UNTIL RECENTLY, skin tears were an underappreciated wound that received very little attention or research. This article discusses standards and recommendations for the assessment, treatment, and prevention of skin tears developed by the International Skin Tear Advisory Panel (ISTAP) based on extensive literature reviews, international input from healthcare professionals, and expert opinion.

ISTAP defines a skin tear as "a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers. 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).”1,2

Skin tears have been reported in the literature as having prevalence rates equal to or greater than those of pressure ulcers.2 The role of identifying skin tears with a comprehensive skin assessment needs further study.

Skin tears are common acute wounds in older adults; however, infants and children are also at risk. Besides those at extremes of age, populations at the highest risk for skin tears include the critically or chronically ill. These patients have a higher risk for developing secondary wound infections.1,3,4

Patients suffering from skin tears complain of pain and decreased quality of life. By recognizing which patients are at risk for skin tears, preventing skin injuries, and using appropriate nonadherent dressings, clinical nurses can save patients undue pain and suffering.1,5 Although preventing skin tears is the primary focus of nursing care, nurses must also be equipped to manage these wounds when they do occur.

Taking a systematic approach
To help diminish the impact of skin tears on patients and the healthcare system, clinicians must implement a systematic prevention program. The
ISTAP has created a tool kit for the prevention, identification, and treatment of skin tears. Each component of the tool kit has been developed to complement other components. For complete information, visit http://www.skintears.org.

The tool kit outlined here was designed to include components that provide a basis for prevention and treatment programs. It includes the following components. For examples and more information, see supplemental digital content online and on the Nursing2014 iPad app.

- **Skin Tear Risk Assessment Pathway**, recommended to determine those at risk and in need of a risk reduction program. This pathway should be used when a patient is admitted to a healthcare setting and whenever the patient’s health status changes. This pathway is a useful tool not only for determining those at risk, but also for allocating resources. (See Skin tear risk assessment pathway.)
- **Quick Reference Guide for the ISTAP Risk Reduction Program**, designed to be used with the ISTAP Risk Reduction Program.
- **Skin Tear Decision Algorithm**, designed to help clinicians assess and treat skin tears, complement the pathway to the assessment/treatment of skin tears, and assist in skin tear

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classification and wound assessment. This algorithm links the classification and wound assessment to product selection options specific to skin tears and local wounds. The skin tear decision algorithm serves as a continuing link between assessing and treating skin tears. (See Skin tear decision algorithm.)

- **Pathway to Assessment/Treatment of Skin Tears**, which builds on the work of Sibbald et al. It was established to link the treatment and prevention of skin tears to the wound bed preparations paradigm. This promotes wound assessment and treatment in accordance with local wound conditions.

- **ISTAP Skin Tear Classification**, developed and validated by the ISTAP groups to allow for a universal language for identifying and documenting skin tears. (See ISTAP skin tear classification system.)

- **Prevalence Study Data Collection Sheet**, which provides a consistent method of collecting skin tear prevalence data. This research will build upon and support the identified risk factors for skin tears, which are currently based on expert opinion.

- **Medications that Can Affect the Skin**, a noninclusive list of drugs that may have a cutaneous or inflammatory interaction/reaction. (See Medications that can affect the skin.)

- **Drugs Associated with Risk of Falls**, which lists high-risk and moderate-risk drugs associated with falls in older adults.

- **Skin Tear Product Selection Guide**, established to identify products currently on the world market that allow for moist wound healing in accordance with wound conditions while respecting the fragile skin of patients at risk for skin tears.

**ISTAP risk reduction program**

The following outline summarizes ISTAP recommendations for reducing the risk of skin tears, noting the strength of evidence for each. (See Strength of evidence.)

1.0 GENERAL HEALTH

1.1 Altered sensory, auditory, and visual status

- **Individual**
  - (strength of evidence = C, D)
    - Participate actively in care.
    - Be cognizant of environment.

- **Healthcare provider/caregiver**
  - (strength of evidence = C, D)
    - Ensure safe environment.
    - Implement a falls assessment and reduction program.
    - Assess footwear.
    - Ensure that individual avoids wearing clothing that could injure the skin (for example, clothing that’s too tight or has zippers).
    - Educate individual and caregivers on safety concerns regarding individual risks for skin tears.

