BEST PRACTICE RECOMMENDATIONS FOR

# UNDERSTANDING DEMENTIA AND SKIN TEARS

**In partnership with:**

NURSES SPECIALIZED IN WOUND, OSTOMY AND CONTINENCE CANADA
INFIRMIÈRES SPÉCIALISÉES EN PLAIES, STOMIES ET CONTINENCE CANADA

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# FOREWORD

With an increasingly ageing global population, an estimated 57 million people are living with dementia worldwide, with nearly 10 million new people diagnosed every year (World Health Organization, 2025a). Dementia is currently the seventh leading cause of death, as well as a major cause of disability and dependency among older people globally (WHO, 2025a).

The International Skin Tear Advisory Panel (ISTAP) are committed to improving the skin health of all people at risk of skin tears and associated damage by providing education to clinicians, patients and everyone involved in providing care. Many of the risk factors for skin tears – particularly advanced age, frailty and some comorbidities – overlap with those for dementia. Therefore, individuals at risk of developing skin tears are at increased risk of dementia and vice versa.

Although there is increasing awareness of the links between dementia and skin damage, there is a key gap in wider knowledge with regard to practical information and guidance addressing this care intersection.

As such, a group of multidisciplinary experts from ISTAP, Nurses Specialized in Wound, Ostomy and Continence Canada (NSWOCC) met online in November 2025 to discuss the issues relating to dementia and skin tears, with the aim of producing best practice guidance to aid all clinicians dealing with at-risk patient groups. This document summarises the discussion and recommendations.

This document aims to:

- Define terms relating to dementia and skin tears
- Explore the intersecting factors between dementia and skin tears, finding commonality and breaking down barriers
- Provide guidance on reducing risk and treating skin tears when they occur, with specific focus on individuals with dementia and how this may affect management of skin tears
- Provide tips on effective and respectful communication and patient engagement.

It is our hope to raise awareness of the importance of skincare and prevention of skin tears in this vulnerable group of people living with dementia to improve their quality of life and health outcomes.

*Professor Karen Ousey, Chair*

## BACKGROUND AND DEFINITIONS RELATING TO DEMENTIA

Dementia is used as an umbrella term for several diseases that affect memory, thinking and the ability to perform daily activities (WHO, 2025a). However, there can be confusion around exact definitions and it is important to be clear when using language and terminology.

Terms such as 'cognitive impairment' or 'cognitive decline' are often used or the terms 'dementia' and 'Alzheimer's disease' (one form of dementia) may be used imprecisely. In this document, we aim to define these terms clearly and use standardised language. It is important to use standard terms and definitions as outlined below.

Words matter so being able to explain the difference between terms such as cognitive decline, dementia, Alzheimer's disease and cognitive impairment in a simple, easy-to-understand way is fundamentally important to caregivers' ability to properly support their patients. The correct use of terminology is also integral to raising awareness and providing education, which are essential steps in the movement towards early intervention and better health outcomes.

People diagnosed with dementia are an especially vulnerable group of the population and have specialised needs, so clear guidance for their care is needed.

**Best Practice Statement: To avoid confusion, correct and specific terminology should be used for dementia and associated conditions.**

### What is dementia?

It is important to note that dementia is a specific and distinct diagnosis, which is not synonymous with cognitive impairment, alteration, deficit or decline. This document will focus on dementia as a diagnosis and its intersection with skin tears.

Dementia refers to a diverse group of chronic, neurological conditions in the brain. The exact aetiology of dementia is unknown; however, it is characterised by a progressive decline in cognitive abilities that is significant enough to interfere with an individual's ability to complete basic day-to-day activities or Activities of Daily Living (ADLs). While a small degree of cognitive decline can be a normal part of the ageing process, dementia is not. It is important to note that dementia is not always linked to ageing; diagnosis of dementia is becoming more common in younger people. When a person develops dementia before the age of 65, this is known as young-onset dementia (Alzheimer's Society, 2025).

The ICD-11 definition of dementia states that (WHO, 2025b): *'Dementia is characterised by the presence of marked impairment in two or more cognitive domains relative to that expected given the individual's age and general premorbid level of cognitive functioning, which represents a decline from the individual's previous level of functioning.'*

Memory impairment is present in most forms of dementia, but cognitive impairment is not restricted to memory (i.e. there is impairment in other areas such as executive functions, attention, language, social cognition and judgement, psychomotor speed, visuoperceptual or visuospatial abilities). Neurobehavioural changes may also be present in some forms of dementia (WHO, 2025b).

