Assess for loneliness
- Cognitive screening
- Dietary advice
- Sight and hearing checks

*No decision about me without me*

### Moderately Frail: 6

**Actions (in addition to those for mildly frail):**

- Consider for case management
- Assessment for care needs
- MDT discussions
- Think about Advance Care Planning e.g. making a will, Lasting Power of Attorney, Advanced Decisions to Refuse Treatment, Treatment Escalation Planning and informing others of wishes

### Severely Frail: 7-9

**Actions (in addition to those for moderately frail):**

- Comprehensive Geriatric Assessment
- Ensure appropriate care package in place
- Consider Gold Standards Framework register
- Recognise possibility of last year of life and advance care plan accordingly
- DE-prescribe
- Follow local End of Life Pathway

(Adapted from: www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale_.pdf by Herts and West Essex ICB)

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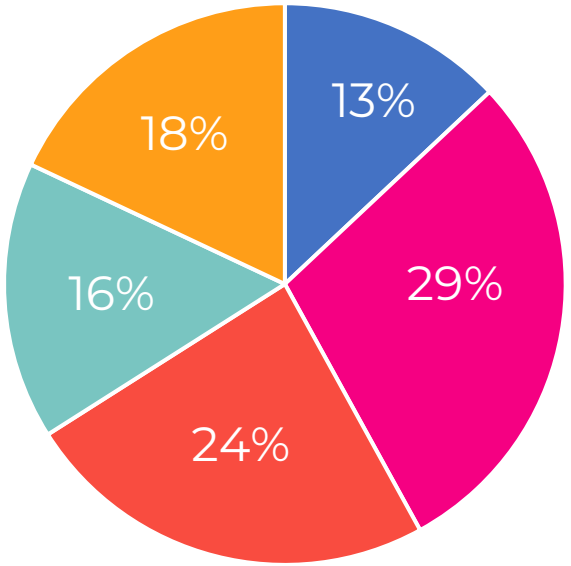
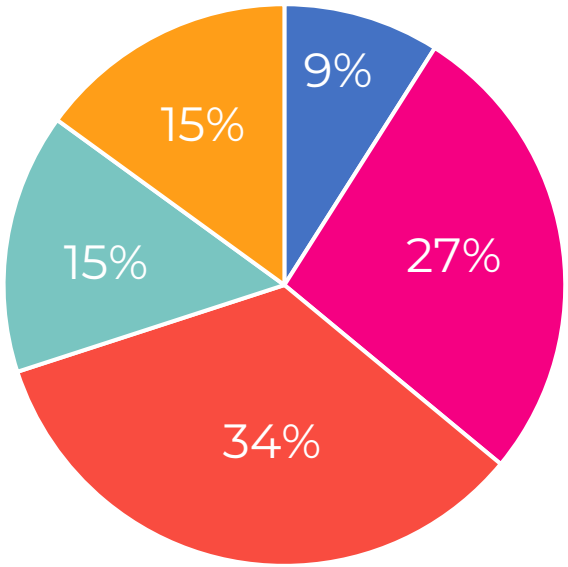
# HERTS & WEST ICB LOWER LIMB NEEDS ASSESSMENT

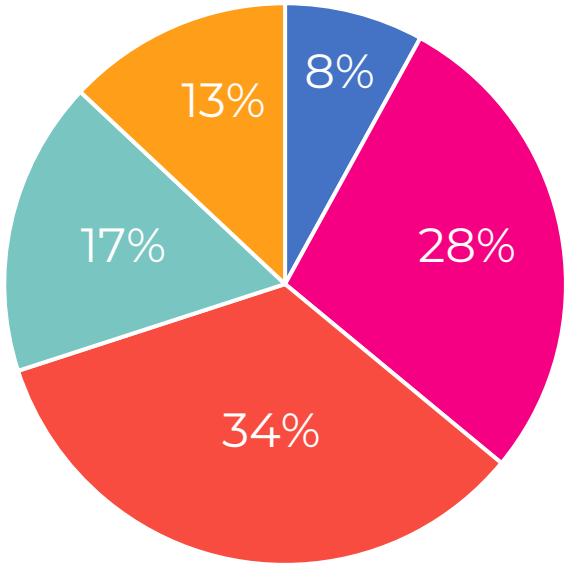
LU Frailty Score




Lymph Frailty Score




Cellulitis Frailty Score

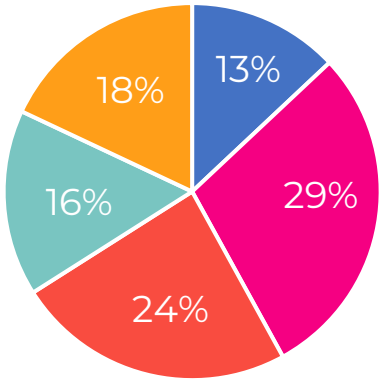



Not Recorded · Mild · Moderate · Severe · Fit

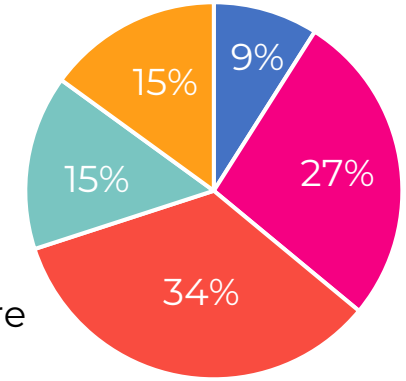
(Figures: Walton, 2019[4])

# HERTS & WEST ICB LOWER LIMB NEEDS ASSESSMENT

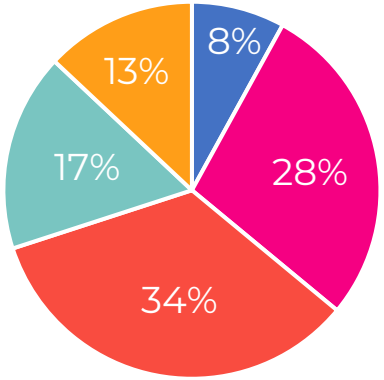
LU frailty score




Lymph frailty score




Cellulitis frailty score




- Not recorded
- Mild
- Moderate
- Severe
- Fit

- **83%** had one or more long-term conditions managed in secondary care[4]
- **14%** had moderate frailty and **9%** had severe frailty[4]
- **33%** receiving social care[4]
- **43.4%** had three or more long-term conditions managed in secondary care[4].

(Figures: Walton, 2019[4])

# WHAT CAUSES SKIN TEARS?

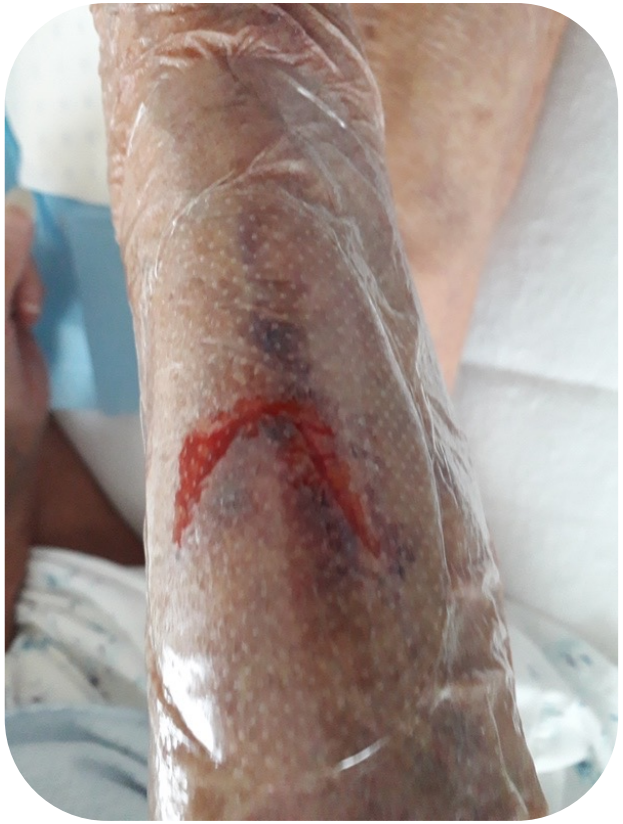
1. Equipment injuries (wheelchair/bed-rails)[2]
2. Blunt trauma[2]
3. Moving and handling[2]

# WHAT CAUSES SKIN TEARS?

4 Falls[2]

5 Dressing/tape removal[2]

6 Activities of daily living (ADLs)[2]



# IDENTIFYING RISK: BEST PRACTICE RECOMMENDATIONS[2]

**Skin Tear Risk Assessment**
(patient, wound, environment)

**Risk Categories**

- **Skin:** extremes of age, dry/fragile skin, previous skin tear
- **Mobility:** history of fall, impaired mobility, dependence on assistance for activities of daily living, mechanical trauma
- **General health:** comorbidities, polypharmacy, impaired cognition (sensory, visual, auditory) and malnutrition

**At Risk**
If patient has **any** identified risk factors

**No** → Reassess when patient's condition changes

**Yes** → **Implement risk reduction programme checklist**
(see Table 1)

(Pathway adapted from LeBlanc et al, 2018[2])

