

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 Community Care Access Centre contracted Community Nursing Agencies in the South West Local Health Integration Network.



Title	Procedure: Predicting Skin Tear Risk
Background	<ul style="list-style-type: none"> • Skin tears are the result of trauma, friction, or shearing forces on the skin (most often the skin on the arms – 80%), with the most common causes being injuries associated with: <ul style="list-style-type: none"> ○ Wheelchair use (25%) ○ Bumping into objects (25%) ○ Transfers (18%) ○ Falls (12.4%)¹ • Skin tears are most likely to occur during peak activity hours, i.e. 0600-1100 and 1500-2100² • Elderly people (especially those over age 85 who are female and Caucasian) are at greatest risk for skin tear development, due to subtle changes in their skin associated with aging, and due to other factors: <ul style="list-style-type: none"> ○ Dermal thinning and loss of subcutaneous tissue ○ Decreased skin surface moisture ○ Reduced tensile strength and elasticity of the skin^{3,4} ○ Dehydration and other comorbid conditions ○ Poor nutrition ○ Impaired cognition ○ Altered mobility ○ Impaired sensation^{5,6} ○ Frequent bathing • Prevention is the primary focus in the management of skin tears, and as such health care professionals must be able to easily identify those at risk for skin tear development • Unlike the “Braden Scale for Predicting Pressure Sore Risk”, there is no valid, reliable risk assessment tool for skin tears. Recognizing the need for such an instrument, Care Partners/ET Now developed the “Skin Tear Risk Assessment Tool”. Despite the fact that the tool has not been validated, it is still a valuable resource to help identify those at risk for skin tear development, so that preventative interventions can be initiated to prevent such wound occurrences
Indications	This procedure is intended to be used by front line registered health care providers, to assist with their assessment and management of individuals admitted with/presenting with a skin tear or at risk for the development of a skin tear.
Procedure	NOTE: The use of the “Skin Tear Risk Assessment Tool” is but one part of the holistic assessment of an individual admitted with/presenting with a skin tear or at risk for a skin tear.

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	<p>Assessment</p> <ol style="list-style-type: none"> 1. Determine if the “Skin Tear Risk Assessment Tool” needs to be completed. NOTE: The initial “Skin Tear Risk Assessment Tool” should be completed: <ol style="list-style-type: none"> a. Within two hours of admission to: <ol style="list-style-type: none"> i. The Intensive Care Unit (ICU), Critical Care Unit (CCU), or Pediatric Intensive Care Unit (PICU) ii. Acute care, sub-acute care, or a rehabilitation unit iii. Acute psychiatry or geriatric psychiatry unit iv. Acute pediatric unit b. Within 24 hours of admission to long term care c. At the initial home visit in the community d. Pre-operatively (the day of surgery) 2. Thoroughly review the person’s available medical records for documentation that reflects the person’s: <ol style="list-style-type: none"> a. History of skin tears b. Current skin condition, i.e. do they currently have a skin tear, bruising, dry/scaly skin, senile purpura and/or open lesions on their extremities, or leg edema c. Cognitive skills, i.e. their ability to make safe and appropriate decisions d. Transferring/mobility status, i.e. do they have an unsteady gait or impaired balance, do they require wheelchair assistance, do they ambulate independently with a wheelchair, are they totally bed/chair bound, or are they mechanically lifted? e. Behaviors, i.e. are they physically abusive, agitated, or do they resist assistance with their activities of daily living (ADLs) f. Ability to perform their ADLs, i.e. does the person require extensive or total assistance with their ADLs g. Sensory impairments, i.e. do they have decreased tactile stimulation, hearing impairment, or hemiplegia/hemiparesis? <p>Planning</p> <ol style="list-style-type: none"> 1. Expected outcomes: <ol style="list-style-type: none"> a. Information from the person’s medical chart, the person and/or their substitute decision maker (SDM)/power of attorney for personal care (POA C), and your assessment will allow for the proper completion of the “Skin Tear Risk Assessment Tool” b. The information gleaned from the completion of the “Skin Tear Risk Assessment Tool”, in addition to your holistic person/wound assessment, will allow for the identification of extrinsic, intrinsic, and iatrogenic factors affecting the person’s ability to heal (if they have a skin tear and healing is the goal), or factors increasing their risk for skin tear development
