BEST PRACTICE RECOMMENDATIONS FOR

THE PREVENTION AND MANAGEMENT OF SKIN TEARS IN AGED SKIN

2nd Edition

In partnership with:

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FOREWORD

Skin tears continue to be a challenge for patients and clinicians, despite advances in awareness, prevention and management. They can be painful wounds, affecting quality of life and causing distress to the patient. Skin tears are associated with an increased likelihood of hospitalisation and prolonged hospitalisation time (Serra et al, 2018; International Skin Tears Advisory Panel [ISTAP], 2018). Estimates of their prevalence differ around the world and across care settings, but there is strong evidence to suggest they occur more frequently than pressure injuries (ISTAP, 2018).

Although skin tears occur across varied patient groups, people with immature or aged and fragile skin are at an increased risk (Langemo et al, 2021; Kacmaz et al, 2023). In older people and patients with chronic diseases, the risk increases due to the frailty syndrome – a 'physiological condition resulting from the cumulative decline of multiple organ systems' (Langemo et al, 2021). With the global rise in an ageing population, the approximate skin tear incidence of 1.5 million per year is likely increasing (Serra et al, 2018). To address this challenge, the expert group focused specifically on the issue of skin tears in aged skin as the majority of research is focused in this area. It was highlighted that further research in other patient groups is still required.

In 2018, ISTAP published the original guidance document: 'Best Practice Recommendations for the Prevention and Management of Skin Tears in Aged Skin', produced by a group of experts from Europe, North America, South America, Asia, Africa and Australia, and reviewed by additional international experts to reflect practice across different parts of the world (ISTAP, 2018).

The 2018 ISTAP guidelines are still widely used in practice, but the need for updated guidance in light of new evidence and debate was identified. For this updated 2025 edition of the guidelines, ISTAP have partnered with Nurses Specialized in Wound, Ostomy and Continence Canada (NSWOCC) and the Wound, Ostomy and Continence Nurses Society™ (WOCN®, USA). This collaboration develops the existing document into clear and definitive guidance for today's clinical practice.

The combined group of experts met in December 2024 to discuss necessary updates based on changes to the healthcare landscape, and to include key current topics, such as impact of patient skin tone, growing number of patients living with dementia, and antimicrobial stewardship-informed practice.

The updated edition also includes the new updated ISTAP data collection tool (the ISTAP DC-Tool) and a glossary [Appendices 1 and 2]. This tool has been validated and is recommended for use in practice to enable accurate data capture in this under-reported and under-recognised area. The ISTAP DC-Tool was developed to provide an accurate method for collecting data to support assessment and management of skin tears. During June-October, 2024, a multiple-method validation process was conducted. Following a two-round consensus process, the Content Validity Ratio (CVR) and Content Validity Index (CVI) calculations were used to quantify content validity, supplemented by a qualitative narrative, based on the opinions of 15 experts, to assess face validity and provide in-depth suggestions for improvement. The finalised tool (hosted on the Microsoft™ Forms™ platform) includes 22 questions that reflect patient/resident information, clinical features of skin tears and relevant additional details. The tool achieved an overall CVI of 0.72, indicating an acceptable level of validity. The intention is that the ISTAP DC-Tool can be used for quality improvement projects as well as research. The tool will help to inform a more precise picture of the true prevalence of skin tears.

Skin integrity is key to wound prevention making prevention strategies and preservation of skin health of paramount importance. This updated guideline aims to provide all clinicians with the information and resources they need to prevent, assess, classify and treat skin tears in practice with confidence, improving patients' overall skin health and outcomes.

Emmy Nokaneng, Chair

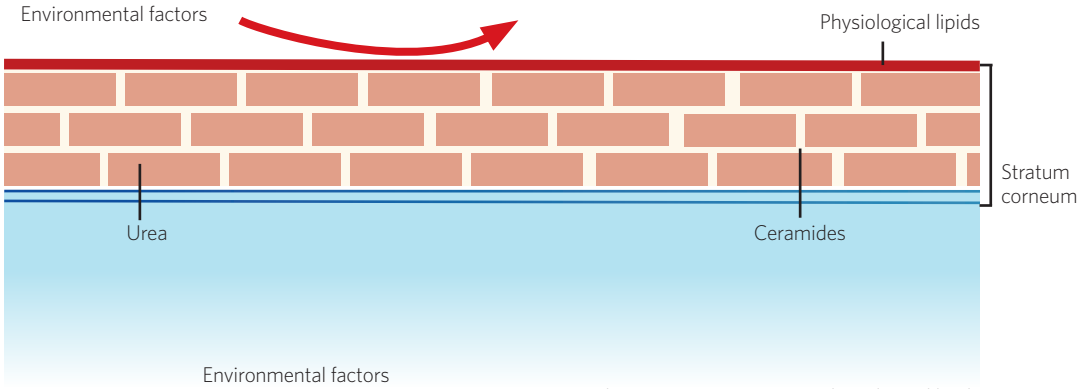
WHAT IS A SKIN TEAR?

An updated skin tear definition has been developed by experts from ISTAP, Nurse Specialized in Wound, Ostomy and Continence Canada (NSWOCC) and the Wound, Ostomy and Continence Nurses Society (WOCN®). The new definition embraces the ISTAP 2018 recommendations (ISTAP, 2018) and reflects recently published critical analyses (Van Tiggelen and Beeckman, 2022). The key update to the definition is to acknowledge the fact that, in addition to systemic factors, wound depth contributes to severity.

This updated definition is provided below:
"A skin tear is a traumatic wound caused by mechanical forces, including removal of adhesives and patient handling, the depth of which may vary (not extending through the subcutaneous layer)"

If a wound extends beyond the subcutaneous tissue layer, it is no longer classified as a skin tear. Instead, it should be described according to the underlying cause of tissue damage, such as the aetiologic or pathophysiologic origin, mechanism of injury, or another appropriate classification system. Deeper tissue involvement reflects more extensive damage and exceeds the anatomical boundaries that define skin tears. Wound depth refers to the extent of tissue damage through the skin's anatomical layers—epidermis, dermis and hypodermis (subcutaneous tissue)—rather than indicating a specific thickness measurement. It is important to remember that skin depth differs [Figures 1 and 2], depending on anatomical location and age of the patient (e.g. thin skin on shins may mean that a skin tear is not 'deep' but is still severe).

A. normal outer epidermis



B. aged outer epidermis

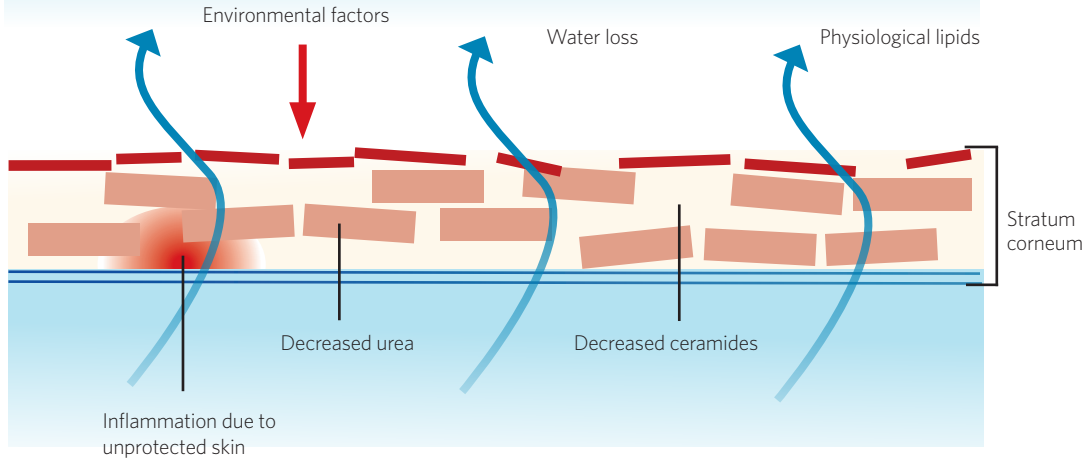


Figure 1. The physiology of the normal outer epidermis (A) and aged outer epidermis (B). (Adapted from Moncrieff et al, 2015.)

Skin tears typically result from:
- Mechanical forces (e.g. shear and friction)
- Trauma (e.g. dressing/adhesive removal or bumping into objects)
- Improper patient handling.

Severity of skin tears may also depend on the degree of inflammation, amount of bleeding, if any, and size of the skin tear. The panel emphasised poor patient handling as a cause of skin tears and highlighted the importance of appropriate practices/techniques and equipment use. In practice, skin tears are often referred to under the general terms of 'laceration' or 'cutaneous laceration'. However, a skin tear is a specific injury that is very different from a general laceration (ISTAP, 2018).

Figure 3 presents examples of skin tears.

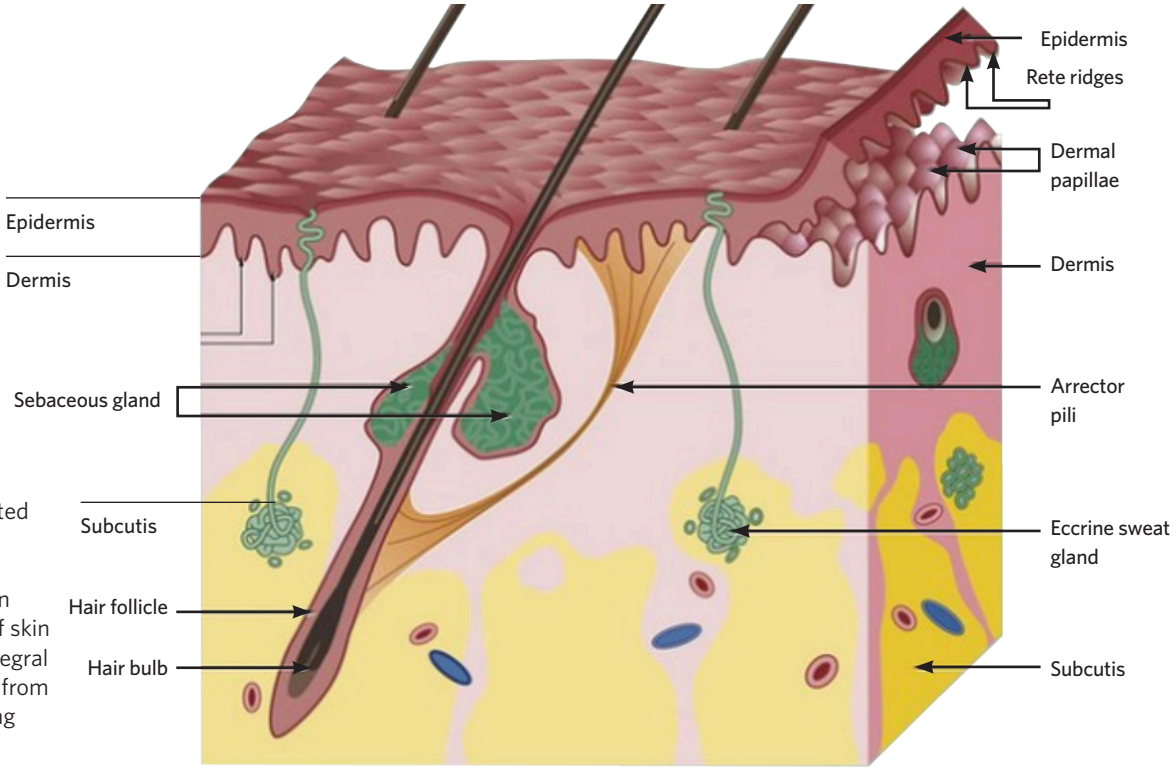


Figure 2. The integrated skin layers. This figure highlights how mechanical forces can result in separation of skin layers due to their integral structures. (Adapted from Mizzou Derm Learning Modules, 2025)

Figure 3. Examples of skin tears. A. medium-tone skin, multiple type 2 skin tears with a partial flap (location: forearm); B: medium-tone skin, type 2 skin tear with partial flap (location: hand); C: light- to medium-tone skin with bruising and type 2 and 3 skin tears (location: forearm); D. dark-tone skin, type 2 skin tear (location: lower calf); E. dark-tone skin, type 3 skin tear (location: back). (Images courtesy of Holly Vance.)

Current variations in definitions and terminology — the distinction between skin tears and lacerations

To distinguish between lacerations and skin tears, it is important to understand the three layers of skin—epidermis, dermis and hypodermis (subcutaneous tissue)—and how lacerations versus skin tears affect them. The updated ISTAP definition explains that a skin tear involves one or more of these skin layers, but 'does not extend through the subcutaneous layer to the fascia below' (Samuriwo et al, 2024). Compared to a skin tear, a laceration is typically a cut, which may have loss of skin.