# RISK REDUCTION: BEST PRACTICE RECOMMENDATIONS[5]

**Table 1: Risk Reduction programme checklist (adapted from LeBlanc and Baranoski, 2011)**

| Risk Factor | Action |
|---|---|
| **Skin** | ❑ Inspect skin and investigate previous history of skin tears<br>❑ If patient has dry, fragile, vulnerable skin, assess risk of accidental trauma<br>❑ Manage dry skin and use emollient to rehydrate limbs as required<br>❑ Implement an individualised skin care plan using a skin-friendly cleanser (not traditional soap) and warm (not hot) water<br>❑ Prevent skin trauma from adhesives, dressings and tapes (use silicone tape and cohesive retention bandages)<br>❑ Consider medications that may directly affect skin (e.g. topical and systemic steroids)<br>❑ Be aware of increased risk due to extremes of age<br>❑ Discuss use of protective clothing (e.g. shin guards, long sleeves or retention bandages)<br>❑ Avoid sharp fingernails or jewellery in patient contact |
| **Mobility** | ❑ Encourage active involvement/exercises if physical function is impaired<br>❑ Avoid friction and shearing (e.g. use glide sheets, hoists), using good manual handling techniques as per local guidelines<br>❑ Conduct falls risk assessment<br>❑ Ensure that sensible/comfortable shoes are worn<br>❑ Apply clothing and compression garments carefully<br>❑ Ensure a safe environment – adequate lighting, removing obstacles<br>❑ Use padding for equipment (as per local policy) and furniture<br>❑ Assess potential skin damage from pets |
| **General Health** | ❑ Educate patient and carers on skin tear risk and prevention<br>❑ Actively involve the patient/carer in care decisions where appropriate<br>❑ Optimise nutrition and hydration, referring to dietician if necessary<br>❑ Refer to appropriate specialist if impaired sensory perception is problematic (e.g. diabetes)<br>❑ Consider possible effects of medications and polypharmacy on the patient's skin |

# RISK REDUCTION: BEST PRACTICE RECOMMENDATIONS[2]

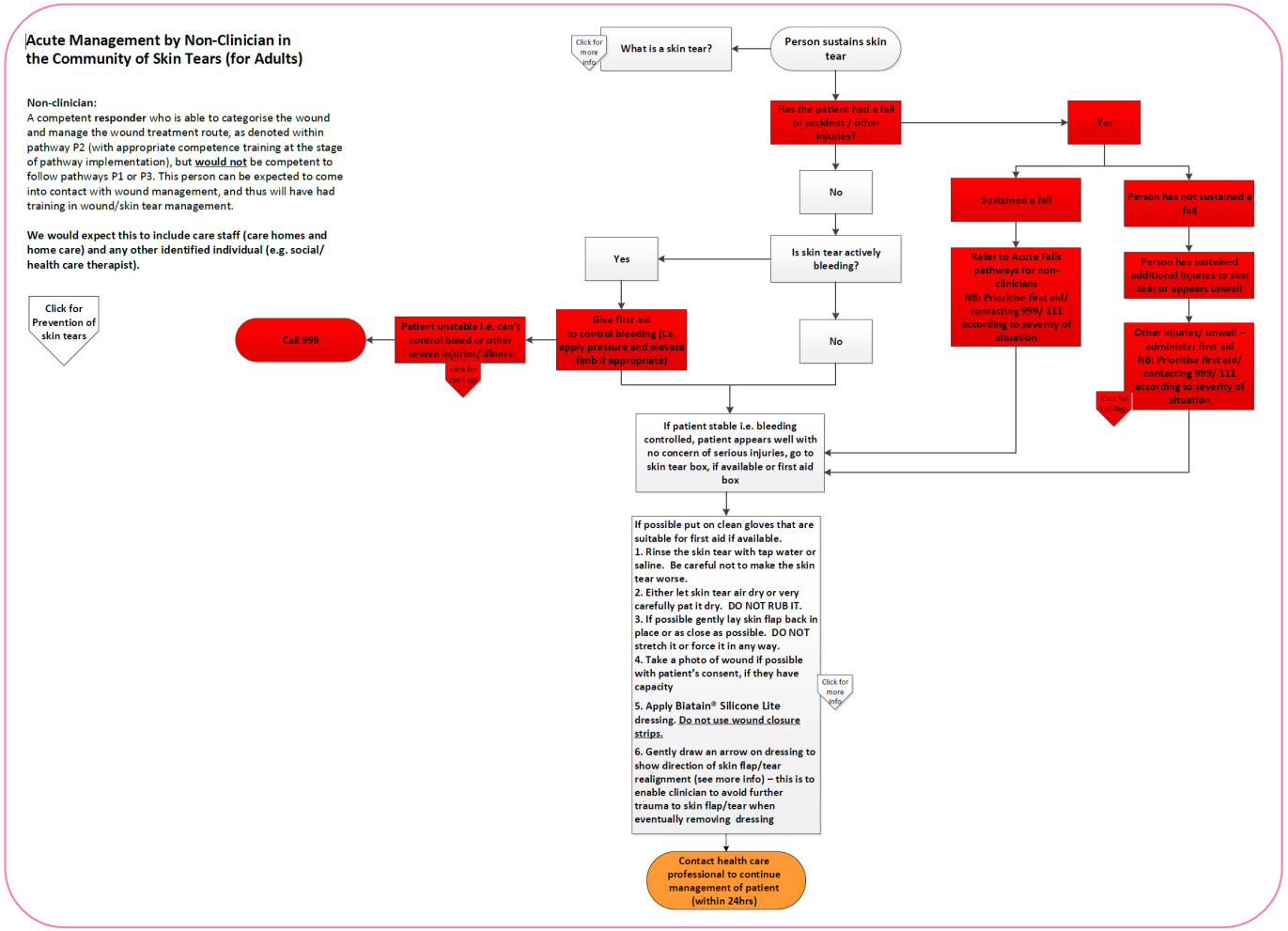
## Risk Factors:

- Skin
- Mobility
- General Health

- MOISTURISE DRY SKIN
- PREVENT TRAUMA FROM ADHESIVES
- AVOID SHARP NAILS AND JEWELLERY
- ENVIRONMENT
- REDUCE FALLS RISK
- OPTIMISE

(LeBlanc et al, 2018[2])

# PATHWAYS

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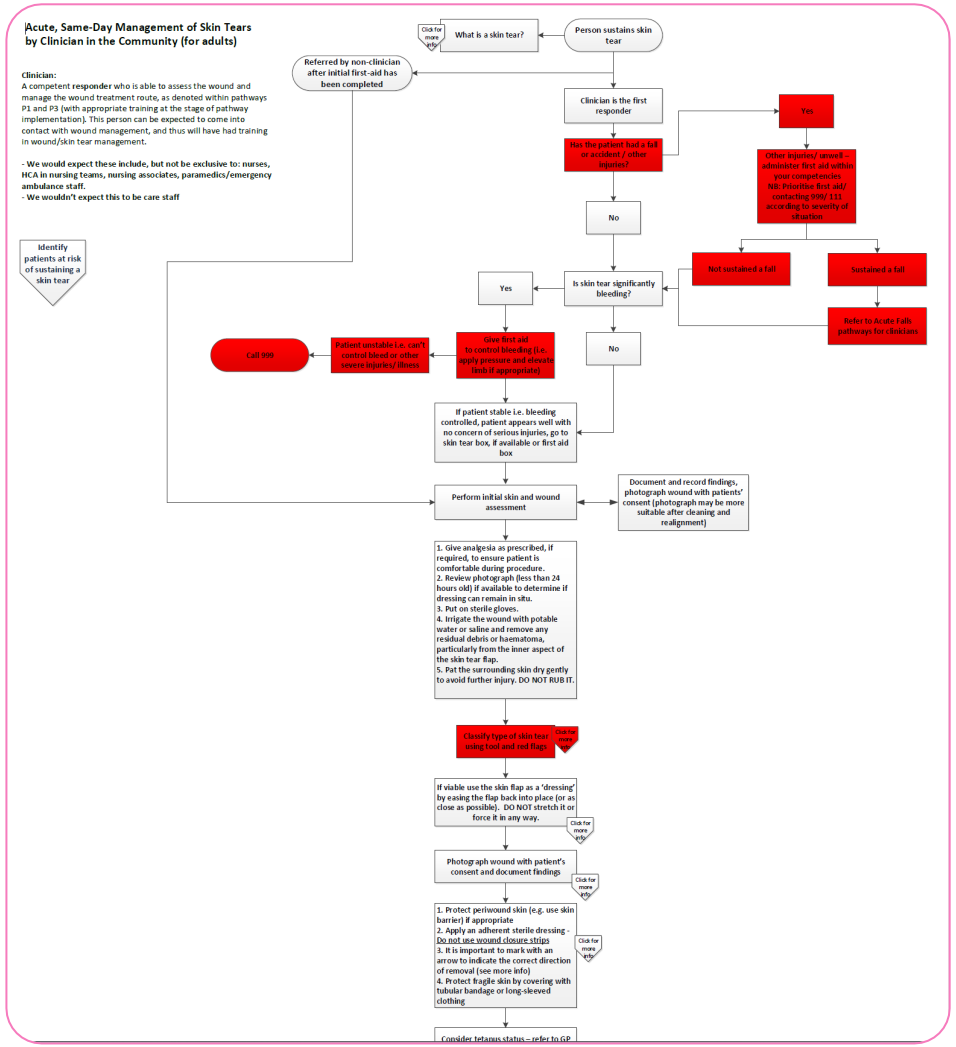
# PATHWAYS