- **Healthcare setting**
  - (strength of evidence = C, D)
    - Recognize the need for and implement a comprehensive skin tear reduction program that includes minimizing risk associated with altered sensory status, including visual and auditory deficits and peripheral neuropathy.
    - Include the prevalence and incidence of skin tears in current wound audit programs.

- **Rationale:** Chronic disease, common in older adults, can lead to altered sensory function. The critically ill and the very young or the very old can also experience altered
Skin tear decision algorithm

1. Sensory status. Aging skin puts patients at risk for skin injury, including acute traumatic wounds or skin tears.

Care of older adults often involves managing those who are among the oldest and fastest-growing segment of the population (age 85 years and older). As people age, the normal wound-healing process slows and the risk of chronic disorders such as dementia, diabetes, and vascular disease increases. As the aging population grows, more individuals will be at risk for developing skin injuries, including chronic wounds and skin tears.

• Discussion: A history of falls has been strongly linked in the literature to an increased risk of skin tears. The patient and his or her caregivers must be part of a comprehensive team approach to ensure protection from potential risk factors. Review of the safety hazards that exist in the environment and the individual’s willingness to wear protective sleeves and trousers/pants is an integral part of any skin tear risk reduction program. (Fall prevention will be discussed in detail later.)

1.2 Cognitive impairment

• Individual (strength of evidence = C, D)
  – Participate actively in care.
  – Be cognizant of environment.

• Healthcare provider (strength of evidence = C, D)
  – Assess cognitive status.
  – Educate individual and caregivers on safety concerns regarding individual impairment and risks for skin tears.
  – Protect individual from self-harm when possible.

• Healthcare setting (strength of evidence = C, D)
  – Recognize the need for and implement a comprehensive skin tear reduction program, which includes minimizing risk associated with cognitive impairment.
  – Include the prevalence and incidence of skin tears in current wound audit programs.

• Rationale: Despite the paucity of literature concerning the causative factors for skin tears, some evidence suggests that altered levels of cognition in the older adult, pediatric, and critically or chronically ill individual increase the risk of skin tear development.

• Discussion: Various types of dementia and other chronic illnesses lead to altered cognitive status and can be an added challenge for caregivers. Cognitive impairment can decrease adherence to prevention programs due to lack of comprehension. Aggressive behavior and agitation associated with altered cognition and dementia can also increase the risk of blunt trauma and self-injury resulting in skin tears. Healthcare settings must support a comprehensive dementia management program in addition to a skin tear prevention program to fully address dementia-related issues and their relationship to skin tear development.

The very young or developmentally challenged individual can’t be forgotten when managing skin tears.
Lack of cognition or insight potentially increases the risk of skin tears in this population. Healthcare providers must be able to intervene on the individual’s behalf to ensure that skin tear prevention strategies are in place and that every attempt is made to ensure maximal understanding of the risks. Family/caregiver education should be the primary focus for the neonatal and developmentally challenged individual.12

1.3 Nutritional concerns

• Individual
  (strength of evidence = C, D)
  – Optimize nutrition and hydration.

• Healthcare provider
  – Consult a dietitian to optimize nutrition and hydration. (A)
  – Promote and monitor nutrition and fluid intake appropriate to age and physiologic status; increase fluid intake as appropriate. (A)
  – Be aware that extremes of weight (for example, bariatric or cachectic) require extra care to prevent skin tears. (C, D)

• Healthcare setting
  (strength of evidence = C, D)
  – Recognize the need for and implement a comprehensive skin tear reduction program, which includes optimizing nutritional support and hydration.
  – Include the prevalence and incidence of skin tears in current wound audit programs.

• Rationale: Adequate nutrition and hydration help maintain tissue viability.15 Assessment of each individual’s nutritional status is vital to ensure health and well-being. Older adults can be at great risk for nutritional impairment. Of hospitalized older adults, 25% to 30% are undernourished, and 46% to 61% are at risk for being undernourished.16

• Discussion: Nursing assessment to determine nutritional status includes monitoring intake, using the Braden subscale on nutrition, and assessing for low body mass index (<18.5 kg/m²), unintentional weight loss, anorexia, difficulty chewing, and lack of dentures or teeth. Weight loss may be suspected from the presence of loose-fitting clothes or jewelry. Lab values for serum protein, zinc, albumin, and prealbumin levels also help the nurse assess nutritional status.5,16,17