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	<ul style="list-style-type: none"> c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with/at risk for a skin tear or their SDM/POA C (if applicable), will be able to use the assessment information to initiate/modify and implement an interdisciplinary plan of care which contains clear directions to staff and others who are providing the person with direct care <p>2. Explain the procedure and purpose behind the skin tear risk assessment to the person and/or their SDM/POA C and obtain verbal or implied consent to proceed with the assessment</p> <p>Implementation</p> <ol style="list-style-type: none"> 1. Provide for privacy and ensure the person is in a comfortable position to facilitate the assessment of their skin 2. Wash your hands and attend to the person with your assessment supplies 3. Ensure the person’s SDM/POA C is present or available if the person does not have a reliable memory or is unable to accurately answer any questions derived from the contents of the “Skin Tear Risk Assessment Tool” 4. Ensure adequate lighting 5. If the person is in a bed, raise the bed (if you are so able) to an appropriate ergonomic working height to allow you to conduct the skin assessment while preventing self-injury 6. If you have the potential to come into contact with bodily fluids during your assessment, apply clean disposable gloves 7. Confirm with/ask the person and/or their SDM/POA C questions, observe, and physically assess to determine whether any of the noted risk factors in the three classification groupings on the “Skin Tear Risk Assessment Tool” are applicable: <ol style="list-style-type: none"> a. Group 1: <ol style="list-style-type: none"> i. Does the person have a history of skin tears and if so, how often on average do they get a skin tear, where are the skin tears most frequently located, what have been the causes of skin tears in the past, and what preventative interventions have been put into place, and are they effective? NOTE: although the “Skin Tear Risk Assessment Tool” does not prompt for the collection of all the noted information, this information is of value, should be investigated, and documented on the risk assessment form for future reference ii. Does the person currently have a skin tear, and if so, how many, where are they located, what were the causes of the skin tears, and what interventions have been put into place to treat/prevent, and have they been effective? NOTE: this will require a physical
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	<p style="text-align: center;">assessment of the person’s skin</p> <p>b. Group 2:</p> <ul style="list-style-type: none"> i. Is the person able to make safe, appropriate decisions, or is their ability to make such decisions slightly, moderately, or highly impaired? ii. Does the person require no, partial, extensive, or total assistance completing their ADLs? iii. Does the person use a wheelchair to ambulate, and if so, are they independent in its use, or do they require physical assistance? iv. If the person can weight bear, how steady are they on their feet? Can they independently come to a standing position? Do they exhibit loss of balance when standing and if so do they require physical assistance to remaining standing/balanced? NOTE: you may need to observe the person ambulate/transfer v. Does the person have a history of falls due to impaired balance or unsteady gait? vi. When the person is walking (if they can so do so), how steady is their gait? Do they have a lurching, slapping or swaying gait? Do they have short, discontinuing steps or shuffling steps? Do they change their gait pattern when walking through doorways? Do they exhibit jerking or instability when making turns? NOTE: you may need to observe the person ambulate/transfer vii. Is the person confined to a bed or chair? viii. Does the person have bruises on their skin, and if so, where and how many? How did they get the bruises? NOTE: this will require a physical assessment of the person’s skin <p>c. Group 3:</p> <ul style="list-style-type: none"> i. Is the person physically abusive, agitated, or do they resist assistance with their ADLs? ii. How well can the person hear, i.e. adequately (normal talk/television volume), with minimal difficulty (i.e. when not in a quiet setting), in special situations only (i.e. do you have to adjust your tone, volume, or speak distinctly when talking to the person), or do they hear with great difficulty (i.e. they don’t hear at all, or do not have useful hearing)? iii. Does the person require hearing aids or other receptive communication aides? Do they use them? How effective are they? iv. Is the person mechanically or manually lifted in order to transfer?
