Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West CCAC contracted Community Nursing Agencies in the South West Local Health Integration Network.	
Title	**Guideline: The Assessment of People with Skin Tears and/or Pre-Tibial Injuries**
Background	1. Skin tears are traumatic wounds which result from friction and/or shear or blunt trauma, separating the epidermis from the dermis (partial thickness wound), or the epidermis and the dermis from the underlying structures (full thickness wound)[5] 2. Skin tears are often difficult to heal as they are associated with aging, and as such, with co-existing illnesses 3. The most common causes of skin tears are[5]: a. Wheelchair injuries (25%) b. Accidentally bumping into objects (25%) c. Transfers (18%) d. Falls (12.4%) 4. 80% of skin tears occur on the arms, most frequency the forearms[1, 5] 5. Skin tears most often occur during peak activity hours, i.e. between 0600-1100 and 1500-2100[2, 5] 6. By using a skin tear risk assessment tool, persons at risk can be identified and appropriate interventions initiated to prevent injury[4] 7. Risk factors for the development of skin tears[3, 5]: a. Advanced age (>85) b. Female gender c. Caucasian race d. Immobility e. Inadequate nutritional intake f. Long-term use of corticosteroids g. History of previous skin tears h. Altered sensory status i. Cognitive impairment j. Stiffness and spasticity k. Polypharmacy l. Presence of ecchymosis m. Dependence in activities of daily living n. Use of assistive devices o. Application and removal of stockings p. Removal tape/adhesives from the skin q. Vascular problems, cardiac, pulmonary, and/or visual problems r. Neuropathy 8. Pre-tibial injuries refer to a broad spectrum of injuries, from small linear lacerations to major de-gloving injuries of the dorsal aspect of the lower leg (the shin) 9. The most common causes of pre-tibial injuries are:

	a. Striking household items and/or furniture (>44%) b. Garden objects (24%) 10. Women are at greater risk for pre-tibial injuries than men, and those over the age of 60 are at increased risk
Indications	This guideline is intended to be used by front line registered health care providers, to guide their assessment of individuals admitted or presenting with a skin tear or pre-tibial injury.
Guideline	**NOTE: The assessment of a person with a skin tear or pre-tibial injury follows the "SWRWCP's Skin Tear/Pre-Tibial Injury Assessment and Management Algorithm".** 1. Upon discovery of a skin tear or pre-tibial injury on a person or upon admission of a person with such a wound to your health care facility/service, conduct a history and focused physical assessment using the SWRWP's "Initial Wound Assessment Form" (see "Procedure: Initial Wound Assessment Form"), if not already done, to determine the persons: a. Health/medical history (and the persons understanding of these) b. Nutritional status c. Wound history d. Wound related pain and quality of life (pain can be an indicator of infection) e. Extrinsic, intrinsic, and iatrogenic factors affecting wound healing and putting the person at risk f. Concordance concerns This form contains the "Nestle Mini Nutritional Assessment (MNA©) Tool" used to evaluate whether a person is malnourished or at risk for malnourishment, which can negatively affect wound healing [see "Procedure: Nestle Mini Nutritional Assessment (MNA©) Tool"]. ***NOTE: Individual permission must be obtained by each organization wishing to use the MNA©*** 2. Assess the person's risk for developing a skin tear using the SWRWCPs "Skin Tear Risk Assessment Tool" (see "Procedure: Skin Tear Risk Assessment Tool'), and categorize the person into the appropriate risk group, i.e. group 1, 2, 3, as this will help guide preventative interventions. ***NOTE: ideally all persons 70 years of age or older, or younger if you suspect risk for skin tears or if they have had a skin tear in the past, and ALL individuals on continuing care units in hospitals and in long-term care homes, should have skin tear risk assessments conducted at admission, quarterly, and when there is a significant change in their overall health to ensure appropriate preventative measures are in place*** 3. If the person has a skin tear on their lower leg or a pre-tibial injury, complete (or review if already completed) the "Interdisciplinary Lower Leg Assessment Form" (see "Procedure: Interdisciplinary Lower Leg Assessment Form") to systematically physically assess the

persons lower leg for:

a. Edema, lymphedema, lipidema (if they so present with such issues)
b. Signs of venous/arterial/mixed leg disease
c. The quality of the person's lower limb circulation (pedal pulses and ABIs) - ***NOTE: people with normal arterial circulation can have absent peripheral pulses due to edema or a fixed ankle joint. Palpable pulses in people with calcified vessels, i.e. those with diabetes, can be misleading and therefore the ability to palpate a pedal pulse in such a person does not necessarily indicate the absence of peripheral arterial disease.*** Ankle brachial index (ABI) tests should be performed by a healthcare professional trained in such testing, i.e. an Enterostomal Therapy (ET) Nurse or Wound Care Specialist (WCS) – ***NOTE: if a person has long-standing diabetes, hypertension or advanced age, the vessels may not be compressible and segmental compression studies or toe pressures may need to be ordered through a diagnostic imaging in order to accurately determine the status of the person's lower limb circulation***