Both obese and undernourished patients can be at risk for adverse effects on tissue/body structure and function. Malnutrition can delay healing and increase infection risk. If a patient consumes less than 50% of his or her meals for more than 3 days, a nutrition consult is warranted.15-17 At that time, he or she should be assessed for the possible need for an appetite stimulant and supplemental vitamins and minerals in addition to the regular diet.17

Adequate hydration is essential for maintaining skin integrity: It can mean the difference between minor trauma causing an ecchymosis or a skin tear.15,19 Dehydration can be assessed by monitoring intake and output, skin turgor, and changes in weight, and by lab values such as serum sodium and osmolality levels.17,18

Vitamins A, B, C, and D, iron, zinc, and copper are needed to maintain healthy skin.5,17,18,20 Clear evidence shows that calcium and vitamin D supplementation reduces the risk of fractures after falls in ambulatory or institutionalized older adults.20 Daily supplementation of 1 to 1.2 g of calcium in combination with at least 800 international units of vitamin D as cholecalciferol (vitamin D3) has been shown to improve both body sway and muscle function in older adults, reducing overall fall risk by more than 20%.20

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**ISTAP skin tear classification system**

**Type 1: No skin loss**
Linear or flap tear that can be repositioned to cover the wound bed

**Type 2: Partial flap loss**
Partial flap loss that can’t be repositioned to cover the wound bed

**Type 3: Total flap loss**
Total flap loss exposing the entire wound bed
1.4 Polypharmacy

- **Individual**
  (strength of evidence = A, B, C, D)
  - Be aware of potential for skin changes with certain medications, such as corticosteroids. (C)
  - Discuss all medications with prescriber or pharmacist.

- **Healthcare provider**
  (strength of evidence = A, B, C, D)
  - Consult with multidisciplinary team to monitor effects of polypharmacy on the individual’s skin; perform medication reconciliation. (C, D)

- **Healthcare setting**
  (strength of evidence = A, B, C, D)
  - Recognize the need for and implement a comprehensive skin tear reduction program, which includes supporting a multidisciplinary team to monitor polypharmacy. (C, D)
  - Consider automatic alerts when certain medications or doses are prescribed. (D)
  - Include the prevalence and incidence of skin tears in current wound audit programs. (D)

- **Rationale:** Polypharmacy (the use of multiple medications that might predispose patients to drug interactions/reactions or confusion) is common among older adults. Numerous medications can be associated with negative health outcomes, including cutaneous reactions and falls, but more research is needed to further delineate the consequences associated with multiple drug use, especially in older adult patients.

- **Discussion:** Various medications can affect the skin, the most common being corticosteroids, which can interfere with epidermal regeneration and collagen synthesis.\textsuperscript{14,15} Corticosteroids may be a contributing factor in skin tear development. Polypharmacy has also been implicated as an independent risk factor for falls.\textsuperscript{21-24} Pervin's research concluded that individuals receiving four or more medications are at a greater fall risk.\textsuperscript{52} In a recent consensus document pertaining to the prevention, assessment, and treatment of skin tears, LeBlanc et al. identified falls as another major risk factor in the development of skin tears. Healthcare professionals should be aware of the risks and fully evaluate all medications to prevent polypharmacy.

2.0 MOBILITY

2.1 Mobility-related issues

- **Individual**
  (strength of evidence = C, D)
  - Participate actively in care.
  - Be cognizant of environment.

- **Healthcare provider**
  (strength of evidence = C, D)
  - Ensure safe handling techniques and safe equipment.
  - Perform daily skin assessments and monitoring for skin tears.
  - Be aware that patients with weight extremes (bariatric, underweight, and cachectic patients) require extra care to prevent skin tears.

- **Healthcare setting**
  (strength of evidence = C, D)
  - Recognize the need for a comprehensive skin tear reduction program, including minimizing risk associated with mobility-related issues.
  - Include the prevalence and incidence of skin tears in current wound audit programs.