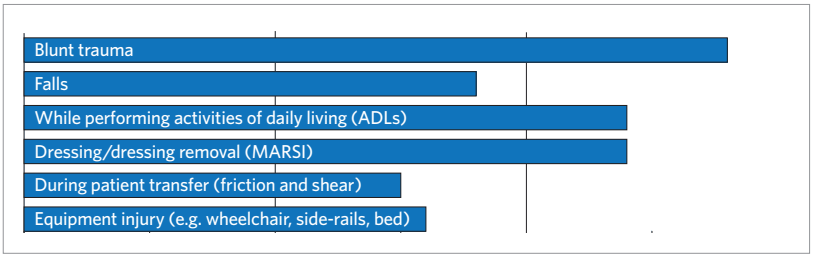
For patients with skin tears to receive optimal treatment, accurate assessment and classification and an understanding of which skin layers are involved in the development of a skin tear are essential; therefore, an accurate definition of skin tears is a crucial starting point to appropriate and timely intervention (LeBlanc and Baranoski, 2011). It is important to remember that skin tears may not have a uniform morphology and may also differ in the tear direction.

The panel highlighted the importance of understanding the definition of a flap in a skin tear, recommending the following by Van Tiggelen et al (2020) to be used:
'A flap in skin tears is defined as a portion of the skin (epidermis/dermis) that is unintentionally separated (partially or fully) 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'.

Clinical practice point: It is crucial to ensure the definition of skin tears is appropriately translated in different global languages. Use of a standardised definition globally can help clinicians adequately diagnose and classify skin tears and provide appropriate, timely interventions.

Causes and aetiology

Skin tears are traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces, including blunt trauma, falls, inappropriate handling, equipment injury or removal of adherent dressings [see Figure 4]. The risk of skin tears is increased with the relative magnitude of mechanical force and the intrinsic quality of the skin (e.g. tensile strength). In already fragile or vulnerable skin (e.g. in aged or premature or under-developed skin), less force is required to cause a traumatic injury; as a result, the risk of skin tears is often increased (Woo and LeBlanc, 2018; Van Tiggelen and Beeckman, 2022).



*Note that almost half of skin tears are found without any apparent documented cause

Figure 4. Range of causes of skin tears* (from LeBlanc et al, 2013). *Abbreviations: ADL, activities of daily living; MARSI, medical adhesive-related skin injury*

Skin tears can occur on any part of the body but are often sustained on the extremities or the dorsal aspect of the hands (LeBlanc and Baranoski, 2011; Koyano et al, 2016). These areas are susceptible to injuries because they are often uncovered/unprotected.

In a systematic analysis of 17 studies, Cilluffo et al (2023) highlighted that skin tears were associated with the following:

- Washing with cold water and soap
- Lack of moisturisation of dry skin
- Short sleeves (i.e. skin exposed to mechanical forces that may cause skin tears).

In addition to the above, adhesive bandages, jewellery (worn by both staff or patients), long nails and lack of gentle handling can cause skin tears (Cilluffo et al, 2023). Koyano et al (2016) found that approximately half of all skin tears developed on the dorsal forearm (n=410; median age, 87 years).

Skin tears are often misdiagnosed, or the cause is not accurately established or identified (Van Tiggelen et al, 2020). To improve healthcare providers' knowledge and apply best practice, a designated skin and wound care programme and team should be established. In addition, appropriate and timely

documentation of the skin assessment will allow for accurate identification of skin tears, including accurate assessment, classification and documentation of the wound and its cause (Formosa and Holloway, 2022).

It is important to consider the aetiology of injury—e.g. how a skin tear differs in definition from a pressure ulcer (LeBlanc et al, 2016a; Ousey et al, 2017; Cilluffo et al, 2023; also see Box 1). In practice, the cause of the wound (e.g. mechanical forces such as shearing or frictional forces, blunt trauma, falls, poor handling, equipment injury or MARSI) must be determined. This cause must be clearly documented for clinicians to develop and implement a prevention and management plan.

A MARSI is one of many causes of skin tears and should be carefully documented. Figure 5 illustrates a situation where the use of medical adhesives may pose a risk of MARSI if not managed properly. MARSI is classified into three categories: mechanical injuries (epidermal removal, skin tears, and tension-induced injury), dermatitis (contact or allergic) and other types of MARSI (maceration and folliculitis; Savine and Snelson, 2024). Not all skin tears are MARSI and not all MARSI conditions are classified as skin tears.

Figure 5. Illustration of how inappropriate use or removal of medical adhesives, such as adhesive skin closure strips, can potentially lead to a MARSI upon removal. (Image courtesy of Holly Vance.)

BOX 1. What is not a skin tear?

- A laceration is not a skin tear: lacerations are wounds that extend through the subcutaneous layer, whereas skin tears do not. Using the updated definition provided in this document helps to distinguish a skin tear from a laceration and enable more accurate documentation
- Not every MARSI is a skin tear. MARSI can refer to one specific type of skin tear, caused by adhesives. In addition to skin tears, epidermal removal, tension-induced injury, dermatitis, maceration and folliculitis are also classified as a MARSI when induced by adhesives
- When a blister ruptures (e.g. due to trauma), the resultant wound may be confused with a skin tear. Although blisters have many causes that may appear similar to the causes of skin tear (e.g. friction and trauma), they are not considered skin tears.

Clinical practice point: Cause of the skin tear (if known) must be documented.

Complicated or uncomplicated?

Skin tears are defined as acute wounds (ISTAP, 2018) which have the potential to heal; yet, they are at high risk of developing into chronic wounds if improperly treated (Idensohn et al, 2019a) or if the patient has comorbidities that may negatively affect the normal healing trajectory. Therefore, skin tears can be further defined as 'uncomplicated' or 'complicated'.

An uncomplicated skin tear is expected to achieve full epithelisation or heal within approximately 4 weeks. A complicated skin tear does not heal within 4 weeks and may become a chronic wound. Skin tears on the lower limb and/or in patients with multiple comorbidities (e.g. peripheral arterial disease and diabetes) are likely to be considered complicated; older patients are also more likely to develop infections, another complication of skin tears (ISTAP, 2018).

It should be noted that all skin tears are potentially painful due to the inflammatory response after trauma. This pain is also due to the fact that skin tears involve the dermis, where sensory nerve endings are present (Cilluffo et al, 2023). Fear of re-injury, anxiety, bleeding, and pain exacerbation is distressing for the patient and their relatives, for both physical and cosmetic reasons. Although research is scarce, skin tears may also affect patients' body image, mobility, sleep, and mood.

Clinical practice point: Document the duration of the skin tear and determine whether it is uncomplicated or complicated.

Prevalence — the scale of the problem

There remain limited incidence studies in the current literature on skin tears, and reported prevalence varies. In newer studies, outcomes, such as skin tear prevalence in long-term care, have not significantly improved and remain elevated in recent years. This suggests that further awareness and guidance is required in practice to improve translation of knowledge to practice. In relation to MARSI, where skin tear is one type of injury, there is currently a lack of consensus on its definition as well as on incidence and prevalence data (Savine and Snelson, 2024).

Estimates of skin tear prevalence vary across different care settings and countries. Variation in the reported prevalence may be due to differences in methodologies, operational definitions, genetic makeup and cultural practices that contribute to skin health.

Recent prevalence studies from across the world have reported:

- 3.0% in long-term care in Belgium (*n*=24/795; 10 facilities, age ≥65 years; Van Tiggelen et al, 2019)
- 20.8% in long-term care in Canada (*n*=79/380; 4 facilities, age ≥65 years; LeBlanc et al, 2020)
- 41.2% in long-term care in Australia (*n*=14/34; 2 facilities for people with dementia; Parker et al, 2020)
- 11.6% in long-term care facilities in Brazil (*n*=8/69; 3 settings; age 81±9.3 years; Peres et al, 2022)
- 1.1% in a point prevalence study in a tertiary care setting in Turkey (*n*=17/418; age 74.76±7.14 years; Kacmaz et al, 2022)
- 12.2% in intensive care and in-patient setting in Brazil (*n*=29/148; 1 facility; adults and older adults age 60.1±19.0 years; Souza et al, 2021)
- 14.5% in intensive care units in Turkey (*n*=29/200; 5 facilities; age 75.48±7.94 years; Kacmaz et al, 2025)
- 8.9% overall pooled prevalence in an acute care setting in Australia (*n*=29/328; age 79.7±10.9 years; Miles et al, 2022)
- 6.0% pooled prevalence (confidence interval [CI], 3-11%) in a systematic review of 13 studies (*n*=19,397; age ≥60 years; Yang et al, 2024)
- 7% in a study conducted in a private South African wound clinic (*n*=31/460 individuals, with skin tear prevalence of *n*=86/876 wounds; Idensohn et al, 2025).

Similarly, recent incidence studies have reported:

- 9.7% over a time period of 1 year in a long-term older people's care facility in Japan (*n*=152/156; Furukawa, 2019)
- 7.2% over a time period of 45 days in 32 nursing homes in the US (*n*=40/555; age 82.2±11.5 years; Kapoor et al, 2019)
- 19% (pooled incidence; CI, 5.0-19.0%) in a systematic review of 13 studies (*n*=19,397; age ≥60 years; Yang et al, 2024)

Consistent with the observations above, Van Tiggelen et al (2022) summarised >20 different studies on skin tear prevalence, reporting a prevalence of 1.1-41.2% and 1.1-19.8% in long-term and acute care facilities, respectively; this variation between the reported studies and by Van Tiggelen et al (2022) highlights the importance of using a standardised definition and accurate diagnosis when reporting skin tears. Skin tears are frequently under-reported or misdiagnosed, resulting in an incomplete understanding of their true clinical and financial burden within healthcare systems. Despite limited data, evidence suggests that skin tears significantly increase costs through the need for wound care dressings, prolonged clinical management, and the treatment of complications associated with underlying comorbidities, among other factors. As the population of older adults continues to rise, the incidence of skin tears and their associated resource demands remains a significant rising challenge to clinicians and healthcare systems (Yang et al, 2024).

Future studies should address the incidence and prevalence, complications, chronicity, and disability associated with skin tears.

Clinical practice point: The ISTAP DC-tool is recommended for use in practice to ensure consistent and standardised data collection (see Appendix 1, page 28).

Access the ISTAP DC-Tool: Scan the QR code to access the ISTAP website and register to download a copy of the validated ISTAP DC-Tool (see also Appendix 1, page 28).

Prevention

Prevention is generally based around the following patient factors:

- General health
- Mobility
- Skin, and skin care/hygiene practice and handling.

Tailored, evidence-based skin care can help improve skin tear prevention (Völzer et al, 2024; O'Brien et al, 2024). Wherever possible, prevention should be the main aim, especially in the at-risk population (Beeckman et al, 2020; Konya et al, 2024).

A quick reference guide for the ISTAP risk reduction programme is shown in Table 1.

Table 1. Quick reference guide for the ISTAP risk reduction programme

Risk factor	Individual	Caregiver/provider
General health	• Educate patient (if cognitive function is not impaired) • Optimise nutrition and hydration	• Safe patient environment • Educate client and caregivers • Protect from self harm • Consult a dietitian • Review polypharmacy
Mobility	• Encourage active involvement (if physical function not impaired) • Appropriate selection and use of assistive devices	• Perform a daily skin assessment and monitor for skin tears • Safe patient handling/equipment, including proper transferring and repositioning • Falls prevention programme (remove clutter, proper lighting) • Use padding on equipment • Avoid grabbing with fingertips
Skin	• Encourage awareness of medication-induced skin fragility • Wear protective clothing • Frequently moisturise skin • Keep fingernails short • Manage comorbidities	• Skin hygiene — warm/tepid water, soap-free pH-neutral cleansers, moisturise skin • Avoid strong adhesives, dressings, tapes • Avoid grabbing with fingertips • Routinely use adhesive removers and liquid skin sealants

It is important to assess the patient's risk factors in relation to their individual context, needs, and preferences, considering the following:

- The patient's goals, daily activities, physical mobility and living environment
- The clinician's scope of practice, expertise and familiarity with evidence-based prevention strategies
- The healthcare setting and available resources where care is delivered
- The broader context of the patient's values, lifestyle and care priorities.

Skin tear prevention programme

Holistic care is vital for all patients, particularly those with aged or fragile skin. Provision of appropriate skin care and consideration of modifiable risk factors affecting skin health helps to reduce the risk of not only skin tears but also other forms of skin damage (e.g. MARSI).

Moisturising should be seen as a vital part of skincare for patients with aged or fragile skin. Use of moisturising products has long been established to promote general skin health and twice-daily application has been proven to reduce incidence of skin tears by 50% (Finch et al, 2018; Baki et al, 2021;

Vuorinen and Ram, 2023). An ideal moisturiser has the following properties:

- Hydrates the skin and decreases trans-epidermal water loss
- Restores and maintains the lipid barrier
- Fragrance-free and hypoallergenic
- Does not block skin pores
- Affordable and easy-to-access in routine care settings (National Library of Medicine [NLM] 2024a; Sethi et al, 2016).

Figure 6 demonstrates the effects of ageing in the epidermis.

