SAMPLE POLICY ON SKIN TEAR PREVENTION

This document is not meant to be used “as is” and is only being distributed as an example of the kind of policy you may wish to implement in your facility. Because different types of facilities have different requirements and staffing, there is no “one size fits all” policy statement related to skin tear prevention. We suggest that you consult with your legal counsel and clinical managers in developing this or any policy or procedure.

Purpose

To provide comprehensive preventative skin care to all patients especially those vulnerable individuals susceptible to skin tear trauma.

Definitions

Skin Tear – Traumatic wound which occurs most often on extremities resulting in the separation of the epidermis from the dermis or both the epidermis and the dermis from the underlying structures.

Transfer – Moving a patient from the bed to a chair, wheel chair, stretcher, etc.

Repositioning – Changing the position of the patient in any situation, in bed, chair, wheelchair, etc.

Prevention Interventions

1. Do a risk assessment for skin tears on admission:
   a. Inspect extremities for evidence of thin, friable dry skin, healed skin tears, ecchymosis, senile purpura or pitting edema.
   b. History of long term systemic or topical steroid treatment.
   c. Document assessment results and intervene accordingly

2. If no risk is determined provide routine skin care.

3. If risk is determined protect the patient from injury:
   a. Assure a safe environment:
      i. Inspect the patient room, hospital bed, side rails and equipment for sharp edges and pad areas especially bed railings
      ii. Provide adequate lighting to aid visualization of furniture and equipment
      iii. Offer pajama bottoms and encourage wearing long sleeves to protect extremities
b. Increase skin care:
   i. Initiate twice a day lotion especially on dry skin on extremities
   ii. Use emollient antibacterial soap

c. Educate staff, patient and family of risk of injury and importance for:
   i. Engaging the patient and family in vigilance of skin protection
   ii. Using proper lifting techniques when transferring the patient
   iii. Using a draw sheet to minimize friction and shearing.
   iv. Encouraging good nutrition and hydration
   v. Obtaining a dietary consult

d. Protect the patient from injury by:
   i. Minimizing friction and shearing when: positioning, turning, lifting, sliding and transferring
   ii. Using a draw sheet to reposition a patient by lifting rather than dragging when moving a patient up in bed or from side to side
   iii. Using the draw sheet when transferring the patient from bed to chair or stretcher
   iv. Exercising caution when using equipment such as commodes, wheelchairs, stretchers, side rails
   v. Using pillows and blanket to pad sharp edges of equipment when included in patient’s care
   vi. Preventing dangling limbs by tucking arms and legs inside the wheelchair or stretcher and, when necessary, using pillows to support and maintain positioning
   vii. Eliminating quick or harsh movements

e. When dressings are needed:
   i. Using non adherent dressings
   ii. Using stockinettes or other wrap type dressings such as gauze to hold a primary dressing in place
   iii. Using only paper or cloth tape when necessary
   iv. Applying skin sealant before applying tape
   v. Using adhesive remover to remove tape
   vi. Removing tape by applying counter pressure and gently rolling it off

References