- **Rationale:** When skin tears are reported, the causative factor is often not known.\textsuperscript{25-27} Nevertheless, skin tears are frequently linked to wheelchair injuries, falls, transfers, or blunt trauma from bumping into objects.\textsuperscript{5} Skin tears are also reported to occur around peak care times. White et al. concluded that most skin tears occur during the peak activity hours of 0600 to 1100 and 1500 to 2100.\textsuperscript{25}

- **Discussion:** In older adults, skin tears are often environmentally related.\textsuperscript{10} In 1990, Payne and Martin conducted a 3-month descriptive study in 10 long-term-care facilities to describe skin tears, identify risk factors, and determine the rate of healing of skin tears.\textsuperscript{56} Among the predominant risk factors, impaired activity, mobility, sensation, and cognition all demonstrated an increased risk for skin tear development. McGough-Csarny and Kopac conducted a similar study in a Veterans Affairs long-term-care facility and concluded that dependency for activities of daily living (ADLs), sensory loss, limited mobility, use of assistive devices, and impaired cognition were risk factors for skin tear development.\textsuperscript{27}

Individuals at risk for skin tears, care providers, and healthcare settings must all identify the mobility-related issues associated with skin tears and incorporate a united approach to minimizing these risks.\textsuperscript{5} These mobility-related issues may include blunt trauma to shins, hands, and arms secondary to hitting objects when seated in a wheelchair or when using canes and walkers, and inadvertent skin tears when using transfer devices or other movement aids.\textsuperscript{5}

Strategies for preventing mobility-related skin tears include, but aren't limited to, the following:

- **padding devices and hard objects in the individual’s environment**
- **long sleeves and trousers**
- **knee-high socks**

**Medications that can affect the skin**\textsuperscript{14,15}

Be aware that use of the following can cause various types of cutaneous or inflammatory interactions/reactions:

- **Antibacterials**
- **Antihypertensives**
- **Analgesics**
- **Tricyclic antidepressants**
- **Antihistamines**
- **Antineoplastic drugs**
- **Antipsychotic drugs**
- **Diuretics**
- **Oral diabetes agents**
- **Nonsteroidal anti-inflammatory drugs**
- **Oral contraceptives**
- **Steroids**
• gloves
• skin/elbow pads
• uncluttered environment.

2.2 Assistance with ADLs

• Individual
  (strength of evidence = C, D)
  – Participate actively in care.
  – Be cognizant of environment.

• Healthcare provider
  (strength of evidence = C, D)
  – Provide protection from trauma during routine care and ADLs.
  – Use proper transferring and positioning techniques.
  – Ensure a safe environment.
  – Educate individuals and caregivers on proper transferring and positioning techniques.

• Healthcare setting
  (strength of evidence = C, D)
  – Include the prevalence and incidence of skin tears in current wound audit programs.

• Rationale: Individuals frequently acquire skin tears during routine activities such as dressing, bathing, positioning, and transferring. Those who are dependent on others for total care are at the greatest risk for skin tears. Individuals who are independent in ambulation report high numbers of skin tears, occurring primarily on the lower extremities. A 2011 survey reported that the perceived top causes of skin tears included equipment injury, patient transfers, falls, ADLs, treatment, and dressing removal.

• Discussion. Nurses must educate caregivers on gentle handling of older adults with fragile skin. Any harsh movement or pulling can create a skin tear. Patients and families should understand the importance of proper positioning, turning, lifting, and transferring. Use lift sheets to move patients up in bed. Provide padding for side rails, wheelchair arm and leg supports, and other equipment. Patients at risk are encouraged to wear long sleeves and trousers/pants for added protection. Patients and caregivers should keep their fingernails short; use no-rinse, pH-balanced soap for bathing; and moisturize the skin with creams rather than lotions.

Unlike lotions, cream moisturizers donate moisture and help retain moisture on the skin surface.

A comprehensive assessment of risk factors for skin tears should be conducted for all individuals within the context of their environment. Just as pressure ulcer risk assessment may reduce the prevalence of pressure ulcers, identifying those at high risk for skin tears and instituting prevention strategies may reduce skin tears.

National guidelines and the ISTAP skin tear tool kit recommend a comprehensive head-to-toe assessment upon admission to a healthcare service and thereafter whenever the individual’s condition changes or per agency/facility policy. The Registered Nurses’ Association of Ontario, National Pressure Ulcer Advisory Panel, and the National Institute for Clinical Health and Excellence guidelines support the use of validated risk assessment tools.