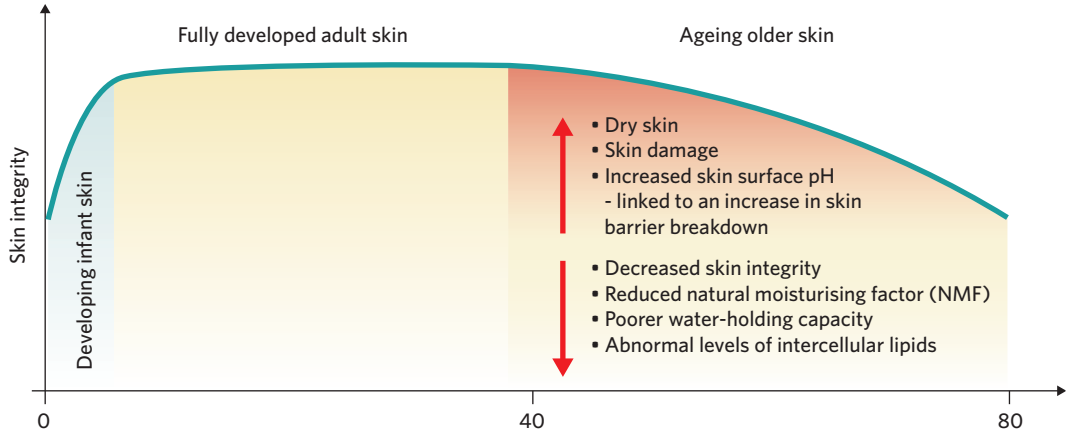


Figure 6. Changes in the epidermis as it ages (adapted from Moncrieff et al, 2015)

It should be noted that the standard 'twice-daily' guidance can depend on the type of moisturiser used. Some newer moisturisers may require fewer applications. Additionally, the amount of product needed depends on product formulation and body location.

Total body moisturisation is preferable, but may not be practical, it is important to acknowledge what is realistic in practice. If head-to-toe application is not possible, prioritise regular moisturisation of the extremities or other vulnerable areas.

While previous guidance generally stated that any moisturiser can be used, some moisturisers are now more 'skin-friendly' than others (i.e. gentle and pH-balanced; Hawkins et al, 2021; Brooks et al, 2025). Moisturisers can be formulated as creams, lotions or ointments. Despite variations in formulation, at a minimum, emollient-based, fragrance-free products are recommended.

Emollients work by smoothing and softening skin. They may also be incorporated into liquid cleansers and soap substitutes (NICE, 2024). Additionally, products containing humectants, such as urea and glycerine, can help enhance skin hydration by drawing moisture into the epidermis (trapping) and reducing water loss through evaporation (Wounds UK, 2015).

Standard bars of soap can be drying and disruptive to normal acidic skin pH. For bathing and perineal care, there are soaps available that are pH-balanced and considered 'gentle' for vulnerable skin, which are different to standard bars of soap and should be used where possible. Products containing isopropyl alcohol should be avoided.

Patient choice, acceptability, availability and cost must be considered when deciding which skin care products to use. For example, an ointment such as plain petrolatum may be readily available and inexpensive but is greasy and difficult to remove. Pastes (a type of ointment formulation commonly used for incontinence skin care and protection) should not be used for moisturisation for the patient at risk of or with a skin tear.

The best time to apply moisturisers is immediately after showering or bathing to optimise skin hydration and moisture retention (Coalition for At-Risk Skin, 2022). See Box 2 for recommendations on patient bathing regimen.

The concept of a 'bundled approach' to skin care in older people has emerged. Al Khaleefa et al (2022) identified that provision of skincare bundles to people ≥65 years is associated with a reduction in the number of skin tears. In this study, the authors defined skin care bundles as being:
'a small, straightforward set of evidence-based practices or interventions — usually three to five — that when performed collectively and consistently, have been proven to improve patient outcomes'.

BOX 2. Recommendations for bathing regimen

The patient's bathing and cleansing regimen should be considered, with emollient products used as soap substitutes and pH-balanced products. Frequency of bathing should be minimised where possible (patient choice must be considered). The water temperature should be appropriate because hot water can strip the skin's natural barriers and increase the risk of excessive dryness. Care should be taken to pat (and not rub) the patient's skin dry and soft cloths and towels should be used to avoid abrasion. In certain clinical settings, 'washing without water' may provide an efficient alternative to bathing with water. Schoonhoven et al (2015) describe one technique which involves bathing the patient with disposable wash gloves or wipes containing a no-rinse skin cleanser with fast vaporisation properties. The authors found that this method provided a better alternative to traditional bathing and prevented skin tears without incurring additional costs (Schoonhoven et al, 2015; Veve et al, 2020; Konya et al, 2023). It is also recommended to use disposable, nonwoven towels for this purpose (Konya et al, 2023). A crossover randomised laboratory-controlled trial found that washing/bathing without water may also save time for the nursing staff and reduce their physical discomfort when performing traditional bathing for their patient (Groven et al, 2021). It is essential that staff receive training and education on the range of techniques involved in washing without water (Konya et al, 2023).

An example of a bundled approach is the application of the aSSKINg framework for preventing development of pressure ulcers/injuries, where 'aSSKINg' stands for 'assess risk, Skin assessment and skin care, Surface, Keep moving, Incontinence or increased moisture, Nutrition, give information' (Young, 2021; National Wound Care Strategy Programme [NWCSP], 2025).

Similar bundled approaches can be considered for patients at risk of developing skin tears. A skin tear prevention regimen should assess the patient's general health, such as optimising the patient's nutrition and hydration status. Patients at extremes of weight (bariatric, cachectic or excessively thin) will require extra care to prevent skin tears. Bariatric patients are at a higher risk of moisture-associated skin damage (MASD) and its associated complications (Mitchell and Hill, 2020). Polypharmacy should be considered, when relevant, and appropriate precautions should be taken to address potential medication effects on cognition, gait and skin conditions such as itching (Idensohn et al, 2019b).

Patients with dementia or mental health conditions, particularly those who exhibit agitation or resistance to care and who have fragile or ageing skin, are at increased risk for skin tears. In these cases, additional safety measures, such as maintaining a decluttered environment and using padded bed rails, can help reduce the risk of injury (Idensohn et al, 2019b).

Where mobility is an issue, a falls prevention programme should be developed and implemented for at-risk patients (ISTAP, 2018). Active movement should be encouraged where possible to promote muscle strength and prevent falls related injuries. Assistive devices should be carefully evaluated to ensure they do not contribute to skin damage, particularly at points where the device comes into direct contact with the skin (see 'Healthcare setting' section on page 12).

Clinical practice point: Document the patient's risk factors for skin tears (general health, mobility and skin) and identify approaches for prevention.

Patient self-care

An individual's capacity and capability for self-care should be assessed and supported if appropriate to manage their own skin regimen. If family or carers are involved, they can also be educated in skin care and how they can be involved (Beeckman et al, 2020).

Wherever possible, self-care (also referred to as supported care, self-supported care or shared care in some clinical settings) should be encouraged for suitable patients, to include emollient therapy, encouraging the patient to apply moisturisers themselves where possible. This can be incorporated into the patient's daily routine.

Evidence shows that attitudes and practices of individuals with skin tears can influence their outcomes (Varga et al, 2022). Therefore, it is important for clinicians to involve patients in their own care and educate them on how to recognise age-related changes to their skin, the impact of medications, opportunities for self-management and steps they can take to prevent and manage skin tears. Patients also need to be taught how to be aware of their surroundings, recognise potential risks, monitor their

own skin health and provide basic first aid if a skin tear does occur (e.g. stop the bleeding, clean the wound, dab the wound instead of rubbing it and avoid standard dressings with acrylic- or rubber-based adhesives; Deprez and Beeckman, 2022). In cases where dressings are required, educating patients about the use of gentle adhesives, such as silicone dressings, is important. Atraumatic silicone-based dressings or dressings specifically designed for fragile skin should be used when required (O'Brien et al, 2024). It is important to recognise that patients may be unaware of, or lack access to, specialty dressings. Therefore, healthcare providers should offer education and guidance on the availability and sourcing of appropriate supplies.

Patients with the capacity to understand and perform basic skin self-assessments can be given a self-care checklist to monitor their own skin health and wellbeing [see Box 3].

Clinical practice point: Discuss the potential for self-care with the patient and their caregivers and document information given. Use the teach-back method by asking the patient to repeat their understanding of the process to ensure comprehension.

BOX 3. Self care checklist for patients at risk of skin tears (adapted from Wounds UK, 2015)

- ☐ Have I been given an individualised skin care plan?
- ☐ Am I using an emollient twice a day (e.g. a skin moisturiser)?
- ☐ Am I getting good nutrition and drinking enough water?
- ☐ Am I keeping as active and mobile as possible?
- ☐ Have I thought about wearing clothing to protect my skin - e.g. long sleeves, shin guards or tubular bandages?
- ☐ Has my environment been made as safe as possible - e.g. adequate lighting, no obstacles and using padding on furniture if required? Are there any tripping hazards in my surroundings (e.g. rugs)?
- ☐ Am I wearing well-fitting and comfortable shoes to avoid falls?

Healthcare setting

Prevention of skin tears is essential across all healthcare settings (e.g. acute care, long-term care, patient's own home, hospice/palliative care) to minimise the risk of potential skin trauma.

This should include factors such as:

- Avoiding friction and shearing, ensuring safe manual handling techniques are used, such as glide sheets, where recommended
- Using padding equipment for furniture where recommended as per local guidance
- Ensuring a safe environment (e.g. adequate lighting and removing any manual obstacles, particularly for patients who may have impaired vision or impaired cognition); this includes removing any potentially dangerous furniture or devices (e.g. bed rails and wheelchairs) and keeping environments clutter-free
- Conducting falls risk assessment as appropriate
- Using confusion or delirium prevention screening protocols
- Encouraging use of protective clothing/devices where recommended, such as shin guards, long sleeves and/or tubular bandages/stockinette
- Holding the patient's skin with fingertips during interventions should be avoided (use pads of fingers, instead of fingertips)
- Refraining from wearing rings and/or bracelets (this applies to both staff and patients); staff should have short, smooth nails
- Limiting the use of topical steroids
- Taking measures for oedema control, especially in legs.

Clinical practice point: Assess the patient's environment for potential risk factors for skin tears and identify actions to mitigate these risks.

Clinician education

Education and awareness are essential components of skin tear prevention. It is essential to equip clinicians with the skills and knowledge on how to identify risk factors and implement strategies to maintain skin integrity.

A multidisciplinary approach to care is paramount. It is important to remember that clinicians involved should include registered and unregistered staff (e.g. nursing assistants, aides, patient care assistants) and all members of the multidisciplinary care team (e.g. occupational therapists and physiotherapists).

All staff should be aware of the risks outlined in the 'Healthcare setting' section. They should be informed about the importance of general skin health and be aware of the risk factors in patients with

aged/fragile skin, aiming to minimise risk, wherever possible. It is important to engage patient and carers in all educational activities. A systematic approach to skin tear prevention and management is required that considers patient-, clinician- and setting-related factors to ensure optimal use of education and resources (Heerschap et al, 2019).

To improve awareness of skin tears among clinicians and to help with decision-making, the panel recommends OASES, a tool developed to help clinicians assess their knowledge of skin tears (Van Tiggelen et al, 2021). It includes the following skin tear knowledge domains:

- Aetiology
- Classification
- Observation
- Prevention
- Treatment
- Specific patient groups

OASES score scale ranges from 0-20, with a higher score indicating greater knowledge about skin tears (Van Tiggelen et al, 2021). This tool can be used to establish baseline knowledge for clinicians and inform clinician education programmes.

Clinical practice point: Consider using the OASES knowledge tool to determine healthcare professionals' knowledge of prevention, assessment and management of skin tears.

RISK FACTORS

The populations at the highest risk of skin tears—older adults with fragile, aged skin—are also more vulnerable to infections and comorbidities, increasing the likelihood that skin tears will become significant and progress into complex wounds (Wounds UK, 2015). Skin and tissue ageing is associated with structural and functional changes, increasing susceptibility to skin tear development. In aged skin, wounds take longer to heal and are associated with increased risk for deterioration (Moncrieff et al, 2015).

Certain systemic disorders can lead to itching, making the patient prone to skin tears. Itching can arise from both intrinsic and extrinsic risk factors, contributing to the development of skin tears. Common underlying causes include dermatologic conditions, neurologic disorders, systemic diseases, psychogenic factors, skin infections and adverse reactions to prescription or over-the-counter medications (Dharmarajan and Vyas, 2025). Systemic illnesses often encountered among older adults, such as thyroid, kidney, and liver disease, can increase the risk of itching and, subsequently, skin tears (Kim et al, 2023). Identifying these risk factors early and implementing active management strategies to control itching is essential to reducing the risk of skin tears in vulnerable patients.

Intrinsic risk factors

The normal ageing process (intrinsic ageing) causes changes in the skin that make it more fragile and therefore more vulnerable to damage, including skin tears [see Figures 1, 2 and 6]. With a reduced ability of the skin to regenerate and a less efficient protective immune system, older patients are at an increased risk of skin breakdown from even minor force or trauma (Voegeli, 2007). It is vital that care of the older person's skin is seen as a priority for all clinicians.

Skin changes associated with ageing include (Moncrieff et al, 2015):

- Thinning of the epidermis and flattening of the epidermal junction thus the skin becomes less resistant to shearing forces and tears easily with trauma (Lavker et al, 1987; Khalid et al, 2022)
- Loss of collagen, elastin and glycosaminoglycans
- Atrophy and contraction of the dermis (causing appearance of wrinkles and folds)
- Decreased activity of sweat glands and sebaceous glands, causing the skin to dry out
- Thinning of blood vessel walls and a reduction of blood supply to the extremities
- Increased dermal LEP (low-echogenic pixels), including solar elastosis, may represent a risk factor for skin tears; this indicates that skin tear risk factors might not only represent chronological ageing but also photoageing (Koyano et al, 2016).

