Skin Tears Assessment
Ageing leads to:

- decreased sensation
- increased dryness
- skin thinning
- reduced elasticity and strength of skin
- reduced immune response, takes longer for repairs
- decreased blood supply
What is a skin tear?

A traumatic wound as a result of friction alone, or shearing and friction, which separates the epidermis from the dermis (partial thickness) or separates both the epidermis and the dermis from underlying structures (full thickness wound)

(STAR 2010)
Skin Tears

• Most common wound in older adults

• Locations
  – Arms 49%
  – Legs 48%
  – Back/trunk 2%
Assessment

• Perform a risk assessment on admission
• Implement a prevention protocol for those at risk
• Use a recognised skin tear assessment & classification system

STAR Classification System

Category 1a
A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.

Category 1b
A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened.

Category 2a
A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky or darkened.

Category 2b
A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened.

Category 3
A skin tear where the skin flap is completely absent.
**ISTAP skin tears classification**

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

**Type 2: Partial flap loss**
Flap cannot be repositioned to entirely cover the wound bed - partially covered.

**Type 3: Total flap loss**
The entire wound bed is exposed.
References


Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 2010.