2.3 History or risk of falls

• Individual
  (strength of evidence = C, D)
  – Participate actively in care.
  – Be cognizant of environment.
  – Utilize assistive devices as prescribed.
  – Work with caregivers to follow falls prevention program when capable.

• Healthcare provider
  (strength of evidence = C, D)
  – Initiate falls prevention program per facility/institution/workplace policy. Program should include pediatric/neonatal patients when appropriate.
  – Create a safe environment.
  – Maintain a well-lit environment.
  – Ensure safe handling techniques and safe equipment.

• Healthcare setting
  (strength of evidence = C, D)
  – Recognize the need for and implement a comprehensive skin tear reduction program that includes a falls prevention program.
  – Include the prevalence and incidence of skin tears in current wound audit programs.
• **Rationale:** Falls pose a serious risk of skin tears for older adults. An average long-term-care facility with 100 beds reports 100 to 200 falls annually. Preventing falls in older adults requires several different approaches to mitigate factors that may predispose older adults to this type of injury.

• **Discussion:** A fall is defined as a sudden, unintentional change in position, which results in an individual hitting either the ground or another object below his or her starting point. The American Medical Directors Association reports that falls are a significant cause of injury and death in older adults living in long-term-care facilities. According to McCarthy et al., falls are the leading cause of fatal and nonfatal injuries among Americans age 65 or older, resulting in more than 2 million ED visits.

Predisposing factors for falls include unsteady gait and balance, weak muscles, poor vision, medications, and dementia. Other factors that may contribute to falls include poor lighting, loose rugs, poorly fitting shoes, floor clutter, urinary urgency, and beds or toilets without handrails. Medical conditions that may lead to falls in older adults include hypotension, stroke, Parkinson disease, arthritis, Ménière disease (which causes episodic vertigo), poorly controlled diabetes, thyroid disorders, poorly controlled epilepsy, and other brain disorders.

An important step in reducing skin tear risk is the introduction of a falls prevention program supported by the individual at risk, care provider, and healthcare setting. Implementing a best-practice fall prevention program has proven to be successful in reducing falls in older adult, long-term-care patients. However, best-practice guidelines can be successfully implemented only with adequate planning, resources, organization, and administrative support.

**Practice pearls**

• **Skin tears are acute wounds that have a high risk of becoming complex chronic wounds.**

• **Skin tears have been reported in the literature to have prevalence rates equal to or greater than those of pressure ulcers.**

• **Although commonly associated with older adults, skin tears are also common in the critically ill, pediatric, and premature neonatal population.**

• **A comprehensive risk assessment should include assessment of the individual’s general health (chronic/critical disease, polypharmacy, cognitive, sensory, and nutritional status), mobility (history of falls, impaired mobility, dependent activities, and mechanical trauma), and skin (extremes of age, fragile skin, and previous skin tears).**

• **The ISTAP Skin Tear Classification system should be utilized to ensure a common language for identifying and documenting skin tears.**

2.4 **Mechanical trauma (not related to mobility aids)**

• **Individual**
  (strength of evidence = C, D)
  – Participate actively in care.
  – Be cognizant of environment.
  – Practice behaviors that will reduce the incidence of skin tears.
  – Remove clutter from environment.
  – Avoid using adhesives on skin.

• **Healthcare provider**
  (strength of evidence = C, D)
  – Implement safe activities for those who are at risk for skin tears.
  – Hydrate skin with hypoallergenic moisturizers after bathing, with the skin still damp, not wet; use warm/tapid water for bathing.
  – Utilize soapless, no-rinse, and/or pH-neutral skin cleansers.
  – Provide those at risk with protective clothing, such as long sleeves, long pants/trousers, or knee-high socks or shin/elbow guard pads.
  – Avoid adhesive products on fragile skin. If dressings or tapes are required, use nontraumatic paper/silicone tapes, nonadherent contact layers, nonadherent/silicone foam dressings, or other topical dressings specifically formulated for management of fragile skin, to avoid stripping or tearing the skin with removal. (Ensure proper removal of all adhesives.)
  – Keep caregiver and patient fingernails and the patient’s toenails short and filed to remove rough edges and prevent self-inflicted skin tears.
  – Ensure a safe environment: pad bed rails, wheelchair leg rests, furniture edges, and other objects that may cause blunt trauma; remove unnecessary equipment from environment and keep the environment well lit.
  – Initiate falls prevention program per facility/institution or workplace policy. Program should include the pediatric population when appropriate.
  – Use proper positioning, turning, lifting, and transferring techniques.
  – Provide extra protection (padding) of the skin for individuals with extremes of weight (bariatric, underweight, or cachectic).
  – Educate staff/caregivers on prevention and treatment of skin tears; communicate with other healthcare professionals about the need for gentle care.