Acute, Same-Day Management of Skin Tears by Clinician in the Community (for adults)
Clinician:
A competent responder who is able to assess the wound and manage the wound treatment route, as denoted within pathways P1 and P3 (with appropriate training at the stage of pathway implementation). This person can be expected to come into contact with wound management, and thus will have had training in wound/skin tear management.
- We would expect these include, but not be exclusive to: nurses, HCA in nursing teams, nursing associates, paramedics/emergency ambulance staff.
- We wouldn't expect this to be care staff
Identify patients at risk of sustaining a skin tear
Click for more info
What is a skin tear?
Person sustains skin tear
Referred by non-clinician after initial first-aid has been completed
Clinician is the first responder
Has the patient had a fall or accident / other injuries?
Yes
Other injuries/ unwell - administer first aid within your competencies
NB: Prioritise first aid/ contacting 999/ 111 according to severity of situation
No
Not sustained a fall
Sustained a fall
Refer to Acute Falls pathways for clinicians
Is skin tear significantly bleeding?
Yes
No
Give first aid to control bleeding (i.e. apply pressure and elevate limb if appropriate)
Patient unstable i.e. can't control bleed or other severe injuries/ illness
Call 999
If patient stable i.e. bleeding controlled, patient appears well with no concern of serious injuries, go to skin tear box, if available or first aid box
Perform initial skin and wound assessment
Document and record findings, photograph wound with patients' consent (photograph may be more suitable after cleaning and realignment)
1. Give analgesia as prescribed, if required, to ensure patient is comfortable during procedure.
2. Review photograph (less than 24 hours old) if available to determine if dressing can remain in situ.
3. Put on sterile gloves.
4. Irrigate the wound with potable water or saline and remove any residual debris or haematoma, particularly from the inner aspect of the skin tear flap.
5. Pat the surrounding skin dry gently to avoid further injury. DO NOT RUB IT.
Classify type of skin tear using tool and red flags
Click for more info
If viable use the skin flap as a 'dressing' by easing the flap back into place (or as close as possible). DO NOT stretch it or force it in any way.
Click for more info
Photograph wound with patient's consent and document findings
Click for more info
1. Protect periwound skin (e.g. use skin barrier) if appropriate
2. Apply an adherent sterile dressing - Do not use wound closure strips
3. It is important to mark with an arrow to indicate the correct direction of removal (see more info)
4. Protect fragile skin by covering with tubular bandage or long-sleeved clothing
Click for more info
Consider tetanus status – refer to GP

# PATHWAYS

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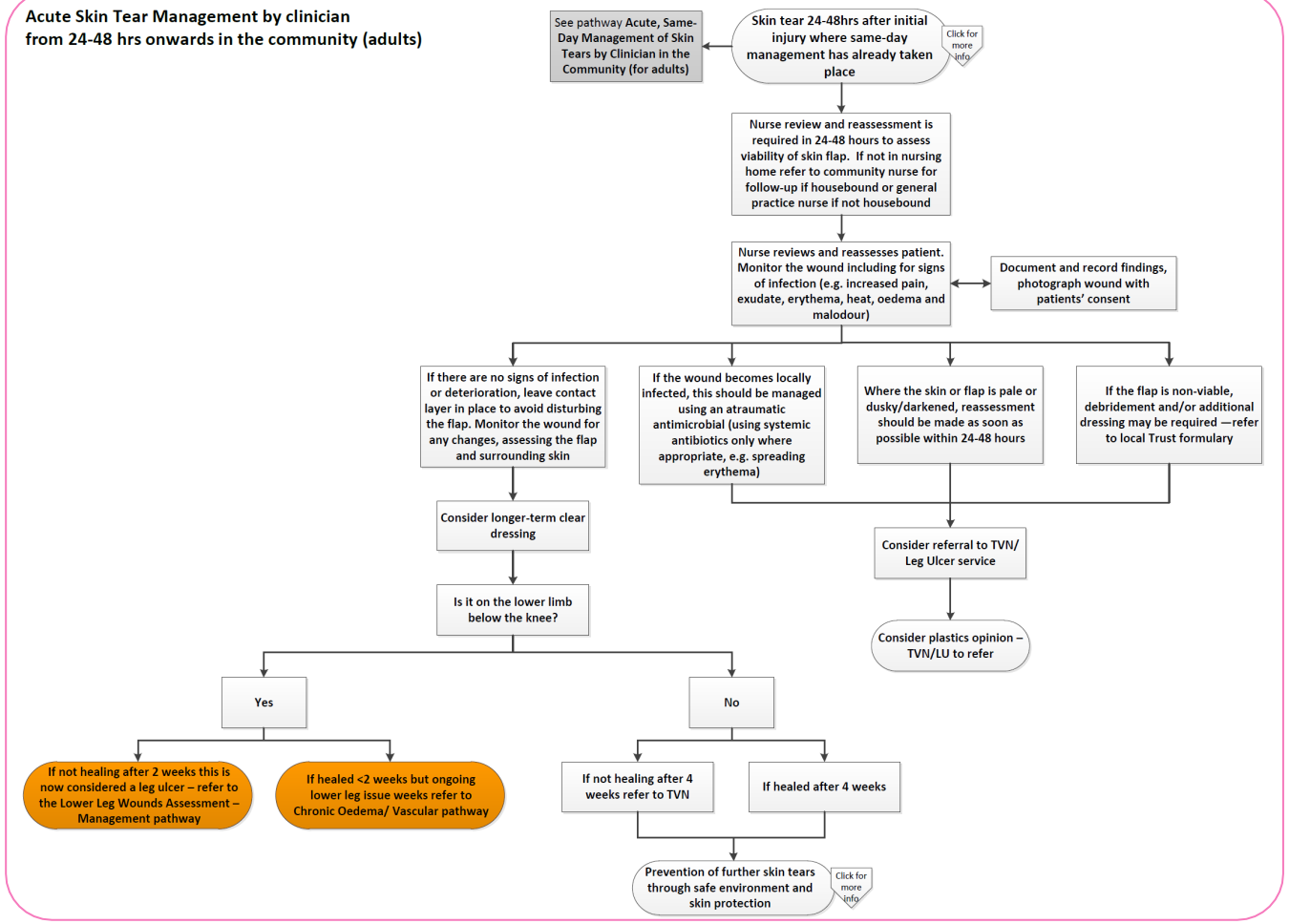
**Acute Skin Tear Management by clinician from 24-48 hrs onwards in the community (adults)**

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# PATHWAYS

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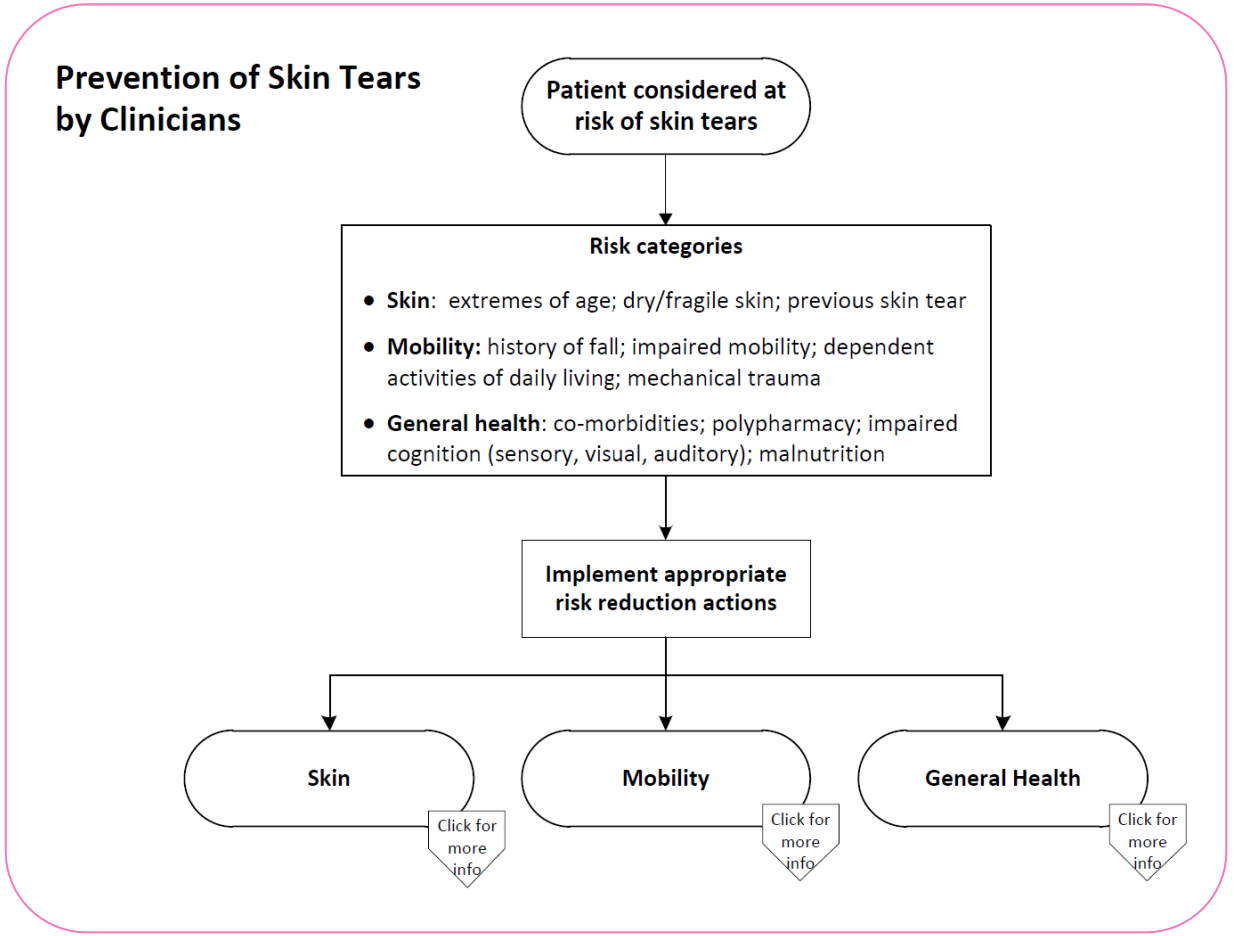


