Skin Tear and Traumatic Wound Pathway

Definition

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) (ISAP, 2025).
A traumatic wound is a sudden physical injury to skin and tissues, caused by external forces like accidents or violence. These unplanned injuries disrupt the skin's integrity and can involve blunt force, penetration, or tissue tearing, such as from falls, impacts, or sharp objects.

Important

Stop the bleeding:
apply clean gauze until the bleeding stops and elevate the limb where possible.
If the bleeding does not stop after 10 minutes of pressure please seek medical assistance.

Cleanse

Undertake wound bed preparation by following the Wound Bed Preparation and Therapeutic Cleansing Pathway

Exlude mechanical debridement unless directed to by the Skin Integrity Team or Tissue Viability and Lymphoedema Service

Assessment

Reapproximate any skin flaps where possible. If a flap is present ease it back into position (reapproximate) without pulling or applying tension. If difficult to align, use moistened gauze for 5-10minutes to rehydrate the area.
Categorise wound type:

- Skin Tear (Type 1 = Skin tears without tissue loss, Type 2 = Skin tears with partial tissue loss, Type 3 = Skin tears with entire skin loss)
- Traumatic Wound

Undertake a wound assessment using T.I.M.E.S (including clinical photography where applicable) and document accordingly

Type 1
Skin tears without tissue loss

Type 2
Skin tears with partial tissue loss

Type 3
Skin tears with entire skin loss

Trauma Injury

Treatment

Dress the wound - apply Urgotul Absorb Border to the wound, ensuring a 2cm border around the wound margins. Mark the dressing with an arrow, to indicate the direction of removal to reduce the risk of flap disturbance, along with the date of change.

Clink or scan the QR code below for the application video

Important

DO NOT USE paper adhesive strips (steri strips), sutures, clips or glue as they may cause addional damage to the fragile skin and prevent the readherence of any reapproximated skin flaps

If the Wound is located to lower limb (below knee to ankle) identify the most appropriate limb shape as below:

Treatment

Good limb shape
Mild/moderate oedema

Abnormal limb shape
Moderate oedema

Abnormal limb shape
Severe oedema

Abnormal limb shape
Severe oedema with skin folds

Treatment

Known to wear compression hosiery/stocking, wrap or bandages

Continue with the compression hosiery/ stocking, wrap or bandages

Currently does not wear compression hosiery/stocking, wrap or bandages

Community and Primary Care

Assess the patient have any red flags?

Community and Primary Care

Refer to the Skin Integrity Team, who will assess for any red flags and if suitable will commence appropriate compression

Leg ulcer with systemic/ severe infection with or without sepsis.	Obtain a wound swab and arrange for antibiotics to be commenced. Dress with UrgoClean Ag, and a Super Absorbent pad if required and follow the **Pathway for Safe Soft Lower Leg Bandaging**. **Practice Nurses:** Transfer urgently to the Emergency Department OR Refer urgently to the Emergency Surgical Assessment Centre (ESAC). **District Nurses:** Transfer urgently to the Emergency Department OR Contact TVALS or GP to arrange admission to ESAC
Clinical evidence of acute limb ischaemia	Obtain a wound swab and arrange for antibiotics to be commenced. Dress with Acticoat flex 3, and a Super Absorbent pad if required and follow the Pathway for **Safe Soft Lower Leg Bandaging**. **Practice Nurses:** Transfer urgently to the Emergency Department OR Refer urgently to the Emergency Surgical Assessment Centre (ESAC). **District Nurses:** Transfer urgently to the Emergency Department OR Contact TVALS or GP to arrange admission to ESAC.
Suspected acute deep vein thrombosis	**Practice/District Nurses:** Refer urgently to the Ambulatory Care Unit.
Suspected Skin Cancer	Refer to the Dermatology Department as per the 2 week wait protocol, either via the GP or dbth.dermatologyteam@nhs.net
Bleeding varicose veins	Transfer to the Emergency Department

Compression

Continue with the compression hosiery/stocking, wrap or bandages

No red flags

Red flags present

The Skin Integrity Team will confirm if compression is to be commenced.

Good Limb Shape: Commence immediate and Necessary Care Compression with Jobst Ulcer Care Liner x 1 (reduced compression).

Abnormal Limb Shape:

If required bandages as per the Pathway for Safe Soft Bandaging

Referrals

Primary/Community Care: Continue with the compression hosiery/stocking, wrap or bandages

Secondary (hospital in patient) Care: Refer to the Skin Integrity Team who will assess if their support is required.

Primary Care: Refer to a Tier 3 or 4 service for a lower limb assessment to be undertaken.

Community Care: Arrange for a lower limb assessment

Refer on as per the Red Flag Table

Ongoing Care

At local level. *(NB: Primary Care: Hosiery/stocking or wrap OR Safe Soft Bandaging = Tier 2 / Compression Bandages = Tier 2LL or 3)*
If there is no improvement after 21 days:
Primary Care: Refer to a Tier 3 or 4 service for a lower limb assessment to be undertaken.
Community Care: Arrange for a lower limb assessment to be undertaken.
Secondary (hospital in patient) Care: Refer to the Skin Integrity Team for a for a lower limb assessment to be undertaken.

At local level. +/- Skin Integrity Team support as required

Promote and encourage patient involvement by:
- Keeping the skin well hydrated by maintaining adequate nutritional and fluid intake.
- Apply an emollient on a daily basis or at bandage change to minimise further skin tear development.
- Protect fragile skin by covering with long sleeved clothing or tubular bandages.

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document.

References : Nokaneng E et al. Best practice recommendations for the prevention and management of skin tears in aged skin. Wounds International 2025. Available to download from www.woundsinternational.com Developed by: Skin Integrity Team and The Tissue Viability and Lymphoedema Service April 2026 (replaces the Skin Tear Pathway. For review by July 2028.