4. Conduct a psychosocial assessment to determine the:
    a. Person's understanding of the wound and their risk factors
    b. Impact of the wound on the person and their body image
    c. Financial concerns and availability of support systems to address concerns
    d. Impact of the persons environment, physical/medical/psychosocial factors, and end-of-life goals on their care, as applicable
    e. Person's preferences for treatment and motivation to comprehend and adhere to the plan of care
    f. Functional, cognitive, and emotional status of the person and their family to manage self-care
    g. Date of the person's last tetanus shot
5. Assess the wound using the "NPUAP PUSH Tool 3.0" (see "Procedure: NPUAP PUSH Tool 3.0"). A comprehensive reassessment using the same tool should be completed weekly at a minimum to determine the wounds progress and the effectiveness of the treatment plan. ***NOTE: Wound measurements (length and width) should be recorded on admission and at least weekly, with a calculation performed to determine the percentage reduction in wound surface area, i.e. a 20-30% reduction in surface area after three - four weeks treatment is predictive of timely wound closure***
6. Classify the skin tear using the "Payne-Martin Classification for Skin Tears" (see "Procedure: Classifying Skin Tears Using the Payne-Martin Classification System for Skin Tears"). For pre-tibial injuries, classify the injury according to the degree of trauma, i.e.:
    a. Type I: Laceration

	b. Type II: Laceration or flap with minimal hematoma and/or skin edge necrosis c. Type III: Laceration or flap with moderate hematoma and/or skin edge necrosis d. Type IV: Major de-gloving injury 7. Assess the wound for signs/symptoms of increased bacterial burden using the "Bioburden Assessment Tool" (see "Procedure: Bioburden Assessment Tool"), as per the "Guideline: Assessment and Management of Bacterial Burden in Acute and Chronic Wounds". ***NOTE: in those with lower leg skin tears or pre-tibial injuries, visible evidence of infection may be muted or non-existent in those with compromised arterial blood flow to their lower legs or in those with diabetes*** 8. Assess the wound's moisture balance and appropriateness of the current dressing using the "Guideline: The Assessment and management of Moisture in Acute and Chronic Wounds" 9. Assess the wound to determine if debridement interventions are warranted. See "Guideline and Procedures: Wound Debridement (excluding conservative sharp debridement) and "Guideline and Procedure: Conservative Sharp Wound Debridement" 10. Determine the healability of the person's skin tear/pre-tibial injury based on your holistic assessment, the persons/caregivers willingness to participate in and adhere to the plan of care, and based on the results of use of the "Determining Healability Tool" (see "Procedure: Determining Healability Tool"). Choose the most appropriate wound healing goal: a. Healable b. Maintenance c. Non-healable/palliative 11. Once you have completed a thorough assessment of the person and their skin tear/pre-tibial injury and determined their 'healability', you may proceed to implement appropriate interventions, as outlined in "Guideline: The Management of People with Skin Tears and/or Pre-Tibial Injuries"
References	1. White M, Karam S, Colwell B. Skin tears in frail elders: A practical approach to prevention. Geriatric Nurse. 1994;15(2):95-9. 2. Baranoski S. How to prevent and manage skin tears. Advances in Skin and Wound Care. 2003;16(5):268. 3. O'Regan A. Skin tears: A review of the literature. World Council of Enterostomal Therapists Journal. 2002;22(2):26-31. 4. Baranoski S. Skin tears: The enemy of frail skin. Advances in Skin and Wound Care, 2000;13:123-126. 5. LeBlanc K, Christensen D, Orsted HL, et al. Best practice recommendations for the prevention and treatment of skin tears. Wound Care Canada. 2008;6(1):14-30.
Related Tools (NOTE: these tools and	• The SWRWCP's Skin Tear/Pre-Tibial Injury Assessment and Management Algorithm

their instructions can be found on the SWRWCP's website: (swrwoundcareprogram.ca)	• Initial Wound Assessment Form • Procedure: Initial Wound Assessment Form • Nestle Mini Nutritional Assessment (MNA©) Tool • Procedure: Nestle Mini Nutritional Assessment (MNA©) Tool • Skin Tear Risk Assessment Tool • Procedure: Skin Tear Risk Assessment Tool • Interdisciplinary Lower Leg Assessment Form • Procedure: Interdisciplinary Lower Leg Assessment Form • NPUAP PUSH Tool 3.0 • Procedure: NPUAP PUSH Tool 3.0 • Payne-Martin Classification for Skin Tears • Procedure: Payne-Martin Classification for Skin Tears • Bioburden Assessment Tool • Procedure: Bioburden Assessment Tool • Guideline: Assessment and Management of Bacterial Burden in Acute and Chronic Wounds • Guideline: Assessment and Management of Moisture Balance in Acute and Chronic Wounds • Guideline and Procedures: Wound Debridement (excluding conservative sharp debridement) • Guideline and Procedure: Conservative Sharp Wound Debridement • Determining Healability Tool • Procedure: Determining Healability Tool • Guideline: The Management of People with Skin Tears and/or Pre-Tibial Injuries