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# ASSESSMENT AND MANAGEMENT[2]

**Skin Tears**

**Assess**

Control bleeding

**Cleanse**

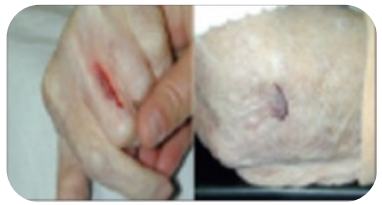
**Approximate Wound Edges**

Classify (measure and document)

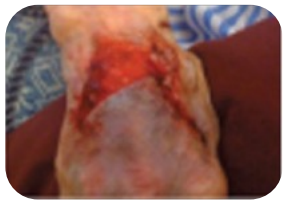
## Goals of treatment

- Treat the cause
- Implement prevention
- Protocol
- Moist wound healing
- Avoid trauma
- Protect periwound skin
- Manage exudate
- Avoid infection
- Pain control

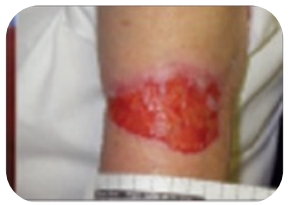
## Treatment options in accordance with local wound conditions



Type 1: No skin loss



Type 2: Partial flap loss



Type 3: Total flap loss

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(Pathway adapted from LeBlanc et al, 2018[2])

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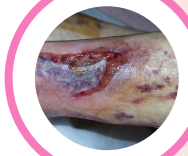
# ASSESSMENT AND CLASSIFICATION

The initial assessment should include a comprehensive assessment of the person and their wound. This includes determining all causative factors, any underlying comorbidities, nutritional status, assessing level of pain, and potential for wound healing[2,6]



Classification of the injury [2,6]

Photograph of the injury [2,6]

T.I.M.E.[7-8]

Wound assessment (where relevant)[2,6].

(LeBlanc et al, 2016[6]; LeBlanc et al, 2018[2])

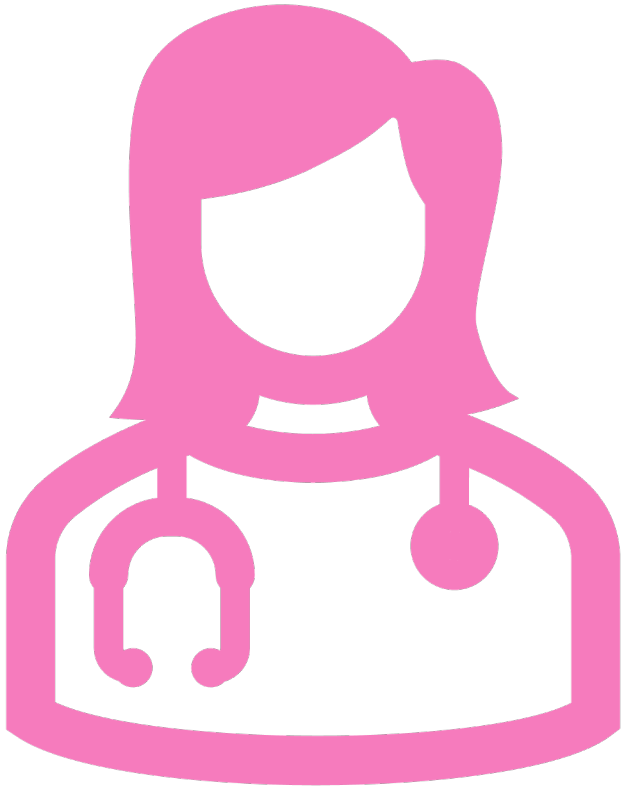
# ASSESSMENT²

Control bleeding ← **Assess**

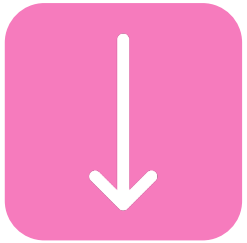
## Do I need to escalate?

- Fall?
- Conscious and breathing?
- Other injuries?
- Skin, bone, head
- Other skin injuries
- Consider all skin, not just the visible injury
- Bleeding
- More than one site?
- Consider medication and underlying conditions
- Can it be controlled?

# ESCALATION



# CONTROL BLEEDING[2]



Apply pressure[2]

Elevate the limb if possible[2]

First aid[2]

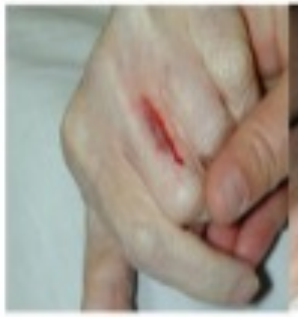
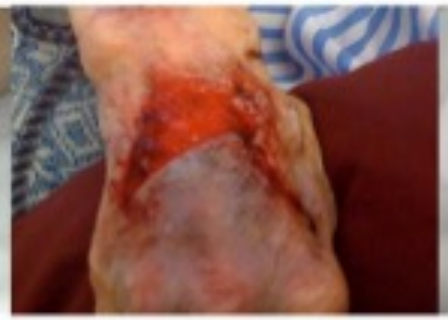
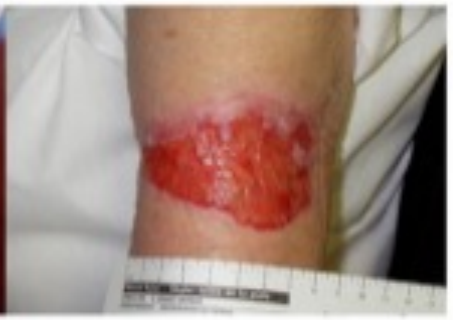
# CLEANSE AND DEBRIDE

Cleanse and irrigate[2]

Remove debris and/or haematoma[2]

# CLASSIFICATION

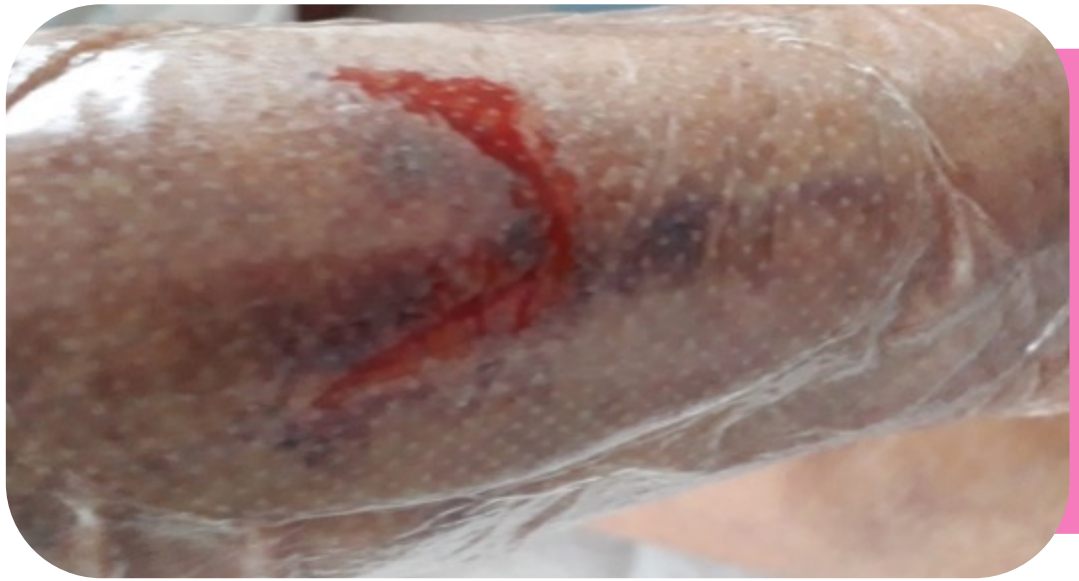
## Skin Tear Classification

| Type 1: No Skin Loss | Type 2: Partial Flap Loss | Type 3: Total Flap Loss |
|---|---|---|
|  |  |  |
| Linear or Flap* Tear which can be repositioned to cover the wound bed | Partial Flap Loss which cannot be repositioned to cover the wound bed | Total Flap Loss exposing entire wound bed |

**A flap in skin tears is defined as a portion of the skin (epidermis/dermis) that is unintentionally separated 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.*