Extrinsic risk factors

Patients who require assistance with activities of daily living, such as mobility, washing and dressing, are at increased risk of skin tears due to handling and associated forces (Wounds UK, 2015). These extrinsic, or environmental, risk factors are combined with the intrinsic risks of aged skin detailed above, compounding the overall vulnerability and significantly increasing the likelihood of skin tears and delayed healing (see section, 'Healthcare setting' for a list of factors that should be considered to minimise the risk of potential trauma).

When caring for patients with vulnerable skin, it is possible to minimise extrinsic risk, by taking measures such as:

- Protecting the skin's general integrity by using gentle, pH-balanced products and preventative emollients (Carville et al, 2014; Wounds UK, 2015; ISTAP, 2018)
- Providing safe walking aids and mobility devices (e.g. with grab bars and anti-slip footwear)
- Ensuring fluid and nutritional intake is optimal.

Clinical practice point: Patients who require assistance with activities of daily living are at increased risk of skin tears.

Early recognition of people who are at risk and minimising risk

Early recognition of individuals at risk for skin tears is a critical component of prevention. Identifying at-risk patients helps minimise the incidence of avoidable skin tears and supports the appropriate allocation of clinical resources.

A full holistic skin assessment should be conducted at the first visit or on admission to the clinical setting, and ongoing inspection of the skin should be incorporated into a daily care regimen and documented, to ensure changes in patients' health status/skin integrity are identified (Wounds UK, 2015; Beeckman et al, 2020; Mitchell, 2022).

The Skin Tear Framework [Figure 7] outlines considerations that need to be made in assessing patient risk.

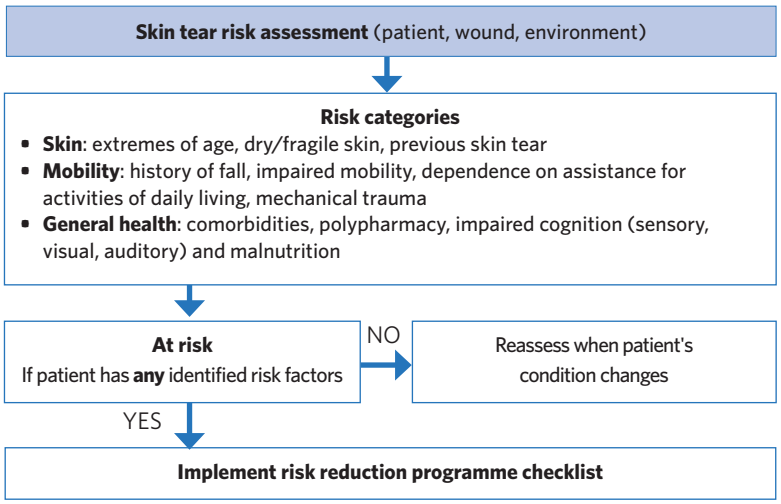


Figure 7. Skin tear risk assessment protocol (adapted from LeBlanc et al, 2013)

ISTAP recommends an inter-disciplinary team approach to the implementation of a systematic skin tear prevention programme. This is based on three risk factor categories:
1. General health
2. Mobility
3. Skin (LeBlanc et al, 2013).

The ISTAP skin tear risk assessment protocol should be used [Figure 7]. If a patient is deemed to be at risk, the risk reduction programme checklist [Table 2] should be implemented.

Table 2. Risk reduction programme checklist (adapted from LeBlanc and Baranoski, 2011)

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

Through a skin tear risk prediction model for older people (aged >65 years), Rayner and Carville (2024) demonstrated it is possible to screen this patient group with high sensitivity and specificity providing early identification of skin tear risk to successfully implement preventive measures. However, there remains a need to develop skin tear risk prediction models with a larger sample size and improved study design (Fan et al, 2024). A nomogram is a mathematical device or model that shows relationships between different factors and acts as a tool to predict outcomes (e.g. a nomogram of patient and skin characteristics can help predict the risk of tears; National Cancer Institute, 2025). In a study of older patients (≥65years), Konya et al (2024) assessed the potential of a nomogram in predicting if a patient may be at risk of skin barrier dysfunction upon exposure to mechanical irritation when receiving routine skin care. The resultant, validated nomogram can act as a risk stratification tool to help clinicians assess the risk of skin damage in at-risk patients (Konya et al, 2024).

Clinical practice point: Implement the ISTAP skin tear risk reduction programme checklist.

Individualised history-taking

Key risk factors for skin tear development include a previous history of skin tears and the presence of skin changes associated with ageing (LeBlanc et al, 2021a). Taking a patient's full history as part of assessment can help to identify risk and inform the patient's prevention plan.

Clinical practice point: Ask the patient about their skin and listen to their perspectives. Document the assessment, take the necessary photographs (as per local guidance) for future reference and reassess as required.

IDENTIFICATION AND ASSESSMENT

Identifying skin tears accurately from first presentation onwards is vital to optimising management. Currently, there are still challenges with correct identification of skin tears, meaning they are often underreported, misdiagnosed and, as a result, frequently mismanaged.

Comprehensive assessment of patient and wound

When a patient presents with a skin tear, the initial assessment should include a holistic patient assessment, an overall skin assessment, a comprehensive wound assessment (including peri-wound skin evaluation) and a risk assessment. For this purpose, the ISTAP DC-Tool is recommended (see page 9 and Appendix 1).

Assessment/evaluation should include:

- Anatomical location
- Duration of injury
- Dimensions (length, width, depth); for further details, see the section 'Wound measurement' on page 19
- Extent of tissue damage (epidermis, dermis and hypodermis/subcutaneous tissue)
- Wound bed characteristics and percentage of viable/non-viable tissue
- Type and amount of exudate
- Presence of bleeding or haematoma
- Integrity of the surrounding skin
- Signs and symptoms of infection
- Skin tone of the patient
- Associated pain and other symptoms (e.g. itching and/or burning; Stephen-Haynes and Carville, 2011; ISTAP, 2018).

Holistic patient assessment should include:

- Medical history
- General health status and comorbidities
- Past history of skin tears
- Skin condition and baseline skin tone
- Medications and potential polypharmacy issues
- Factors affecting capacity/cognition
- Psychosocial and quality of life factors
- Mobility/ability to perform activities of daily living
- Nutrition and hydration (adapted from Wounds UK, 2015; ISTAP, 2018).

It is important to listen to the patient's perspective and their views and feelings on their wound and overall skin condition. This can help to obtain information that might otherwise have been missed (Dhoonmoon et al, 2021; see Box 4).

BOX 4. Questions to consider as part of an overall skin assessment

- What is the condition of wound/periwound compared to the surrounding skin?
- What layers of tissue are involved in the injury?
- Are there any differences in colour?
- Does the skin feel warm/cool? Are there any changes in temperature?
- Does the skin feel spongy or firm to the touch?
- Does the skin look or feel shiny or tight?
- Is there swelling or inflammation?
- Are there any changes in the texture of the skin and underlying tissue?
- How is the overall condition/integrity of the skin?
- Is there any pain, itchiness or change in sensation?

Skin tone assessment

Skin texture and sebum production, which moisturises the skin, can vastly differ based on skin tone. Given that skin changes may present differently in those with dark skin tones (Dhoonmoon et al, 2021), it is imperative that clinicians are mindful of the subtle changes that may be seen in different skin tones, recognise skin tear risks and implement skin tear prevention programmes (LeBlanc et al, 2024).

Research has shown that, due to differences in transepidermal water loss, individuals with dark skin tones have a lower basal water content (WC) than those with light skin tones (Alexis et al, 2021; Peer et al, 2022). It has been suggested that a reduced WC in dark skin tones may result in differences in

vulnerability to pressure ulcers/injuries, due to variations in skin biomechanics (Gefen, 2023). These findings may also be applicable to skin tears, which further highlights the need to improve prevention and treatment strategies for skin tears across different skin tones.

Assessing baseline skin tone is critical, as well as part of subsequent reviews and reassessments (LeBlanc et al, 2024). In order to effectively monitor and identify, any changes to the skin establishing baseline skin tone is an important part of the initial skin inspection and holistic wound assessment (Dhoonmoon et al, 2021).

The Skin Tone Tool [Figure 8] is a validated classification tool that can help to assess changes in a patient's normal skin tone, reducing potential biases and improving assessment accuracy (Dhoonmoon et al, 2021). The tool displays a range of skin colours that can match with a patient's skin tone, with the baseline determined as the tone that matches the inside upper arm of the patient. It is important to remember that the clinician must also compare the skin tone changes with a similar area of the body (e.g. compare the skin on both hands or feet; Dhoonmoon et al, 2021).

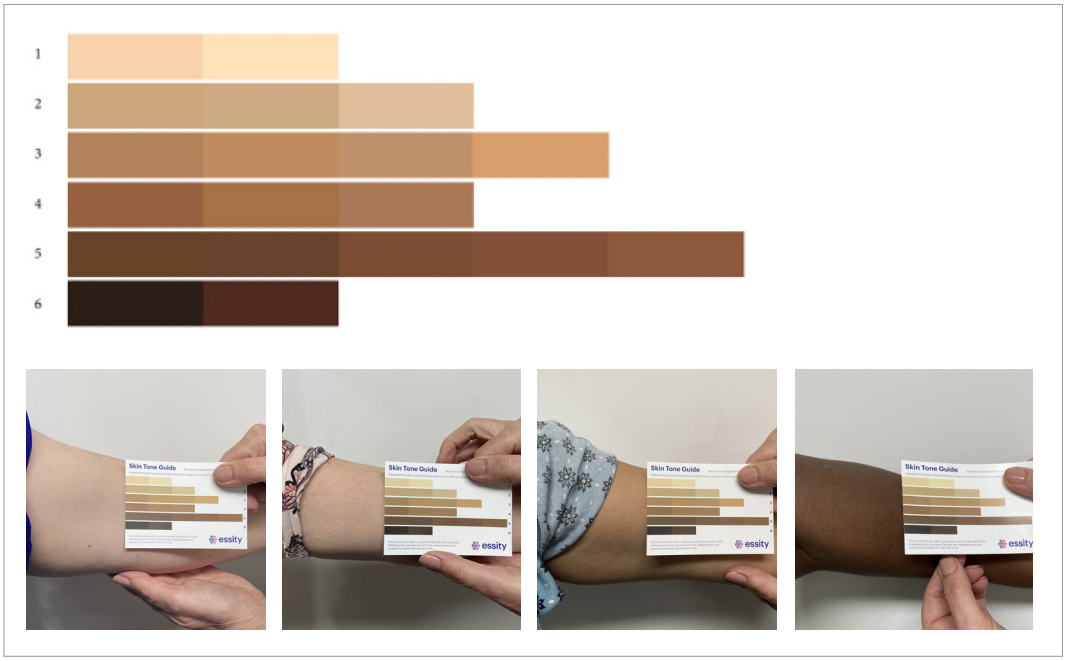


Figure 8. The Skin Tone Tool (top; adapted from Dhoonmoon et al, 2021), and its application in assessing the skin tone in people with a variety of skin tones (bottom; images courtesy of Essity)

It should be noted that erythema does not always appear as 'redness' in many skin tones, especially in those that are dark, and can be missed in the initial assessment; changes in skin colour due to erythema can range from pink to red and purple and, at times, may only be indicated by a 'subtle darkening' of the normal skin tone (Dhoonmoon et al, 2023).

Individuals with dark skin tones may experience post-inflammatory hyperpigmentation, leading to darkened areas around the healed wound site. Although it is usually temporary, this hyperpigmentation can take several months to resolve. Keloid or hypertrophic scarring may also be more common in people with dark skin tones, so wounds need to be monitored closely and appropriate scar management provided where necessary/able (LeBlanc et al, 2024).

It is paramount that clinicians assess for other indicators of injury in people with dark skin tones by using both visual and tactile cues—e.g. purple/blue/grey discolouration and change in temperature. Furthermore, full use of the senses—especially palpation and hearing (i.e. listening to the patient)—is valuable in the assessment of all patients regardless of the tone of their skin. Clinicians need to ask the patient about their skin and listen to their perspective about what they consider to be a problem—e.g. tightness, changes in feeling/sensation and pain, discomfort or numbness over the affected area (Dhoonmoon et al, 2021).

It is important to include the periwound skin in this assessment process. This assessment should focus on (adapted from LeBlanc et al, 2021b):

- Skin integrity
- General condition of the skin—e.g. dry/moist, thinned/thickened, discoloured
- Size of the periwound area—i.e. relating to wound edges

- Temperature—cool/warm/hot
- Colour (e.g. lipodermatosclerosis/venous insufficiency)
- Erythema/cellulitis/lymphangitis/folliculitis
- Maceration/erosion/skin stripping
- Callus/hyperkeratosis/atopic eczema/xerosis
- Swelling/oedema/induration
- Sensation (e.g. for foot wounds, spinal cord injury or other conditions reducing sensation)
- Cause of damage, including scratching and self-harm.