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	<ul style="list-style-type: none"> v. Does the person have any contractures of their arms, legs, shoulders, or hands? NOTE: this will require a physical assessment of the person vi. Does the person have any diagnoses of hemiplegia or hemiparesis? vii. Are they able to control their trunk movements, i.e. can they remain seated in an upright position without supports? viii. Does the person have swelling in their lower limbs, and/or do they have any current skin lesions and/or senile purpura on their extremities, and/or dry/scaly skin? NOTE: this will require a physical assessment of the person's skin <ol style="list-style-type: none"> 8. Once you have completed your questioning/assessment, assist the person to a comfortable position, if needed 9. Lower the person's bed to an appropriate height (if applicable), and ensure the person's safety, i.e. apply side rails, personal alarms, restraints, etc. as per the person's care plan/medical orders 10. Clean reusable equipment/surfaces touched during the procedure with warm soapy water or antimicrobial wipes and dry thoroughly to prevent cross contamination 11. Remove your disposable gloves and discard them in the appropriate receptacle 12. Wash your hands 13. Tally the numbers of checked boxes in each of the skin tear classification groupings and refer to the section, 'Recommendations Based on Risk', found on the tool itself. Automatically initiate skin tear prevention interventions if the person scored a positive response for: <ul style="list-style-type: none"> a. Any one item in Group 1 b. Four items in Group 2 c. Five or more items in Group 3 d. Three items in Group 2 with three or more items in group 3 14. Discuss your findings and the implications of those findings with the person and/or their SDM/POA C 15. Share the results of your assessment with the interdisciplinary members of the person's wound care team 16. Complete documentation as required, i.e.: <ul style="list-style-type: none"> a. Document initial and on-going "Skin Tear Risk Assessment Tool" findings on the designated form according to your organization's policy, and store that document in the assigned location b. Implement interventions to reduce/minimize risk and to address factors affecting skin tear healability, based on the tool results c. Complete/update interdisciplinary person-centered care plans as per your organizations policy, based on the person's score
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	<p>and your holistic assessment</p> <p>Evaluation</p> <ol style="list-style-type: none"> 1. Unexpected outcomes: <ol style="list-style-type: none"> a. The information from the person’s medical records, the person and/or their SDM/POA C, and your assessment do not allow for the thorough completion of the “Skin Tear Risk Assessment Tool” b. The information obtained does not allow for the identification of extrinsic, intrinsic, and iatrogenic factors delaying skin tear healing or putting the person at increased risk for skin tear development c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with/at risk for a skin tear development or their SDM/POA C, are unable to use the assessment information to initiate/modify and implement an appropriate person-centered, interdisciplinary plan of care d. The “Skin Tear Risk Assessment Tool” is not completed according to this procedure and/or appropriate interventions are not put into place 2. Reassess those who score “At Risk”: <ol style="list-style-type: none"> a. Every 12 hours in the PICU and on pediatric acute care units b. Daily in the ICU, CCU c. Every 48 hours in acute care, sub-acute care, acute psychiatry, geriatric psychiatry, on rehabilitation units, and post-operatively d. Weekly for four weeks in community care and long-term care, and then quarterly, and within 24 hours of any return from hospital admission or an absence of greater than 24 hours e. Whenever there is a significant change in the person’s overall health condition/status
<p>References</p>	<ol style="list-style-type: none"> 1. Mason SR. Type of soap and the incidence of skin tears among residents of a long-term care facility. <i>Ostomy/Wound Management</i>. 1997;43(8):26-30. 2. White M, Karam S, Cowell B. Skin tears in frail elders: A practical approach to prevention. <i>Geriatric Nurse</i>. 1994;15(2):95-9. 3. Baranoski S. How to prevent and manage skin tears. <i>Advances in Skin and Wound Care</i>. 2003;16(5):268. 4. Birch S, Coggins T. No-rinse, one step bed bath: The effects on the occurrence of skin tears in a long-term care setting. <i>Ostomy/Wound Management</i>. 2003;49(1):64-67. 5. Bryant R, Rolstand B. Examining threats to skin integrity. <i>Ostomy/Wound Management</i>. 2001;47(6):18-27. 6. McGough-Csarny J, Kopac CA. Skin tears in institutionalized elderly: An epidemiological study. <i>Ostomy/Wound Management</i>. 1998;44:14S-25S.

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Related Tools (NOTE: these tools and their instructions can be found on the SWRWCP's website: swrwoundcareprogram.ca)	<ul style="list-style-type: none">• Skin Tear Risk Assessment Tool
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