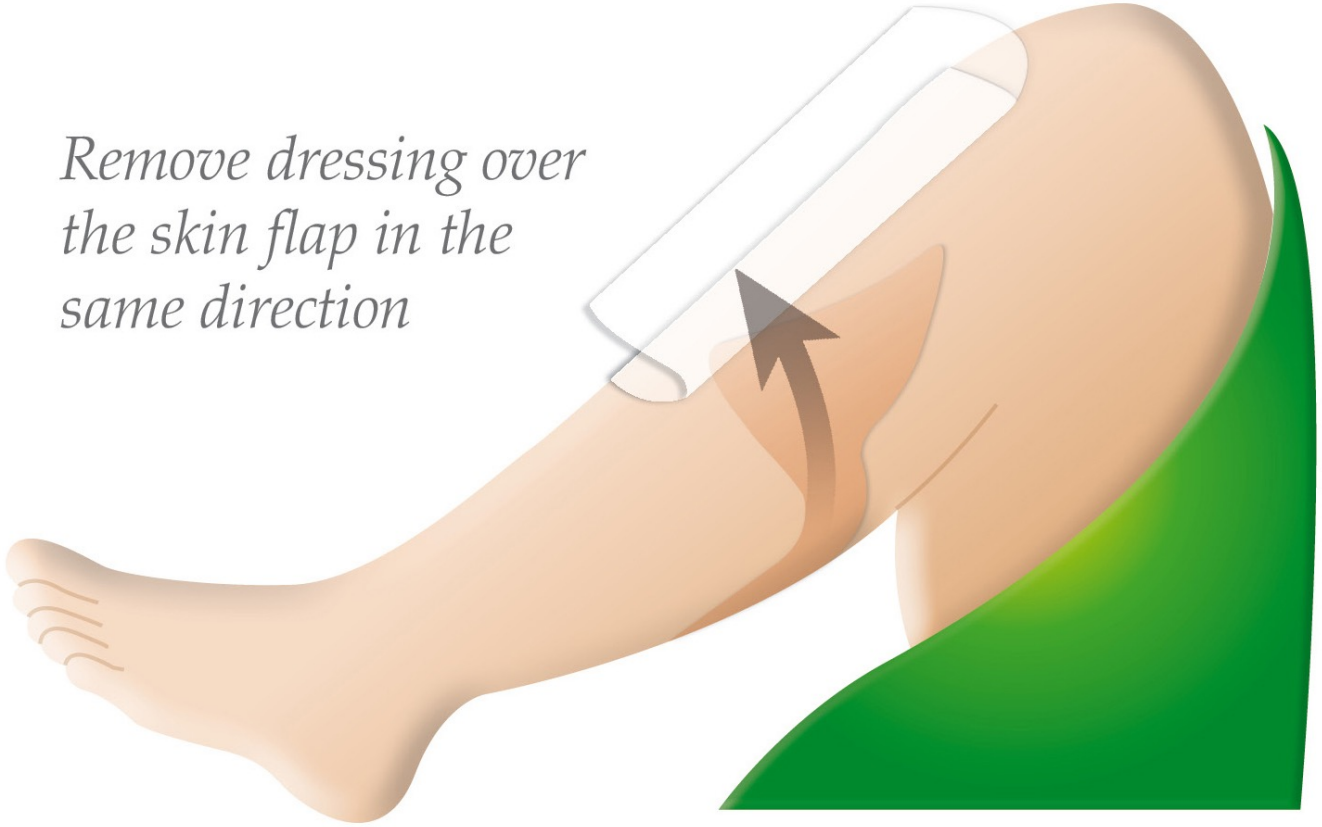
(Figure: Tiggelen et al, 2010[10])

# APPROXIMATE AND CLASSIFY



- Flap rolled out to reposition over wound
- Does not fully cover the wound bed
- Type 2: partial flap loss

# APPLY DRESSING

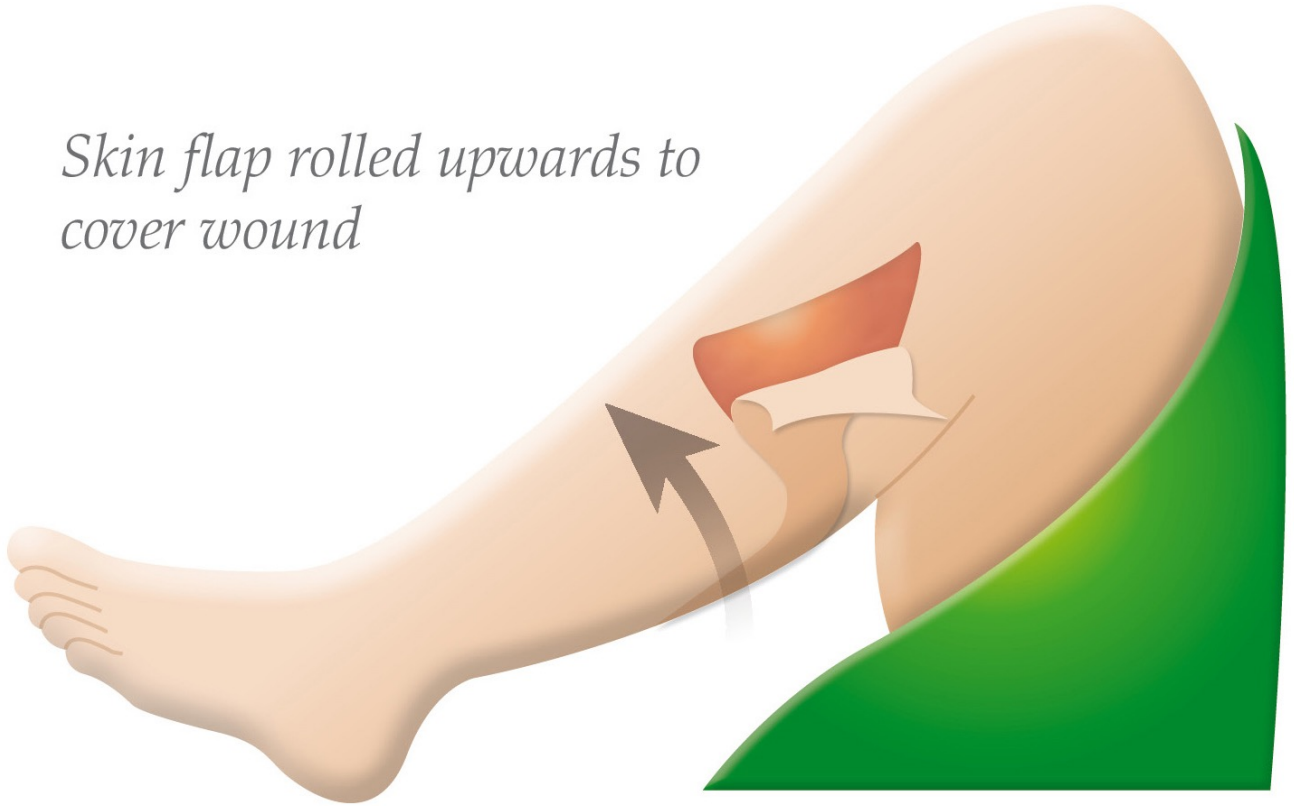



(Figure: created by JCN)

# APPLY DRESSING


(Figure: created by JCN)

# APPLY DRESSING




(Figure: created by JCN)

# Lower Limb - recommendations for care

For further information, please refer to the full NWCSP Lower Limb Recommendations at NationalWoundCareStrategy.net

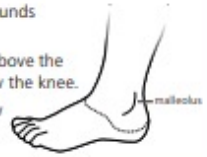
National Wound Care Strategy Programme
Excellence. Every Patient. Every Time.

## Immediate and Necessary Care

For people with one or more wounds below the knee.

**Leg wound**- originating on or above the malleolus (ankle bone) but below the knee.

**Foot wound** - originating below the malleolus.




### RED FLAGS

- Acute infection of leg or foot (e.g. increasing unilateral redness, swelling, pain, pus, heat).
- Symptoms of sepsis.
- Acute or chronic limb threatening ischaemia.
- Suspected deep vein thrombosis (DVT).
- Suspected skin cancer.

- Treat infection.
- Immediately escalate.
- For people in the last few weeks of life, seek input from their other clinicians.

### Immediate care

- Cleaning and emollient.
- Simple low-adherent dressing.
- Leg wounds, first line mild graduated compression.
- Supported self-care (when appropriate).

### Assessment times for diagnosis and treatment

- In hospital with diabetic foot wound - refer to MDT **within 24 hours.**
- Any other type of foot wound - refer to MDT **within 1 working day.**
- Leg wounds - **assess within 14 days.**

## Wounds on the Foot

One or more wounds below the malleolus

### Diagnosis and treatment

**1 Assess and identify contributing causes for non-healing**

**2. Diagnose cause of non-healing and formulate treatment plan**

**People with confirmed or suspected diabetic foot ulceration**

- Refer to diabetic foot team.
- Provide care in line the NICE Guideline for Diabetic Foot Problems.

**People with confirmed or suspected peripheral arterial disease**

- Refer for vascular surgical opinion.
- Provide care in line the NICE Guideline for Peripheral Arterial Disease.

### Ongoing care and review

**Review at each dressing change and at weekly intervals**

- Monitor healing at **4-week intervals** (or more frequently if concerned).
- If unhealed at **12 weeks**, reassess.

## Wounds on the Leg

One or more wounds above the malleolus

### Diagnosis and treatment

**1 Assess and identify contributing causes for non-healing**

**2. Diagnose cause of non-healing and formulate treatment plan**

**Leg wounds with an adequate arterial supply and no aetiology other than venous insufficiency**

- Refer for venous surgical/endovenous interventions.
- Strong compression therapy.