Clinical practice point: Ask the patient direct questions such as 'are any parts of your skin sore?' or 'have you noticed any changes to your skin?'.

Classification

The ISTAP classification system is recommended to classify skin tears (LeBlanc et al, 2013; Van Tiggelen et al, 2020). The ISTAP system was developed using a Delphi process and has been validated globally.

The results of psychometric testing on a sample of 1601 healthcare professionals from 44 countries demonstrated that skin tears can be validly and reliably assessed using the ISTAP classification system (Van Tiggelen et al, 2020).

The ISTAP classification system uses a simple method to classify skin tears, categorising them as either Type 1, Type 2 or Type 3 [Figure 9]:

Type 1 skin tear—no skin loss (linear or flap tear where the skin flap can be repositioned to cover the wound bed).

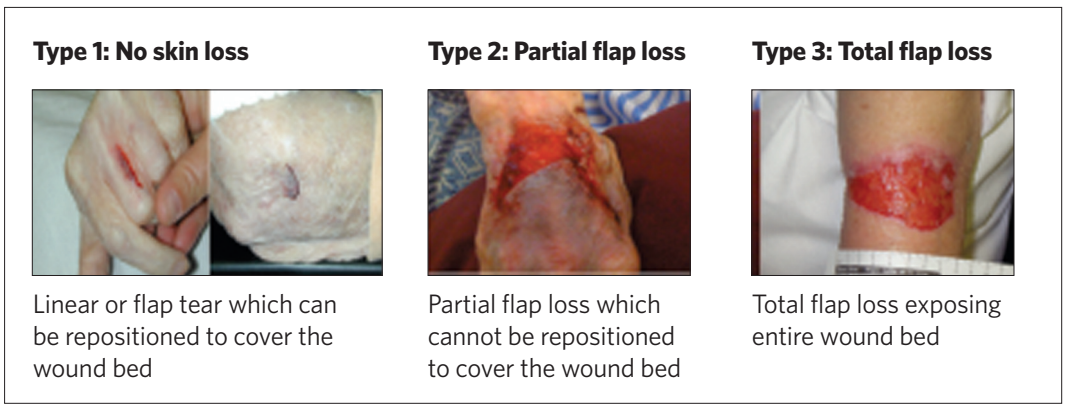
Type 2 skin tear—partial flap loss (the skin flap cannot be repositioned to cover the whole of the wound bed).

Type 3 skin tear—total flap loss (total skin flap loss that exposes the entire wound bed).

It should be noted that, in reference to skin tears, 'flap' refers to the skin flap. Van Tiggelen et al (2020) provide a clear definition of the term 'flap', which the authors proposed is helpful for classification purposes (see the section 'What is a skin tear?' on page 4 for this definition).

Clinical practice point: Use the ISTAP Skin Tear Classification Tool to categorise skin tears.

Figure 9. ISTAP Skin Tear Classification.
'A flap in skin tears is defined as a portion of the skin (epidermis/dermis) that is unintentionally separated (partially or fully) 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, for example, surgical skin grafting (content and images adapted from ISTAP, 2018; Van Tiggelen et al, 2020)



Measurement

Wound measurement is crucial to monitor progress, yet measuring skin tears can be a challenge in clinical practice. For example, it can be difficult to assess where the flap ends and intact skin resumes, or to measure underneath the flap. Measurement should be conducted in line with local policies and guidelines; a general rule is to measure the visible open wound bed, and differentiate this from the flap.

While measuring wound size is important, assessing flap viability is often a more useful indicator of wound status. In some cases, the wound may initially appear to be progressing, but if the skin flap becomes ischaemic or non-viable, it can alter the classification of the skin tear and significantly impact its potential to heal in a timely manner.

The main aim of wound measurement is to monitor whether the wound is decreasing in size as treatment progresses. For monitoring purposes, consistency is key.

Clinical practice point: Measurements should be captured as accurately as possible and the same method used with each measurement to track progress as treatment continues.

Photography

If permitted by the institution/facility policy, photographing the wound may be useful (in addition to measurement) to track the wound and its progress. This is especially true for patients with limited access to wound care facilities (e.g. for those living in rural areas). For monitoring, photographs may help to identify whether the flap is becoming more/less viable or any changes to the skin that may be significant. Clinicians must follow their local guidelines when receiving and viewing sensitive patient information, such as photographs. It is crucial to avoid patient identifiers and employ secure storage. In addition to providing visual documentation of the wound, photography can assist in confirming whether the wound is a skin tear and in determining its appropriate classification.

Wongvibulsin and Feterik (2022) and Dhoonmoon et al (2023) provide an overview of considerations when undertaking clinical photography:

- Obtain informed consent
- Ensure timely preparation and appropriate positioning of the area that is to be photographed
- Consider optimising the effects of orientation, focus, resolution, field of view, scale and colour, and lighting (where possible, use natural lighting)
- Use a calibrated colour chart to ensure true colours are captured
- Store and document the photograph appropriately, ensuring it is saved in an appropriate format
- In some instances, videos can provide more information than static photographs, for example, a video can help view the changes/reactions in skin if pressure is applied or to visualise the wound from several different angles.

The National Wound Care Strategy Programme (NWCSP, 2021) provides step-by-step guidance for clinicians when photographing wounds.

If the patient is able and has been taught, it may be useful to encourage them to take photographs of their own wounds to monitor changes between clinician appointments. See Box 5 for tips for patients who would like to photograph their own wounds. Practical tips for patients from the NWCSP (2023) can help to ensure they are aware of methods to obtain good-quality photographs. Emerging technologies using artificial intelligence are becoming increasingly available in clinical settings to facilitate assessment and documentation.

Clinical practice point: Take a photograph of the skin tear for documentation purposes.

BOX 5. Tips for patients photographing their own wound (adapted from Lindsay Leg Club, 2021)

- Most mobile phones and tablets should be capable of taking a good photograph
- Photographs may help your clinician when assessing progress of your skin tear
- It may help to get someone else to take the photographs, particularly if you can't see your wound clearly
- It may be easier to use a mirror if you have difficulty with focusing on the wound site. If you take the photograph of the wound through the mirror, then the flash should be turned off or it will be too bright and obstruct the image
- Do not get the device too close: most cameras and phones can only focus to about half a metre. If you go closer, it may be blurred. Your clinician can always zoom in on particular areas of the photograph, if required
- When it comes to capturing visual images, light beomes important. Use a bright area or make sure you put the lights on, and the light falls on the wound
- Ask your clinician to provide you with a paper ruler or use a tape measure placed close to the edges of your wound, as it often helps your clinician to assess the size of your wound
- Try to photograph your wound from the same angle every time.

Documentation

Thorough and accurate documentation is essential. A wound assessment must be performed and recorded at every visit or dressing change: the size of the wound, depth, colour and shape, as well as characteristics of drainage and the condition of surrounding skin, should be documented (Hampton, 2015).

This is vital, not only to indicate the stage and progress of the wound, but to ensure that the next clinician caring for the patient has all the information to make appropriate decisions and select an appropriate dressing.

From a legal perspective, if inaccurate, incomplete, or missing documentation contributes to patient harm and results in legal action, an expert witness would have difficulty defending a clinician who failed to provide clear and thorough records (Hampton, 2015).

Clinical practice point: Refer to relevant professional standards for record-keeping/documentation.

MANAGEMENT OF SKIN TEARS

Skin tears identified as acute wounds have the potential to be closed by primary intention. Traditionally, wounds closed by primary intention are secured with sutures, staples or adhesive strips. Using these materials can add further harm to the skin tear if disrupted (e.g. if the strip accidentally lifts off). Due to the fragility of aged skin and the typically shallow nature of skin tears, standard closure methods are not recommended; instead, less potentially traumatic approaches should be used.

Where possible, treatment of skin tears should aim to preserve the skin flap and maintain the surrounding tissue, re-position/re-approximate the flap (without stretching the skin), and reduce the risk of infection and further injury while considering any comorbidities (LeBlanc et al, 2024). Commencing appropriate treatment as soon as possible improves patient outcomes, therefore patients and caregivers should be educated to perform first aid when a skin tear occurs (e.g. stop the bleeding, clean the wound, dab the wound instead of rubbing it and avoid standard dressings with acrylic- or rubber-based adhesives), in order to preserve the viability of the skin flap where possible.

The skin tear decision algorithm [Figure 10] is designed to help clinicians in the assessment and treatment of skin tears, maintaining a continuous link between prevention, assessment, and treatment.

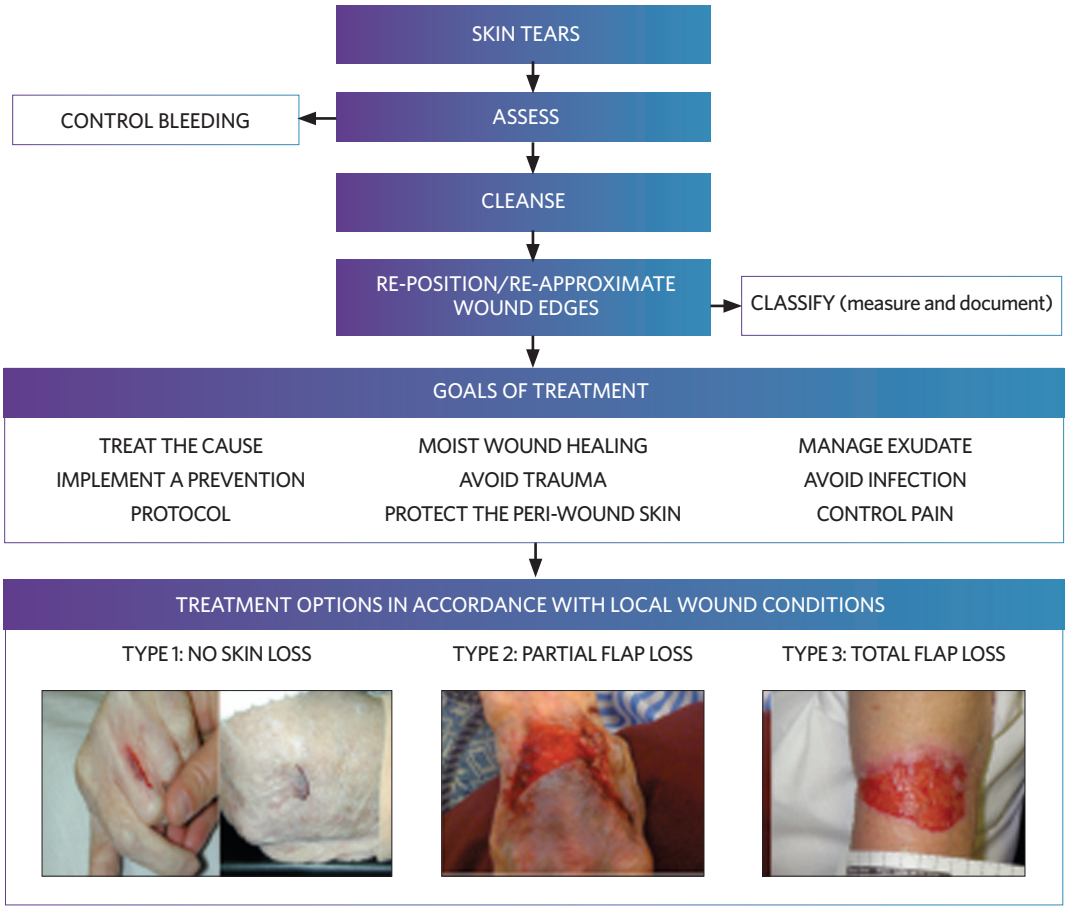


Figure 10. Skin tear decision algorithim (adapted from LeBlanc et al, 2013)

Initial treatment goals

Using the treatment algorithm detailed in Figure 10, it is important to consider the initial goals of treatment and the necessary steps to take in treating the skin tear. Refer to product selection (page 24) for additional information. Upon presentation, the clinician must control bleeding to ensure proper cleaning, accurate assessment and appropriate re-alignment.

Control bleeding:

- Apply gentle pressure and elevate the injured limb if appropriate
- When controlling bleeding is the main goal, dressings (e.g. calcium alginate) or topical agents (e.g. cyanoacrylate) to assist with haemostasis may be used. Non-adherent dressings should be used to avoid compromising the skin flap (LeBlanc et al, 2016b) and dry gauze or any adherent dressing should be avoided to minimise the risk of re-traumatising the wound and causing additional bleeding.

Cleanse and debride:
The following steps should be undertaken by clinicians as per local guidelines in an appropriate clinical setting.

- Cleanse/irrigate the wound as per institution/facility protocol and remove any residual debris or haematoma; gently pat the surrounding skin dry to avoid further injury (for more information, see the publication, 'Therapeutic wound and skin cleansing' from the International Wound Infection Institute [2025])
- If the skin flap is present but necrotic it may need to be debrided; care should be taken during debridement to ensure that viable skin flaps are left intact and fragile skin is protected. Debridement facilitates the removal of necrotic tissue and debris, and thus reduces bacterial colonisation and improves tissue perfusion (Nokaneng and Fourie, 2025). The choice of appropriate debridement is dependent on the wound characteristics and the clinician's expertise (Nokaneng and Fourie, 2025)
- If viable, re-approximate the skin flap onto the wound bed, i.e. gently ease the flap back into place using a gloved finger and dampened cotton tip applicator. At this point, the skin tear should be classified according to the ISTAP's skin tear classification system (Nokaneng and Fourie, 2025)
- For a Type 1 linear skin tear, re-approximate the wound edges; for a Type 2 skin tear, re-approximate the flap as much as possible; for a Type 3 skin tear, there is no flap.