• **Healthcare setting**
  (strength of evidence = C, D)
  – Recognize the need for and implement a comprehensive skin tear reduction program, which includes minimizing risk associated with mechanical trauma. Utilize atraumatic topical wound care products to minimize the risk of skin tears with dressing and/or adhesive removal.
  – Include the prevalence and incidence of skin tears in current wound audit programs.

• **Rationale:** Intrinsic factors, such as age, pertain to an individual’s inherent biologic or genetic makeup. Extremes in age impact not only...
how individuals heal but also their susceptibility to developing a wound.8 With increasing age, individuals experience dermal and subcutaneous tissue loss, epidermal thinning, and serum composition changes, all of which increase skin vulnerability to trauma.1,4,10,12 In turn, the skin's elasticity and tensile strength decrease.5,14,15,30 These factors are common in older adults in all care settings and combine to increase the skin's vulnerability to trauma.1-4,43-46

• Discussion: Premature and term neonates are also susceptible to skin tears. Normally, a child’s epidermis is only 60% of an adult’s epidermal thickness, and the skin of premature neonates is underdeveloped.12 Neonates have decreased epidermal-to-dermal cohesion, deficient stratum corneum, impaired thermoregulation, a body surface-weight ratio nearly five times greater than that of an adult, and immature immune, hepatic, and renal systems. A combination of these factors places this population at increased risk for epidermal stripping, infection, and increased transepidermal water loss with resultant heat loss, and toxicity.12,43-46

Mechanical trauma causing skin tears is often related to topical dressing choices and dressing removal techniques.1,2,5 Blunt trauma from falls, dressing/changing clothing, bathing, and repositioning1,4,3-46 Changes related to aging skin, immature skin, or skin affected by chronic or acute illness increase the risk of mechanical trauma. Among neonates, mechanical trauma is the number one cause of skin tears.12

3.0 SKIN

3.1 Skin changes related to extremes of age and critical illness

• Individual (strength of evidence = C, D)
  – Participate actively in care.
  – Be cognizant of environment.
  – Know if the individual is at risk for skin tears and how to reduce the risk of skin tears.
  – Practice behaviors that will reduce the incidence of skin tears.

• Healthcare provider (strength of evidence = A, B, C, D)
  – Implement safe activities for those at risk for skin tears.
  – Hydrate skin with hypoallergenic moisturizers after bathing when the skin is still damp, not wet; use warm/tepid water for bathing.
  – Utilize soapless, no-rinse, and/or pH-neutral skin cleansers.
  – Provide those at risk with protective clothing, such as long sleeves, long pants/trousers, or knee-high socks or shin/elbow guard pads.
  – Avoid adhesive products on fragile skin. If dressings or tapes are required, use nontraumatic paper/silicone tapes, nonadherent contact layers, nonadherent/silicone foam dressings, or other topical dressings specifically formulated for management of fragile skin, to avoid stripping or tearing the skin with removal.
  – Keep caregiver and patient fingernails and the patient's toenails short and filed to remove rough edges and prevent self-inflicted skin tears.
  – Educate staff/caregivers on the importance of gentle care.

• Healthcare setting (strength of evidence = C, D)
  – Recognize the need for and implement a comprehensive skin tear reduction program, which includes addressing skin considerations related to extremes of age. Support the use of atraumatic topical dressing options to treat skin tears to minimize the risk of further skin damage.
  – Include the prevalence and incidence of skin tears in current wound audit programs.