**Leg wounds with signs of arterial disease**

- Refer for vascular surgical/endovenous interventions and advice on compression.
- Pending vascular opinion, if no symptoms of arterial insufficiency, continue with mild graduated compression.

**Leg wounds of other or uncertain aetiology**

- Refer for dermatology opinion (or other specialist depending on symptoms and service arrangements).
  - Pending specialist opinion if no symptoms of arterial insufficiency, continue with mild graduated compression.

**Lymphoedema**

- Refer for expert diagnosis and advice about lymphoedema.

### Ongoing care and review

**Review at each dressing change and weekly intervals**

**Monitor healing at 4-week intervals (or more frequently if concerned)**

- If deteriorating or no significant progress towards healing, escalate.

**If unhealed at 12 weeks, reassess**

- If progressing to healing but still unhealed, undertake comprehensive re-assessment.
- If deteriorating or no significant progress towards healing, escalate.

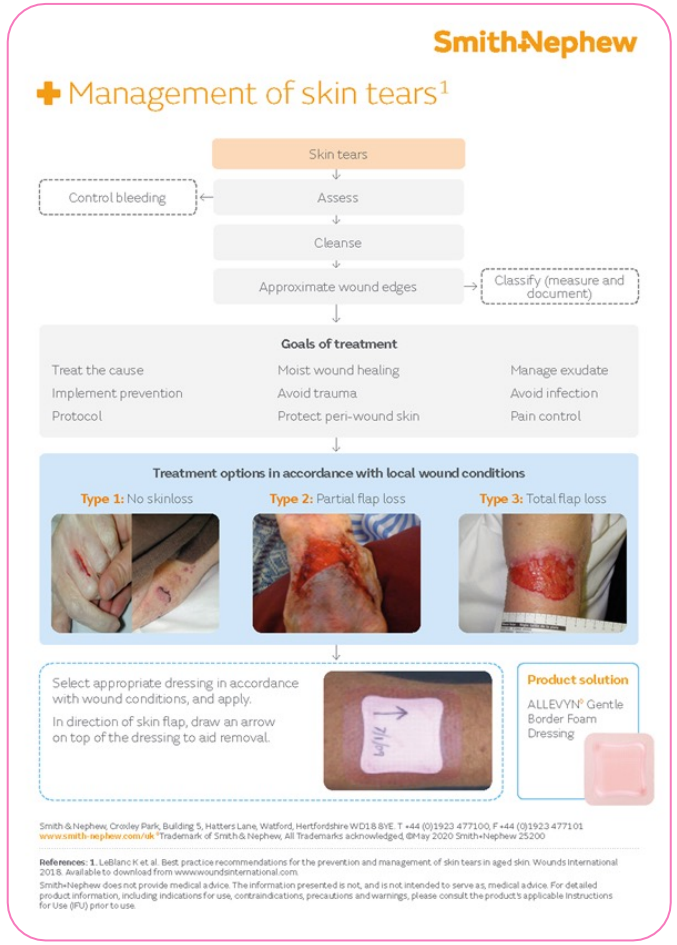
### Following healing

**Venous Leg Ulceration**

- Compression hosiery.
- 6-monthly review for replacement of compression garments and ongoing advice.
- If changes in lower limb symptoms or skin problems relating to hosiery, undertake comprehensive re-assessment.

(Figure: National Wound Care Strategy Programme, 2021[11])

# PATHWAYS AND MANAGEMENT



Smith+Nephew

## Management of skin tears[1]

Skin tears

Control bleeding ← Assess

Cleanse

Approximate wound edges → Classify (measure and document)

**Goals of treatment**

| | | |
|---|---|---|
| Treat the cause | Moist wound healing | Manage exudate |
| Implement prevention | Avoid trauma | Avoid infection |
| Protocol | Protect peri-wound skin | Pain control |

**Treatment options in accordance with local wound conditions**

**Type 1:** No skinloss | **Type 2:** Partial flap loss | **Type 3:** Total flap loss

Select appropriate dressing in accordance with wound conditions, and apply.

In direction of skin flap, draw an arrow on top of the dressing to aid removal.

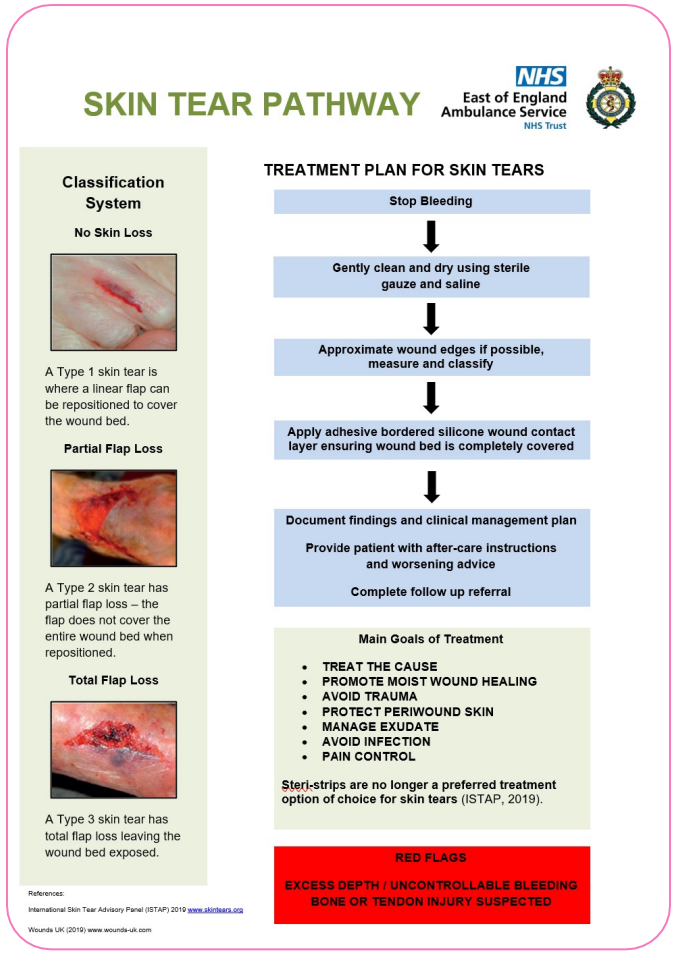
**Product solution**

ALLEVYN® Gentle Border Foam Dressing

Smith & Nephew, Croxley Park, Building 5, Hatters Lane, Watford, Hertfordshire WD18 8YE. T +44 (0)1923 477100, F +44 (0)1923 477101
www.smith-nephew.com/uk


**References: 1.** LeBlanc K et al. Best practice recommendations for the prevention and management of skin tears in aged skin. Wounds International 2018. Available to download from www.woundsinternational.com





## SKIN TEAR PATHWAY

NHS East of England Ambulance Service NHS Trust

**Classification System**

**No Skin Loss**



A Type 1 skin tear is where a linear flap can be repositioned to cover the wound bed.

**Partial Flap Loss**



A Type 2 skin tear has partial flap loss – the flap does not cover the entire wound bed when repositioned.

**Total Flap Loss**



A Type 3 skin tear has total flap loss leaving the wound bed exposed.

References:
International Skin Tear Advisory Panel (ISTAP) 2019 www.skintears.org
Wounds UK (2019) www.wounds-uk.com

**TREATMENT PLAN FOR SKIN TEARS**

**Stop Bleeding**

↓

**Gently clean and dry using sterile gauze and saline**

↓

**Approximate wound edges if possible, measure and classify**

↓

**Apply adhesive bordered silicone wound contact layer ensuring wound bed is completely covered**

↓

**Document findings and clinical management plan**

**Provide patient with after-care instructions and worsening advice**

**Complete follow up referral**

**Main Goals of Treatment**

- **TREAT THE CAUSE**
- **PROMOTE MOIST WOUND HEALING**
- **AVOID TRAUMA**
- **PROTECT PERIWOUND SKIN**
- **MANAGE EXUDATE**
- **AVOID INFECTION**
- **PAIN CONTROL**

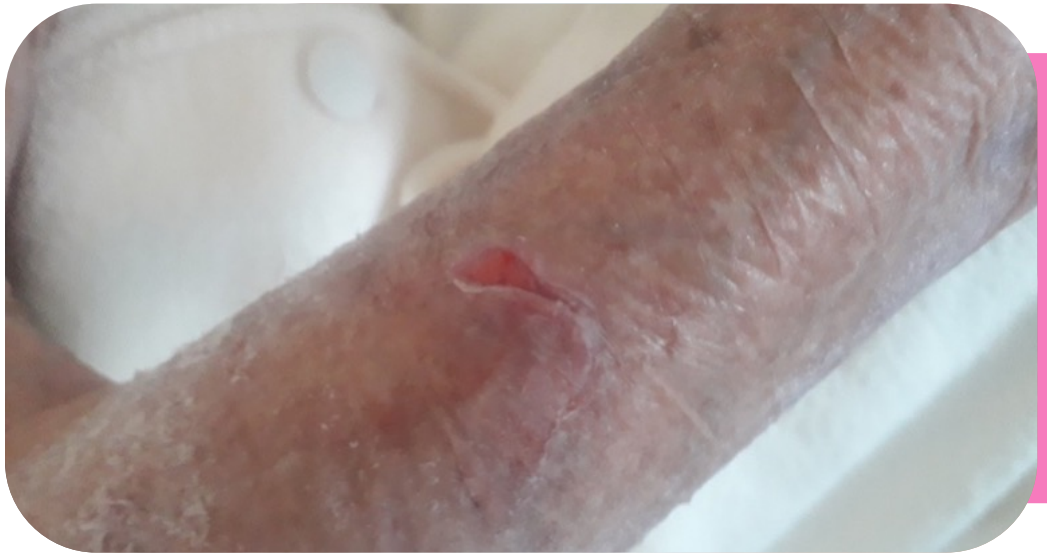
**Steri-strips are no longer a preferred treatment option of choice for skin tears** (ISTAP, 2019).