Manage infection/inflammation:

- Wound inflammation should be distinguished from wound infection for more information
- Wound infection can result in pain and delayed wound healing
- Diagnosis of infection should be based on clinical assessment and appropriate infection control measures taken
- Routine or preventative use of topical or systemic antibiotics or antimicrobials is not indicated
- Check tetanus immunisation status and seek guidance on what further steps may be required
- Consider moisture balance/exudate control
- Initially, the skin tear may have excessive exudate; subsequently, however, skin tears are at risk of drying-out. There may be some circumstances in which exudate can be an issue. For example, excessive exudate may indicate an overgrowth of bacteria/infection
- Moisture balance is essential to promote wound healing and to protect the peri-wound skin from maceration or desiccation (drying out)
- Observe the volume and viscosity of the exudate when selecting a topical wound dressing
- Monitor wound edge/closure
- Skin tears are acute wounds that should typically proceed to closure in a timely fashion, i.e. 14–21 days or prior to 4 weeks
- Ensure that all potential factors that could delay healing (e.g. diabetes, peripheral oedema, nutritional issues) have been addressed and optimised
- Compression therapy should be considered if the wound is on the lower leg. Before applying compression, a full leg assessment including vascular assessment—e.g. Ankle-Brachial Pressure Index/Ankle Brachial Index (ABPI/ABI)—should be carried out (see Box 6 for more information on compression therapy).

Clinical practice point: Following a vascular assessment and exclusion of significant arterial disease, consider the use of compression therapy in patients with a skin tear on the lower limb.

BOX 6. Compression therapy in skin tears (for a detailed discussion on compression therapy for skin tears, see Wounds UK, 2020)

- Oedema is often present in patients with lower limb wounds and reduces healing progression; if present concomitantly, oedema is likely to negatively impact skin tear healing; note that presence of oedema may not always be obvious
- Compression therapy has been shown to reduce time to healing and improve patient outcomes in people with skin tears; a thorough assessment of perfusion status should be done prior to initiating compression (Wounds UK, 2020)
- The patient must receive a full assessment to determine whether compression is safe
- Anyone who presents with a lower limb wound should have a lower limb assessment and receive compression therapy if appropriate (e.g. up to 10mmHg in all patients, and up to 40mmHg in patients who have been deemed suitable after full vascular assessment (Wounds UK, 2020)
- If compression therapy is deemed safe for the patient, compression for arms may also be beneficial.

Wound care product selection
When skin tears occur, it is vital that wound care products chosen will optimise wound healing and not increase the risk of further skin damage and infection. This should include specialised dressings and products to cleanse and moisturise the skin, as available.

The ideal dressing for managing skin tears should:
- Provide absorption
- Be easy to apply and remove
- Be atraumatic and reduce pain upon removal
- Provide a protective anti-friction barrier
- Optimise the physiological healing environment (e.g. control moisture, bacterial balance, temperature, pH)
- Be flexible and mould to contours
- Provide secure, but not aggressive, retention/adhesion
- Afford extended wear time
- Optimise quality of life and cosmetic factors
- Be cost-effective (Carville and Smith, 2004; ISTAP, 2018).

Remember not all dressing options are available in all geographical and clinical settings. Therefore, it is important to provide the best treatment with the products available, ensuring individual needs of the wound and the patient, and the basic principles of moist wound healing, are met using local guidance. If available, silicone dressings should be used as data indicate they improve skin tear healing compared to non-silicone, non-adherent dressings. Recent data indicate that silicone dressings versus non-silicone nonadherent dressings may improve skin tear healing (LeBlanc and Woo, 2022; O'Brien et al, 2024).

Moist wound healing
The principles of moist wound healing apply when making treatment decisions regarding skin tears. Dry wounds may require additional moisture, whereas wounds with larger volumes of exudate might require dressings that contain absorptive capacity and the ability to prevent exudate from damaging the surrounding skin (LeBlanc et al, 2021b).

Dressing with an atraumatic wound contact layer (e.g. lipidocolloid dressing, impregnated gauze mesh, silicone mesh) are generally a good choice for all skin tears (dry or exudative) as they have the ability to maintain moisture balance for different levels of wound exudate, and facilitate atraumatic removal to prevent further damage to fragile skin (ISTAP, 2018). The use of silicone foam dressings have been demonstrated to support healing and wound closure within an expected healing trajectory, quicker time to wound closure and faster mean healing times, as compared to non-silicone dressings (LeBlanc and Woo, 2022).

Dressing adhesion
People with skin tears will often have fragile skin that needs to be protected from further damage, so dressing adhesion is a key consideration. This can be challenging in practice, as there is no recognised scale of adhesion, so it may be difficult to know which dressings are more/less adhesive. Silicone-based adhesives are generally less aggressive than acrylate-based adhesives. When selecting adhesive dressings and tapes, it is useful to ask manufacturers for data regarding the 'skin-friendliness' of their products.

Dressings should be selected using the lowest level of adhesion appropriate for the patient's needs. If a more adherent dressing is required, extra care should be taken during removal to minimise the risk of skin damage. Appropriate, sterile adhesive-removal products should be used, where needed. Liquid adhesive removers are available in various delivery formats and are helpful in removing adherent dressings, tapes and ostomy pouches. Alcohol-free barrier films can be applied to skin under adhesives to help prevent skin tears. It is important to distinguish barrier films from adhesion promoters such as benzoin tincture. Adhesion promoters should be avoided in patients with at-risk skin.

See Table 3 for considerations on the types of adhesives commonly used in medical devices and dressings; see Box 7 for tips to ensure best dressing practice and reduce the risk of further skin damage (e.g. MARSI).

Dressing removal tips
To minimise pain at dressing change and MARSI, consider removing dressings slowly while:
- supporting the surrounding skin and gently removing the dressing in the direction the skin flap lies
- focusing on small areas at a time during removal
- aiming at a low angle of traction of the skin
- applying counter-traction (with one finger) and
- using adhesive removers/solvents when necessary.
- Removing the dressing in the direction of the flap helps prevent accidentally lifting or disrupting the fragile skin flap that is trying to heal. Pulling against the flap risks reopening the wound, causing bleeding, pain and delayed healing.

Table 3. Type of adhesives used in medical devices and dressings and their potential impact when used for people at risk of skin tears (adapted from Fumarola et al, 2020)

Type	Advantages	Disadvantages
Silicone	• Biocompatible with skin • Repositionable (extends dressing wear time) • Useful for repeat application to the same area • Moisture/water-resistant • Permeable • Atraumatic removal from skin • Latex-free • Hypoallergenic	• More expensive than acrylate adhesives • Less moisture-resistant than acrylate tape
Acrylate	• Less expensive than silicone adhesives	• Can cause more skin trauma during removal
Hydrocolloids	• Adhesion can weaken over time depending on its water content	• Can cause skin trauma during removal

BOX 7. 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. The image in this box depicts this concept (image adapted from LeBlanc et al, 2016b)
- Adhesive removers can be used when removing the dressing to minimise trauma
- Take time to remove dressings slowly
- Consider using a skin barrier product to protect the surrounding skin (e.g. to prevent maceration if the wound has high exudate levels)
- 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 or the wound deteriorates, refer to an appropriate specialist as per local protocol.

Clinical practice point: Select a product with the lowest level of adhesive possible for the individual needs of the patient and their wound.

Undisturbed wound healing (UWH)

In recent years, there has been growing evidence of the benefits of undisturbed wound healing (UWH). In appropriate patients, dressings with a longer wear time can result in a range of benefits including:

- Optimal wound healing when the wound remains undisturbed (unless there is a specific reason not to do so)
- Reduced risk of contamination and potential infection is reduced
- Further potential benefits, such as cost-savings and decreased clinician time (Brindle and Farmer, 2019).

Brindle and Farmer (2019) recommend decreasing the frequency of dressing changes to every 5–7 days, provided it is appropriate based on wound and patient assessments.

There are cases when promoting UWH is not suitable; for example, when moderate to high levels of exudate lead to dressing saturation, strikethrough or fluid leakage (Morgan-Jones et al, 2019). Consider various potential indicators that may warrant a dressing change including:

- Strikethrough or saturation of the dressing
- Dressing leakage
- Excessive bleeding
- Peri-wound maceration

- Suspected local infection (e.g. local wound pain, redness, swelling)
- Wound deterioration
- Loss of adherence of the dressing (i.e. the dressing is peeling off).

Clinical practice point: Carefully assess whether UWH is an appropriate approach to skin tear healing.

Traditional/indigenous medicine

All healthcare clinicians should be culturally aware and respect patients individual cultural beliefs. In some cultures, there may be mistrust of 'mainstream' medicine, so it is necessary to work in partnership with the patient at a level that feels comfortable for them (Sandy-Hodgetts et al, 2022; Dhoonmoon et al, 2023).

An integrative-medicine approach may be considered to deliver care that honours the patient's values, preferences and individual needs. In some cases, it may be necessary to work alongside 'traditional' healers or other leaders within the patient's community (Sandy-Hodgetts et al, 2022). Traditional medicine (e.g. aloe vera plant, banana leaves/skin), can also be an option in facilitating moist wound healing in some areas.

Products not recommended for use in skin tears

Acknowledging that product availability may pose challenges, it is advisable to avoid the use of iodine-based dressings and other products with cytotoxic properties, whenever possible.

- Iodine causes drying of the wound and peri-wound skin and dry skin is a major risk factor for skin tear development (ISTAP, 2018). Therefore, iodine-based products should not be used for the management of skin tears or for those who are deemed at risk for skin tears (LeBlanc et al, 2016b).

Transparent film/hydrocolloid dressings with strong adhesives

- Films/hydrocolloid dressings with an acrylic- or rubber-based adhesive have a strong adhesive component and have been reported to contribute to medical-adhesive related skin tears (McNichol et al, 2013). These dressings are not recommended for use in those who have, or are at high risk of, a skin tear
- Note that these considerations do not apply to silicone films which are generally less agressive or non-adherent (LeBlanc and Woo, 2022).

Adhesive skin closure strips

- Expert opinion suggests that adhesive wound closure strips are no longer a preferred treatment for skin tears (Holmes et al, 2013; Wounds UK, 2015; LeBlanc et al, 2016b; ISTAP, 2018).

Gauze

- Plain gauze without a silicone contact layer is not recommended, as it does not adequately secure the skin flap, and it increases the risk of flap displacement during removal due to adhesion to the tissue
- It should be noted that, in settings where product availability is an issue or resources are limited, wherever possible, an alternative should be used in preference to gauze.

Clinical practice point: Discuss with your colleagues which products should not be used on skin tears.

CONCLUSIONS AND THE FUTURE

Updating these best practice recommendations has highlighted that evidence underpinning skin tears is still evolving and requires further research. Above all, although largely preventable, skin tears still represent a challenge to patients and the clinicians who treat them.

It should be emphasised that prevention of skin tears should always be the primary aim. As well as improving patients' quality of life, prevention is less costly than treatment and reduces the burden on often overstretched clinicians and healthcare services.

Focusing on skin integrity and preserving the patient's skin has been shown to reduce the risk of further types of skin damage, in addition to skin tears, vastly improving overall outcomes (Beeckman et al, 2020). When skin tears occur, early identification, accurate assessment and appropriate treatment are critical. Product selection should prioritise minimising additional trauma, with careful consideration of the fragile skin surrounding the wound during all stages of treatment and dressing application.

Both prevention and treatment may be difficult where there is a lack of access to necessary products and resources. It is important that all clinicians have the knowledge and confidence to provide the best evidence-based care for their patients using the resources available.

Gaps in evidence, clinician knowledge and practice persist, highlighting the need for further research, ongoing education and the development of standardised skin tear prevention and treatment protocols (Wang et al, 2025; Bandeira da Silva et al, 2025; Jiang et al, 2025). Key areas identified for future research include:

- Healing outcomes using specific dressing types
- Collection of skin tear prevalence and incidence data
- Increased evidence for identification and treatment of skin tears across a range of skin tones
- Skin tears and health economics
- Use of data collection tools for accurate data (see Appendix 1, page 28)
- Evaluation of risk factors for skin tear development across the continuum of life and care settings (Bandeira da Silva et al, 2025)
- The potential role of artificial intelligence/machine technology, particularly for risk assessment.

With the projected global rise in ageing population and the associated burden on clincians and healthcare systems (Khan et al, 2024), it is paramount to optimise skin tear prevention and care. All clinicians should employ the knowledge and tools outlined in this publication for appropriate approaches to reducing skin tear burden for their patients.

APPENDIX 1: ISTAP SKIN TEAR DATA COLLECTION TOOL (V1)

Access the ISTAP DC-Tool: Scan the QR code to access the ISTAP website and register to download a copy of the validated ISTAP DC-Tool.