• Rationale: Skin tears commonly develop in individuals at the extremes of age, the critically ill or medically compromised, and those requiring assistance with personal care.1,5

• Discussion: As the skin ages, many changes occur within the dermis making the skin more susceptible to skin tears:
  1. Loss of subcutaneous fat and atrophy, specifically in the face, dorsal aspect of the hands, shins, and plantar aspects of the foot, increases the energy absorbed by the skin during trauma, raising the risk of skin tears.14,15,46
  2. Blood vessels become thinner and more fragile, leading to hemorrhaging (senile purpura). Skin tears often occur at sites of senile purpura.14,15,47
  3. The skin's elasticity and tensile strength decrease and skin becomes more easily stretched because of a decrease in elastin fibers.14,15,47-49
  4. The flattening of rete ridges/pegs (epithelial extensions that project into the underlying connective tissue in both skin and mucous membranes) results in a less effective anchoring of the epidermis to dermis, making the skin more susceptible to shearing and separation of the skin layers.7,15
  5. Rete ridge flattening also impairs the ability of the skin to retain moisture. This flattening, in combination with diminished or loss of sebaceous and sweat gland activity, results in xerosis cutis (dry skin),

Mechanical trauma causing skin tears is often related to topical dressing choices and dressing removal techniques.
which makes the skin more vulnerable to trauma.\textsuperscript{4,13}
Skin cleansers can further alter the stratum corneum by reducing the thickness and number of cell layers and by removing lipids, natural lubrication, and resident bacteria (normal flora). Harsh soaps (especially those with a high pH) dry the skin by interfering with its water-holding capacity.\textsuperscript{1,5}

4.0 SKIN TEAR MANAGEMENT AND TREATMENT

4.1 Management or treatment of skin tears. This varies according to institution, and little has been published regarding preferred treatments for skin tears. However, completing a thorough wound assessment is fundamental.\textsuperscript{30} To adequately treat wounds, several areas must be addressed: coexisting factors, nutritional support, pain management, local wound conditions, and optimal dressing selection.\textsuperscript{6}

4.2 Wound assessment

- Assess skin flap or pedicle, and determine the type of skin tear using the ISTAP classification (types I, II, III).
- Control bleeding.
- Cleanse the wound with 0.9% sodium chloride solution or wound surfactant.
- Remove debride and/or necrotic tissue.
- Realign pedicle or skin flap (don’t remove flap unless necrotic).
- Assess fragility of surrounding skin.
- Prevent infection.
- Control pain.
- Promote healing and patient comfort with appropriate dressing selection.

Administer tetanus immune globulin (TIG) if indicated according to institution protocol.\textsuperscript{51} Administer TIG before wound debridement because wound manipulation may release exotoxin.\textsuperscript{51}

4.3 Dressing selection

Many types of skin and wound care products are used to promote a healing environment. Actual product selection depends on wound assessment.\textsuperscript{3,5,6,32,33} Choose a dressing that will:
- maintain a moist wound-healing environment.
- be appropriate for the local wound environment.
- protect the periwound skin.
- control or manage exudate.
- control or manage infection.
- optimize caregiver time.

Best practice supports that a skin flap/pedicle should be approached if possible and covered with one of the following dressing types: hydrogel, alginate, lipido-colloid–based mesh, foam dressing, soft silicone, absorbent clear acrylic dressing, or nonadherent impregnated gauze mesh dressing applied depending on wound bed characteristics.\textsuperscript{1} Hydrocolloids and transparent film dressings aren’t recommended over skin tears, as they may cause skin stripping and injury to the healing skin if not removed properly.\textsuperscript{52}

**Interprofesional approach to care**

The ISTAP tool kit for healthcare professionals provides recommendations for effective skin tear prevention, identification, and treatment through an interprofessional approach to care. The document includes an implementation guide with tools and resources designed to be used in multiple healthcare settings and by all levels of staff and caregivers.

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Complete the registration information and course evaluation. Mail the completed form and registration fee of $27.95 to: Lippincott Williams & Wilkins, CE Group, 74 Brick Blvd., Bldg. 4, Suite 206, Brick, NJ 08723. We will mail your certificate in 4 to 6 weeks. For faster service, include a fax number and we will fax your certificate within 2 business days of receiving your enrollment form.

You will receive your CE certificate of earned contact hours and an answer key to review your results. There is no minimum passing grade.

Registration deadline is May 31, 2016.

Send two or more tests in any nursing journal published by Lippincott Williams & Wilkins together by mail, and deduct $0.95 from the price of each test.

We also offer CE accounts for hospitals and other healthcare facilities on nursingcenter.com. Call 1-800-787-8985 for details.

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Your certificate is valid in all states.

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