**RED FLAGS**

**EXCESS DEPTH / UNCONTROLLABLE BLEEDING**
**BONE OR TENDON INJURY SUSPECTED**

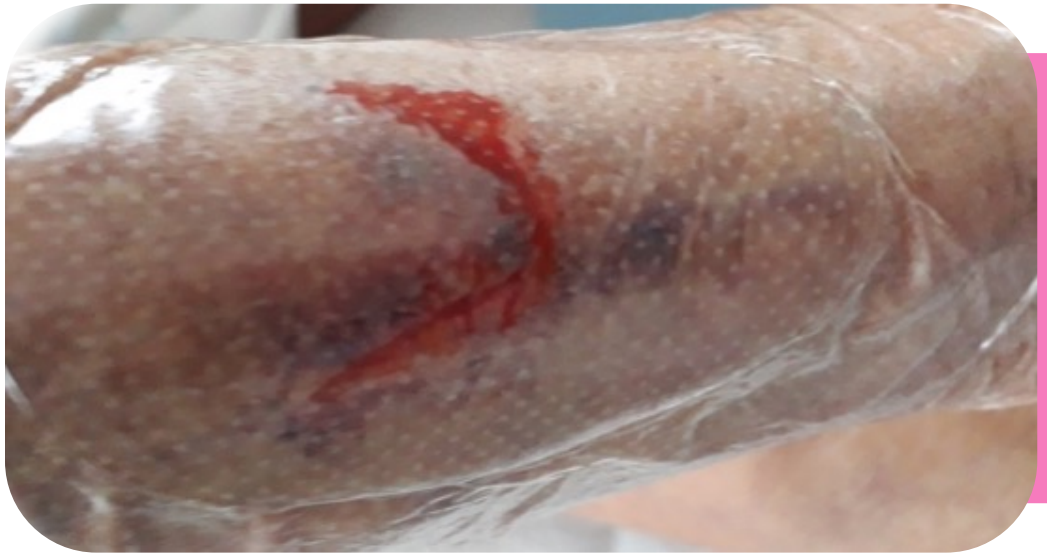
(Hickey and Ayres, 2021[12])

# AFTERCARE



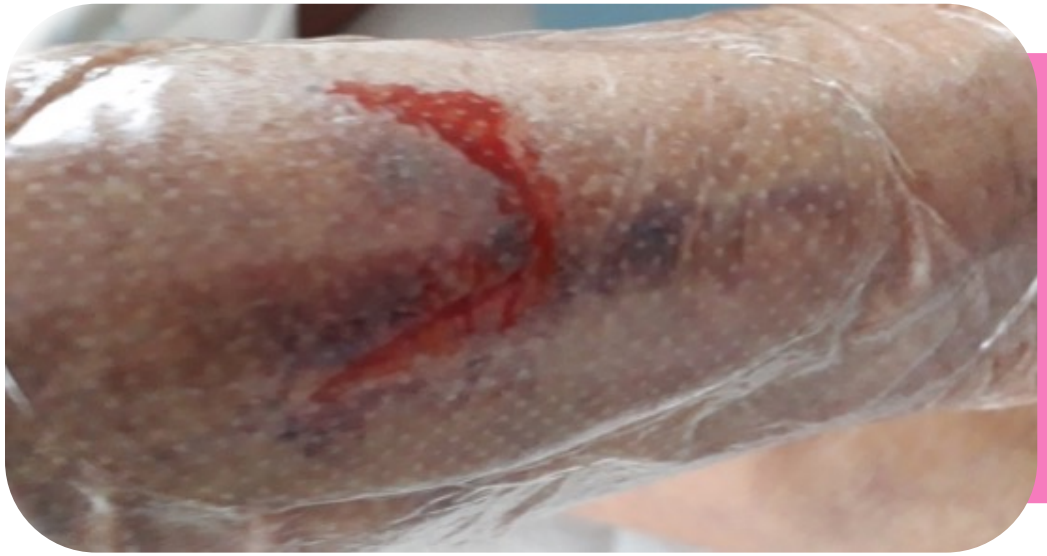
- Flap rolled out to reposition over wound
- Does not fully cover the wound bed
- Type 2: partial flap loss

# AFTERCARE



- Two weeks dressing in place
- Small open area left to heal

# AFTERCARE



- Skin Care

# NOT RESPONDING TO TREATMENT

If on the lower leg has compression been considered?

Infection and biofilm

T.I.M.E.[7-8]

Full holistic wound assessment considering factors delaying healing[6, 7]

Nutrition

# PREVENT ANOTHER[2]

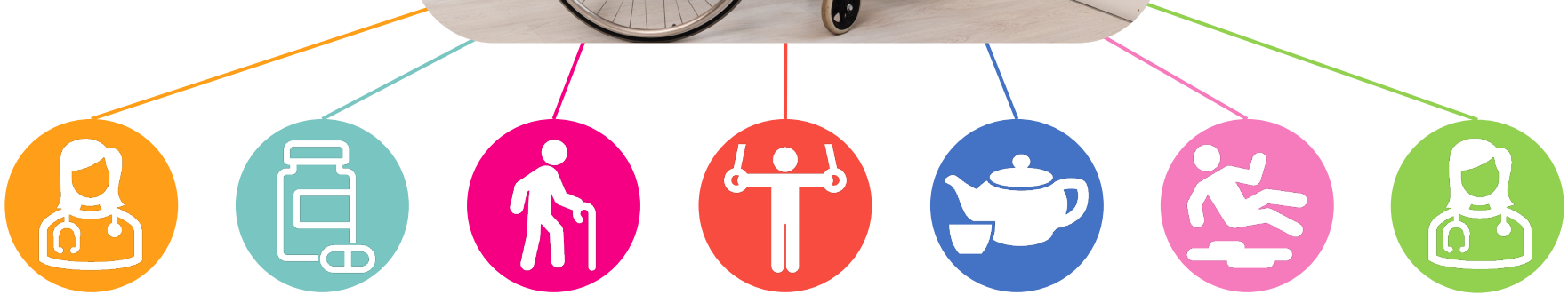
## Risk factors:

- Skin
- Mobility
- General Health

- MOISTURISE DRY SKIN
- PREVENT TRAUMA FROM ADHESIVES
- AVOID SHARP NAILS AND JEWELLERY
- ENVIRONMENT
- REDUCE FALLS RISK
- OPTIMISE

(LeBlanc et al, 2018[2])

# MULTIDISCIPLINARY TEAM



# MANAGEMENT AND TREATMENT OF SKIN TEARS

- Skin tears are **acute wounds** that have the potential to be closed by **primary intention**
- Traditionally, wounds closed by primary intention are secured with sutures, staples or adhesive strips; however, given the **fragility of aged skin** and that skin tears are **generally not deep**, these are **not viable options**
- The use of adhesive strips is **no longer recommended**[2].

(LeBlanc et al, 2018[2])

# SUITABLE DRESSINGS FOR SKIN TEARS

When skin tears occur, it is vital that the wound care products chosen will optimise wound healing and not increase the risk of further skin damage.

The **ideal dressing** for managing skin tears should:

- Control bleeding
- Be easy to apply and remove
- Not cause trauma on removal
- Provide a protective anti-shear barrier
- Be flexible and mould to contours
- Provide secure, but not aggressive, retention
- Afford extended wear time
- Be cost-effective

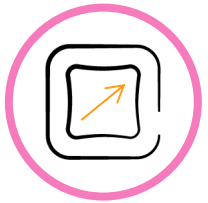
# SUITABLE DRESSINGS FOR SKIN TEARS

If possible, leave the dressing in place for **several days** to avoid disturbing the skin flap.

The skin flap should not be disturbed for at least five days to allow for **adherence to the cellular structures below**[13].


(Stephen-Haynes and Carville, 2011[13])

# TIPS IN PRACTICE



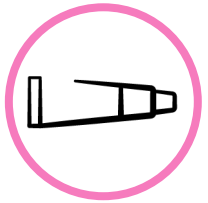
Mark the dressing with an **arrow to indicate the correct direction of removal** and make sure that this is clearly explained in the notes.

**Adhesive removers** can be used when removing the dressing to minimise trauma.

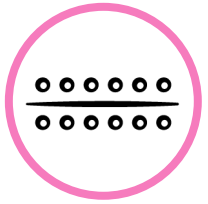
Take time to **remove dressings slowly**.

# TIPS IN PRACTICE

Consider using a **skin barrier product** to protect the surrounding skin (e.g. to prevent maceration if the wound has a high exudate volume).