Question*	Example	Comments
Date of data collection (required)	Input as Month/Date/Year	
Designation of person completing this form (required)	Free text response	
Select the patient/person's current setting (required)	5 options, includes 'other' with free text	Collecting these data will help to determine which settings are most commonly associated with skin tears
Please assign a patient/person code or number (required)	e.g. #PT01-ICU)	This is to ensure patient anonymity for data collection purposes according to Good Clinical Practice standards
Patients year of birth (required)	e.g. 1974	These data will help to determine which age groups are most at risk of skin tears
Patient gender (required)	4 options, including prefer not to say	It's not known if gender is a specific risk factor for skin tears. Collecting these data will help to inform epidemiology
Skin tone tool (adapted from Ho and Robinson 2015): Use the picture below to select the nearest skin tone of the patient/person and select the appropriate number (1-6) (required)	6 options	There are a lack of data regarding the prevalence/incidence of skin tears in different skin tones. Collecting this variable will help to determine prevalence/incidence in order to determine if particular skin tones are at a higher risk of skin tears
Number of skin tears currently present (required)	Allows data for up to 3 skin tears to be entered. If more than three skin tears are present, complete an additional form with the same patient/person code	
Location of skin tear (required)	10 options, including other which is a free text response	Existing data suggests that skin tears are more common on the upper limbs (arms and hands) and lower limb (shins). Skin tears are less common on other anatomical areas. Location of the injury may help with differential diagnosis from other wound types such as pressure ulcers/injuries, moisture-associated skin damage, and irritant contact dermatitis
Classify the type of skin tear(s) according to the ISTAP classification shown in the image below (required)	Type 1 (Type 1 Linear or Type 1 Flap), Type 2 or Type 3	The ISTAP classification Tool is a validated tool which is recommended for use in clinical practice and research (Van Tiggelen et al, 2020). It is available in 15 different languages, please see https://www.skintears.org/resources
Where did the Skin Tear #1 occur? (required)	Drop down menu, includes other	Will help to determine if the skin tear was facility acquired. Depending on local policy an incident form (datix report) should be completed
What wound treatment or dressing is currently in place on Skin Tear #1? (required)	10 options, including other which is a free text response	The ISTAP Best Practice Recommendations (2018) provide a list of suggested products: Nonadherent mesh dressings (e.g. lipidocolloid mesh, impregnated gauze mesh, silicone mesh, petrolatum), Foam Dressings, Hydrogels, -Octyl cyanoacrylate topical bandage (skin glue), calcium alginates, gelling fibres, acyrlic dressings. For infected wounds Methylene blue and gentian violet dressings or ionic silver dressings. IF IODINE DRESSINGS, FILMS, HYDROCOLLOIDS, GAUZE OR WOUND CLOSURE STRIPS ARE BEING USED CHANGE TO ONE OF THE RECOMMENDED PRODUCTS. See the ISTAP Pathway to Assessment/Treatment https://www.skintears.org/resources

Question*	Example	Comments
How long has the Skin Tear #1 been present (Please select the most appropriate option) (required)	6 options	Skin Tears are acute wounds and if uncomplicated should heal within 14-21 days. If it has been present for more than 3 weeks consider referring to a specialist for advice. For skin tears on the lower limb (leg) a vascular assessment should be undertaken, including an ankle brachial pressure index (ABPI)/ankle brachial index (ABI). In the absence of arterial disease consider the use of compression therapy, see: https://wounds-uk.com/best-practice-statements/management-lower-limb-skin-tears-adults/
How did the Skin Tear #1 occur? (required)	7 options	Expert opinion suggests that there are a number of common causes of skin tears. Collecting these data will help to determine cause and also help to identify if the skin tear was facility acquired. For example 'removal of adhesive/device/dressing would be considered a Medical Adhesive Related Skin Injury (MARSI). Collection of these data will also help to identify what aspects of a risk reduction pathway need to be implemented see: LeBlanc, K et al: A Tool Kit to Aid in the Prevention, Assessment, and Treatment of Skin Tears Using a Simplified Classification System©. Advances in Skin & Wound Care 26(10):p 459-476, October 2013. | DOI: 10.1097/01.ASW.0000434056.04071.68
Indicate the patient's pain level at the time of sustaining the skin tear on a scale of 0 – 10 (0 = no pain, 10 = worst pain) (required)	NRS or Wong Baker Faces Scale can be used depending on level of cognitive impairment	There are a lack of data on how painful skin tears are. Assessing the level of pain will help to inform treatment options.
Indicate the patient's pain level after wound treatment or a wound dressing was applied on a scale of 0 – 10 (0 = no pain, 10 = worst pain) (required)	As above	Assesment of pain after dressing application will help to determine appropriate product choice amd guide treatment
Any history of previous skin tears? (required)	3 responses	Expert opinion suggests that individuals who have a history of previous skin tears are at risk of further skin tears. Collecting these data will help to determine if there is a correlation
Patient/Person's risk factors (required)	9 options including other which is a free text response	A review of the evidence has suggested that are a number of risk factors for skin tears. Collecting these data will facilitate analysis in order to determine if a correlation exists
Medications (required)	4 options	A review of the evidence has suggested that are a number of medications that may place an individual at hogher risk for skin tears. Collecting these data will facilitate analysis in order to determine if a correlation exists
Has a nutritional assessment been done? (required)	3 options	Adequate nutrition and hydration is required to maintain skin integrity and to promote wound healing. Undertaking a nutritional assessment will help to determine if the patient is nutritionally deficient. If the patient is at risk they should be referred to a dietitian
Has a falls risk assessment been done? (required)	3 options	Expert opinion suggests that falls are a risk factor skin tears. Collecting these data will help to determine if there is a correlation
Any additional information? (optional)	Free text response	
**Of all questions listed above, only the last question is 'optional'.*		

APPENDIX 2: GLOSSARY OF TERMS

Acute wound
'Disruptions in the integrity of the skin that heals uneventfully with time are considered acute wounds' (Sen et al, 2019).

Atraumatic
Being atraumatic means not causing trauma (e.g. a wound dressing may be considered atraumatic if it does not cause skin trauma or injury upon removal).

Blister (vesicles and bullae)
Blisters are 'visible accumulations of fluid within or beneath the epidermis' (NLM, 2024b).

Blisters can be divided into two types: vesicles and bullae.

BMJ Best Practice (2025) describes vesicles and bullae as:
- 'Vesicles are circumscribed, fluid-filled epidermal elevations <1 cm in diameter'
- 'Bullae are blisters >1 cm in diameter containing serous or seropurulent fluid'.

Chronic wound
'Wounds are considered chronic when healing fails to proceed normally and the anatomic and functional integrity of the skin is not achieved in approximately 1 month' (Clinton and Carter, 2015).

Complex wound
'Complex wounds can be defined as superficial-, partial-, or full-thickness skin loss wounds healing by secondary intention' (Hall et al, 2014).

Flap
'A flap in skin tears is defined as a portion of the skin (epidermis/dermis) that is unintentionally separated (partially or fully) from its original place due to shear, friction, and/or blunt force'
(Van Tiggelen et al, 2020).

Laceration
NICE (2022) defines lacerations as 'a deep cut or tear in the skin and/or underlying tissue, commonly caused by blunt trauma (such as a fall or collision), incision by a sharp object, or mammalian bite'.

MARSI
A medical adhesive-related skin injury (MARSI) includes any form of skin damage, such as skin tears, blistering or other forms of skin damage, that is caused by a medical adhesive (Savine and Snelson, 2024).

Skin tear
A skin tear is a traumatic wound caused by mechanical forces, including removal of adhesives and patient handling, the depth of which may vary (not extending through the subcutaneous layer).

REFERENCES

Alexis AF, Woolery-Lloyd H, Williams K et al (2021) Racial/ethnic variations in skin barrier: Implications for skin care recommendations in skin of color. *J Drugs Dermatol* 20(9): 932-8

Al Khaleefa N, Moore Z, Avsar P et al (2022) What is the impact of skincare bundles on the development of skin tears in older adults? A systematic review. *Int J Older People Nurs* 17(4): e12455

Baki DAA, Avsar P, Patton D et al (2021) What is the impact of topical preparations on the incidence of skin tears in older people? A systematic review. *Wounds UK* 17(2): 33-43

Bandeira da Silva CV, Beeckman D, de Gouveia Santos VLC (2025) Nurses' knowledge of skin tears: A cross-sectional survey study across four hospitals in São Paulo, Brazil. *J Tissue Viab* 34(1): 100874

Beeckman D, Campbell KE, LeBlanc K (2020) *Best practice recommendations for holistic strategies to promote and maintain skin integrity.* Wounds International

BMJ Best Practice (2025) Accessement of vesicular-bullous rash. Available at: https://bestpractice.bmj.com/topics/en-gb/775#:~:text=Last%20updated:%2031%20Dec%202024,infection%2C%20typically%20heal%20without%20scarring (accessed 11.04.2025)

Brindle T, Farmer P (2019) Undisturbed wound healing. *Wounds International* 10(2): 40-8

Brooks SG, Mahmoud RH, Lin RR et al (2025) The Skin Acid Mantle: An Update on Skin pH. *J Inves Dermatol* 145(3): 509-21

Carville K, Smith J (2004) A report on the effectiveness of comprehensive wound assessment and documentation in the community. *Prim Intent* 12(1): 41-9

Carville K, Leslie G, Osseiran-Moisson R et al (2014) The effectiveness of a twice-daily skin-moisturising regimen for reducing the incidence of skin tears. *Int Wound J* 11: 446-53

Cilluffo S, Bassola B, Beeckman D et al (2023) Risk of skin tears associated with nursing interventions: A systematic review. *J Tissue Viab* 32(1): 120–9

Clinton A, Carter T (2015) Chronic Wound Biofilms: Pathogenesis and Potential Therapies. *Lab Med* 46(4): 277-84

Coalition for At-Risk Skin (2022) At-Risk Skin: 21 Consensus Statements From the Coalition for At-Risk Skin. Available at: https://cdn.coverstand.com/67867/769223/bf47f724cd2d7f37b95ef4eb533b3ea9892fbf23.2.pdf (accessed 11.03.2025)

Deprez J, Beeckman D (2022) Measures that patients living in the community can take for the prevention and treatment of skin tears: A comprehensive review of the literature. *J Wound Manage* 23(2): 70-7

Dharmarajan TS, Vyas D (2025) Pruritus. In: Norman R, Dharmarajan TS, eds. *Geriatric dermatology.* Springer, London: 1-27

Dhoonmoon L, Fletcher J, Atkin L et al (2021) *Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones.* Wounds UK

Dhoonmoon L, Nair HKR, Abbas Z et al (2023) *International Consensus Document: Wound care and skin tone. Signs, symptoms and terminology for all skin tones.* Wounds International

Fan S, Jiang H, Shen J et al (2024) Prediction models for skin tears in the elderly: A systematic review and meta-analysis. *Geriatr Nurs* 59: 103-12

Finch K, Osseiran-Moisson R, Carville K et al (2018) Skin tear prevention in elderly patients using twice-daily moisturiser. *Wound Prac Res* 26(2): 99-109

Formosa E, Holloway S (2022) A cross-sectional study using the skin tear knowledge assessment instrument (OASES) to assess registered nurse's knowledge about the identification, classification, prevention, assessment, and management of skin tears in a geriatric rehabilitation hospital. *J Wound Manage* 23(2): 109-18

Fumarola S, Allaway R, Callaghan R et al (2020) Overlooked and underestimated: medical adhesive-related skin injuries. *J Wound Care* 29(Sup3c): S1-24

Furukawa C (2019) Factors related to skin tears in a long term care facility. *Gan To Kagaku Ryoho* 46(Sup1): 154-6

Gefen A (2023) Role of shear in skin tolerance to pressure ulcers and implications for skin tone diversity. *J Wound Care* 32(8): 469

Groven FMV, Zwakhalen SMG, Odekerken-Schröder G et al (2021) Comfort during the bed bath-A randomised crossover trial on the effect of washing without water versus water and soap in nursing students. *J Clin Nurs* 30(15-16): 2234-45

Hall J, Buckley HL, Lamb KA et al (2014) Point prevalence of complex wounds in a defined United Kingdom population. *Wound Rep Reg* 22: 694-700

Hampton S (2015) Accurate documentation and wound measurement. *Nurs Times* 111(48): 16-9

Hawkins S, Dasgupta BR, Ananthapadmanabhan KP (2021) Role of pH in skin cleansing. *Int J Cosmetic Sci* 43(4): 474-83

Heerschap C, Nicholas A, Whitehead M (2019) Wound management: Investigating the interprofessional decision-making process. *Int Wound J* 16(1): 233-42

Holmes RF, Davidson MW, Thompson BJ et al (2013) Skin tears: care and management of the older adult at home. *Home Healthcare Nurse* 31(2): 90-101

Idensohn P, Beeckman D, Campbell KE et al (2019a) Skin tears: A case-based and practical overview of prevention, assessment and management. *J Community Nurs* 33(2): 32-41

Idensohn P, Beeckman D, Santos VLCG et al (2019b) Ten top tips: skin tears. *Wounds International* 10(2): 10-4

Idensohn PJ, Gilbert K, Boodhoo K et al (2025) The Prevalence, Aetiology and Healing Trajectories of Hard-To-Heal Wounds in South Africa. *Int Wound J* 22(3): e70155

International Skin Tears Advisory Panel (2018) *Best practice recommendations for the prevention and management of skin tears in aged skin.* Wounds International

International Wound Infection Institute. *Therapeutic wound and skin cleansing: Clinical evidence and ecommendations.* Wounds International. 2025

Jiang Q, He H, Jing K et al (2025) Knowledge status of skin tear prevention and its demographic and occupational influencing factors: A National cross sectional survey among nurses. *J Adv Nurs* 81(3): 1412-22

Kacmaz HY, Karadag A, Kahraman H et al (2022) The prevalence and factors associated with skin tears in hospitalized older adults: A point prevalence study. *J Tissue Viab* 31(3): 387-94

Kacmaz YH, Kahraman H, Cinar SL et al (2023) Skin properties associated with skin tears in older adults: A case-control study. *J Tissue Viab* 32(4): 585-9

Kacmaz YH, Kahraman H, Topal Hancer A et al (2025) Skin tears in older patients in intensive care units: A multicentre point prevalence study. *Nurs Crit Care* 30(2): e13131

Kapoor A, Field T, Handler S et al (2019) Adverse events in long-term care residents transitioning from hospital back to nursing home. *JAMA Int Med* 179(9): 1254-61

Khalid KA, Nawi AFM, Zulkifli N et al (2022) Aging and Wound Healing of the Skin: A Review of Clinical and Pathophysiological Hallmarks. *Life (Basel)* 12(12): 2142

Khan HTA, Addo KM, Findlay H (2024) Public Health Challenges and Responses to the GrowingAgeing Populations. *Pub Health Chall* 3: e213

Kim JC, Shim WS, Kwak IS et al (2023) Pathogenesis and Treatment of Pruritus Associated with Chronic Kidney Disease and Cholestasis. *Int J Mol Sci* 24(2): 1559

Konya I, Nishiya K, Shishido I et al (2023) Minimum wiping pressure and number of wipes that can remove dirt during bed baths using disposable towels: a multi-study approach. *BMC Nurs* 22(1): 18

Konya I, Shishido I, Nemoto M et al (2024) Risk factors of skin barrier dysfunction in older adults: A systematic review. *Jpn J Nurs Sci* 21(3): e12597

Koyano K, Nakagami G, Iizaka S et al (2016). Exploring the prevalence of skin tears and skin properties related to skin tears in elderly patients at a long- term medical facility in Japan. *Int Wound J* 13(2): 189-97

Langemo D, Campbell KE, Holloway S et al (2021) Applying Frailty Syndrome to the Skin: A Review and Guide for Prevention and Management. *Adv Skin Wound Care* 34(8): 444-7

Lavker RM, Zheng PS, Dong G (1987) Aged skin: a study by light, transmission electron, and scanning electron microscopy. *J Invest Dermatol* 88(3 Suppl): 44s-51s

LeBlanc K, Baranoski S (2011) Skin tears– State of the science: Consensus statements for the prevention, prediction, assessment, and treatment of skin tears. *Adv Skin Wound Care* 24(9): 2-15

LeBlanc K, Christensen D, Cook J et al (2013) Prevalence of skin tears in a long-term care facility. *J Wound Ostomy Continence Nurs* 40(6): 580-4

LeBlanc K, Alam T, Langemo D et al (2016a) Clinical Challenges of Differentiating Skin Tears from Pressure Ulcers. *EWMA J* 16(1): 17-23

LeBlanc K, Baranoski S, Christensen D et al (2016b) The art of dressing selection: a consensus statement on skin tears and best practice. *Adv Skin Wound Care* 29(1): 32-46

LeBlanc K, Woo K, Van Den Kerkhof E et al (2020) Skin tear prevalence and incidence in the long-term care population: A prospective study. *J Wound Care* 29(Sup7): S16-22

LeBlanc K, Woo K, Van Den Kerkhof E et al (2021a) Risk Factors Associated with Skin Tear Development in the Canadian Long-term Care population. *Adv Skin Wound Care* 34(2): 87-95

LeBlanc K, Beeckman D, Campbell K et al (2021b) *Best practice recommendations for prevention and management of periwound skin complications.* Wounds International

LeBlanc K, Woo K (2022) A pragmatic randomised controlled clinical study to evaluate the use of silicone dressings for the treatment of skin tears. *Int Wound J* 19(1): 125-34

LeBlanc K, Dhoonmoon L, Samuriwo R (2024) *Skin tears and skin tone Made Easy*. Wounds International

Lindsay Leg Club (2021) Resources. Available at: https://www.legclub.org/resources (accessed 24.01.2025)

McNichol L, Lund C, Rosen T et al (2013) Medical adhesives and patient safety: state of the science: consensus statements for the assessment, prevention, and treatment of adhesive-related skin injuries. *Orthop Nurse* 32(5): 267-81

Miles SJ, Fulbrook P, Williams DM (2022) Skin tear prevalence in an Australian acute care hospital: A 10-year analysis. *Int Wound J* 19(6): 1418–27

Mizzou Derm Learning Modules (accessed 2025) Gross anatomy. Available at: https://mizzouderm.weebly.com/anatomy.html (accessed 14.05.2025)

Mitchell A, Hill B (2020) Moisture-associated skin damage: an overview of its diagnosis and management. *Br J Community Nurs* 25(3): S12-8

Mitchell A (2022) Skin assessment in adults. *Br J Nurs* 31(5): 274-8

Moncrieff G, Van Onselen J, Young T (2015) The role of emollients in maintaining skin integrity. *Wounds UK* 11(1): 68-74

Morgan-Jones R, Bishay M, Hernandez-Hermoso JA et al (2019) *Incision care and dressing selection in surgical wounds.* Wounds International

National Cancer Institute (2025) Nomogram. Available at: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/nomogram (accessed 06.05.2025)

National Institute for Health and Care Excellence (2022) Lacerations. Available at: https://cks.nice.org.uk/topics/lacerations/ (accessed 18.03.2025)

National Institute for Health and Care Excellence (2024) Emollients. Available at: https://cks.nice.org.uk/topics/eczema-atopic/prescribing-information/emollients/ (accessed 16.01.2025)

National Library of Medicine (2024a) Moisturizers. Available at: https://www.ncbi.nlm.nih.gov/books/NBK545171/ (accessed 11.03.2025)

National Library of Medicine (2024b) Blister. Available at: https://www.ncbi.nlm.nih.gov/mesh?Db=mesh&Cmd=DetailsSearch&Term=%22Blister%22%5BMeSH+Terms%5D (accessed 18.03.2025)

National Wound Care Strategy Programme (2025) The aSSKINg Framework. Available at: https://www.nationalwoundcarestrategy.net/wp-content/uploads/2023/10/The-aSSKINg-Framework.pdf (accessed 28.03.2025)

National Wound Care Strategy Programme (2023) Taking a photograph of your wound. Available at: https://www.nationalwoundcarestrategy.net/wp-content/uploads/2023/06/NWCSP-Digital-imaging-PIS-5Jun23.pdf (accessed 11.03.2025)

National Wound Care Strategy Programme (2021) Practical Recommendations for the use of Digital Images in Wound Care. Available at: https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/09/Digital-Images-in-wound-care-17Sept21.pdf (accessed 11.03.2025)

Nokaneng E, Fourie A (2025) Management of Skin Tears in Vulnerable Populations from Older Adults to Critically Ill Patients: ISTAP Part 2. *Adv Skin Wound Care* 38(2): 64-6

O'Brien J, Parker CN, Bui U et al (2024) What is the evidence on skin care for maintaining skin integrity and prevention of wounds? An integrative review. *Wound Prac Res* 32(1): 25-33

Ousey K, Cooper K, Fumarola S et al (2017) Findings from a multidisciplinary focus group meeting to discuss the issue of medical adhesive-related skin injury (MARSI) in the UK: the way forward. *Wounds UK 13(4): 141-5*

Parker CN, Finlayson KJ, Edwards HE et al (2020) Exploring the prevalence and management of wounds for people with dementia in long term care. *Int Wound J* 17(3): 650-9

Peer RP, Burli A, Maibach HI (2022) Did human evolution in skin of color enhance the TEWL barrier? *Arch Dermatol Res* 314(2): 121-32

Peres GRP, Bandeira da Silva CV, Strazzieri-Pulido KC et al (2022) Skin tears in older adult residents of long-term care facilities: prevalence and associated factors. *J Wound Care* 31(6): 468-78

Rayner RL, Carville KJ (2024) External validation of a predictive model for aged-related skin tears in Fitzpatrick skin types I-IV cohort. *Int Wound J* 21(8): e70031

Samuriwo R, Holloway S, Ousey K et al (2024) Critical analysis of the consensus document on current advances in risk assessment, prevention, and treatment of skin tears. A response from ISTAP. *J Wound Manag* 25(2): 77-80

Sandy-Hodgetts K, Ademuyiwa A, Awang P et al (2022) *Incision care and dressing selection in surgical incision wounds: Findings from an international meeting of surgeons and wound care specialists from Africa.* Wounds International

Savine L, Snelson K (2024) Medical adhesive-related skin injury (MARSI): Preventing patient harm. *Wounds International* 15(3): 28-36

Schoonhoven L, van Gaal BG, Teerenstra S et al (2015) Cost-consequence analysis of "washing without water" for nursing home residents: a cluster randomized trial. *Int J Nurs Stud* 52(1): 112-20

Sen CK (2019) Human Wounds and Its Burden: An Updated Compendium of Estimates. *Adv Wound Care (New Rochelle)* 8(2): 39-48

Serra R, Ielapi N, Barbetta A et al (2018) Skin tears and risk factors assessment: a systematic review on evidence-based medicine. *Int Wound J* 15(1): 38-42

Sethi A, Kaur T, Malhotra SK et al (2016) Moisturizers: The Slippery Road. *Indian J Dermatol* 61(3): 279-87

Souza LM, Teixeira GDS, Silva DMD et al (2021) Prevalence of skin tears in hospitalized adults and older adults. *Rev Esc Enferm USP* 55: e03683

Stephen Haynes J, Carville K (2011) Skin Tears Made Easy. *Wounds International* 2(4): 1-6

Van Tiggelen H, Van Damme N, Theys S et al (2019) The prevalence and associated factors of skin tears in Belgian nursing homes: A cross-sectional observational study. *J Tissue Viab* 28(2): 100-6

Van Tiggelen H, LeBlanc K, Campbell K et al (2020) Standardizing the classification of skin tears: Validity and reliability testing of the International Skin Tear Advisory Panel Classification System in 44 countries. *Br J Dermatol* 183: 146-54

Van Tiggelen H, Alves P, Ayello E et al (2021) Development and psychometric property testing of a skin tear knowledge assessment instrument (OASES) in 37 countries. *J Adv Nurs* 77(3): 1609-23

Van Tiggelen H, Beeckman D (2022) Skin tears anno 2022: An update on definition, epidemiology, classification, aetiology, prevention and treatment. *J Wound Manag* 23(2): 38-51

Varga M, LeBlanc K, Whitehead L et al (2022) Engaging the person with a lower leg skin tear in the wound-healing journey: A case study. *J Wound Manage* 23(2): 52-9

Veje PL, Chen M, Jensen CS et al (2020) Effectiveness of two bed bath methods in removing microorganisms from hospitalized patients: A prospective randomized crossover study. *Am J Infect Control* 48(6): 638-43

Voegeli D (2007) Factors that exacerbate skin breakdown and ulceration. Available at: https://www.researchgate.net/publication/313098689_Factors_that_exacerbate_skin_breakdown_and_ulceration (accessed 26.03.2025)

Völzer B, El Genedy-Kalyoncu M, Fastner A et al (2024) Enhancing skin health and safety in aged care (SKINCARE trial): A cluster-randomised pragmatic trial. *Int J Nurs* St 149: 104627

Vuorinen M, Ram F (2023) Effectiveness of moisturiser for the prevention of skin tears in older adults residing in long-term care facilities: a clinical review. *Br J Commun Nurs* 28(Sup9): S14-8

Wang G, Wang H, Wang L et al (2025) Assessing Skin Tear Knowledge Among Nurses: A Multicentre Cross-Sectional Survey. *J Clin Nurs* 34(4): 1409-19

Wongvibulsin S, Feterik K (2022) Recommendations for Better Adoption of Medical Photography as a Clinical Tool. *Interact J Med Res* 11(2): e36102

Woo K, LeBlanc K (2018) Prevalence of skin tears among frail older adults living in Canadian long-term care facilities. *Int J Palliat Nurs* 24(6): 288-94

Wounds UK (2015) *All Wales Guidance for the prevention and management of skin tears*

Wounds UK (2020) *Best Practice Statement: Management of lower limb skin tears in adults.* Wounds UK, London

Yang S, Liang X, She J et al (2024) Prevalence and incidence of skin tear in older adults: A systematic review and meta-analysis. *J Tissue Viab* 33(4): 1017-24

Young C (2021) Using the 'aSSKINg' model in pressure ulcer prevention and care planning. *Nurs Stand* 36(2): 61-6