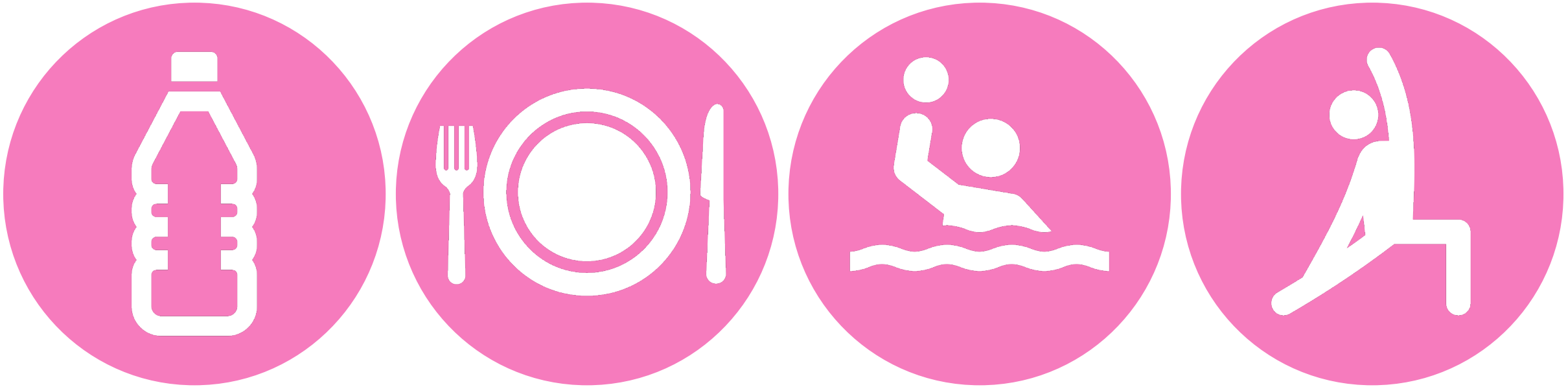


**Use an emollient** to soften and smooth wider skin area and prevent further tears.



Continue to **monitor the wound for changes or signs of infection**; if there is no improvement (e.g. after four assessments), or the wound deteriorates, refer to appropriate specialist as per local protocol.

# LET'S START NOW...



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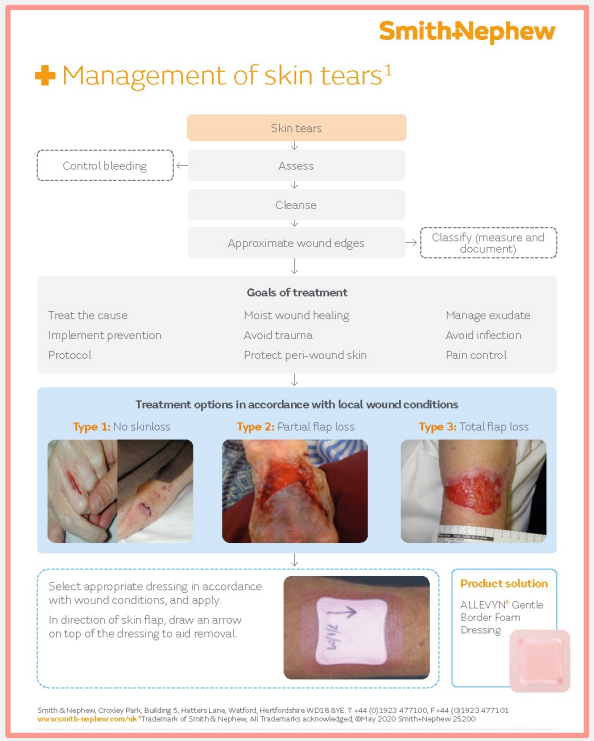
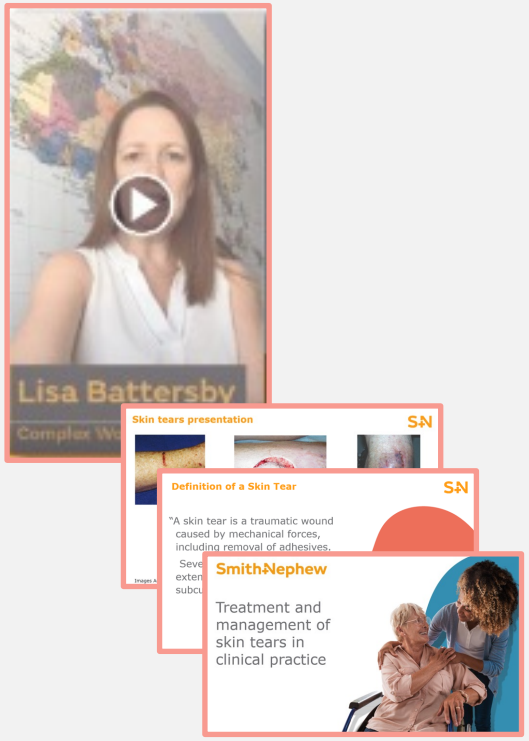
# RESOURCES

# SUPPORT FROM Smith+Nephew

## Pathway




## Training Materials




## Skin Tear Box


## Audits


JCN Journal of Community Nursing

woundclub with Smith+Nephew live

# SUPPORT FROM Smith+Nephew

ALLEVYN Gentle Border webpage

Questions

JCN

woundclub with Smith+Nephew live

# RESOURCES

Smith+Nephew website

Smith+Nephew Wound Club Online

skintears.org ISTAP

Wound Care Today website

TVS Website

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Building 5, Hatters Lane, Watford,
Hertfordshire WD18 8YE
T +44 (0) 1923 477100
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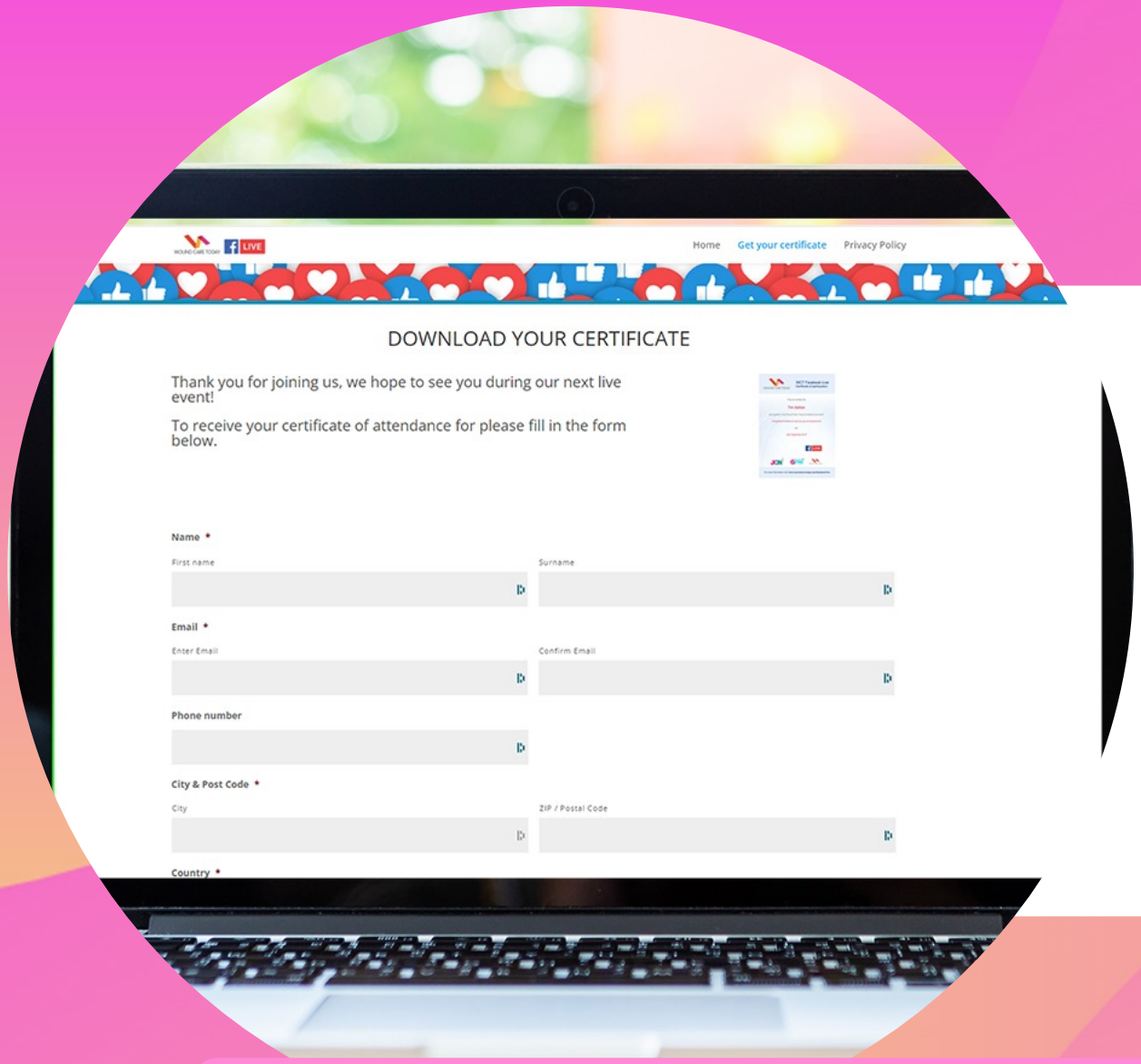


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