While there is no definitive way to confirm a diagnosis of dementia, screening tests – including imaging, blood tests, history and other standardised cognitive tests – may help identify the condition. Assessment of functional ability is made via two measures: the more basic ADLs to the more advanced activities necessary for self-care (Instrumental Activities of Daily Living; IADLs). The category of ADLs includes all tasks that are needed to be performed for the individual to survive comfortably: mobility, toilet and bathing/continence, personal hygiene, dressing and feeding. Conversely, IADLs are more complex, including activities such as transportation, shopping, preparing meals, managing households, managing finances, using communication devices and managing medication. Performance of these basic and instrumental activities of daily living depends on different cognitive (e.g. reasoning, planning), motor (e.g. balance, dexterity) and perceptual (including sensory) functions (Cipriani et al, 2020).

### Classification of dementia

The person's degree of dementia and its impact on their daily functioning may fluctuate. The extent to which dementia interferes with functional abilities can vary in response to both intrinsic and extrinsic factors, including medication effects, environmental changes and co-morbid conditions.

The nature of dementia that a person has can be rated as Mild, Moderate or Severe, according to the degree of neurocognitive and functional impairment, and capacity for independence in ADLs. Dementia

severity ratings are based on objective clinical examination and information provided by an informant who has sufficient contact with the individual, such as a family member or caregiver (WHO, 2025b). See [Table 1] for a summary of dementia severity classification and how people with different types of this condition are likely to present in practice.

**Table 1. Severity classification of dementia (ICD-11; WHO, 2025b)**

| Classification | Presentation |
|---|---|
| Early stage (Mild) dementia or pre-dementia | • Individuals may be able to live independently, but some supervision and/or support is often required<br>• Individuals can still take part in community or social activities without help and may appear unimpaired to those who do not know them well. Judgement and problem solving are typically impaired, but social judgement may be preserved, depending on dementia aetiology<br>• The individual may have difficulty making complex decisions, making plans and/or handling finances (e.g. calculating change, paying bills). |
| Middle stage (Moderate) dementia | • Individuals require support to function outside the home and only simple household tasks are maintained<br>• Individuals have difficulties with basic activities of daily living, such as dressing and personal hygiene<br>• Often characterised by significant memory loss<br>• Judgement and problem-solving are typically significantly impaired, and social judgment is often compromised<br>• The individual has increasing difficulty making complex or important decisions and is often easily confused<br>• The individual may have difficulty communicating with individuals outside the home without caregiver assistance<br>• Socialising is increasingly difficult as the individual may behave inappropriately (e.g. in disinhibited or agitated ways) with associated behaviour changes (e.g. calling out, clinging, wandering, disturbed sleep or hallucinations)<br>• The difficulties are often obvious to most individuals who have contact with the individual. |
| Late stage or advanced (Severe) dementia | • Typically characterised by severe memory impairment, but this varies according to the aetiology.<br>• There is often total disorientation for time and place.<br>• The individual is often completely unable to make judgements or solve problems.<br>• Individuals may have difficulty understanding what is happening around them.<br>• Individuals are fully dependent on others for basic personal care in activities such as for bathing, toileting and feeding.<br>• Urinary and faecal incontinence may emerge at this stage. |

## Types of dementia

Alzheimer's disease, the most common form of dementia, is caused by an accumulation of toxic protein leading to inflammation and cell death (Alzheimer's Society, 2025). Dementia can be caused by many other diseases; see [Table 2] for prevalence rates of common dementia types. These diseases affect the brain in different ways, resulting in different symptoms of dementia. Understanding the spectrum of dementia types and associated risk factors is crucial for effective management (Mundada et al, 2024).

**Table 2. Common dementia types and their prevalence (adapted from Mundada et al, 2024; Alzheimer's Society, 2025)**

| Dementia type | Prevalence rate |
|---|---|
| Alzheimer's disease | 34.5% |
| Vascular dementia | 19.7% |
| Mixed dementia | 13.5% |
| Parkinson's dementia | 4.9% |
| Frontotemporal dementia | 4.9% |
| Lewy body dementia | 2.46% |
| Creutzfeldt-Jakob disease | 1.2% |
| Other | 18.84% |

Some people develop multiple types of dementia; this is known as mixed dementia. It is also possible for a younger person to develop early-onset dementia (Alzheimer's Society, 2025).

There are also rarer types of dementia that are caused by other diseases and conditions. Other conditions and reversible causes have been found to account for a significant proportion of cases: alcohol-associated dementia (6.1%), hypothyroid-associated dementia (3.7%), HIV-associated dementia (2.46%), herpes simplex dementia (1.2%), neurosyphilis-associated dementia (1.2%) and normal pressure hydrocephalus (NPH)-associated dementia (2.4%; Mundada et al, 2024).

### The extent of the issue

Dementia is a significant and growing issue. The number of people living with dementia is expected to reach 115.4 million by 2050 (Hugo and Ganguli, 2015). The World Health Organization (WHO, 2025a) has identified dementia as a public health improvement priority, developing a global plan to: increase awareness of dementia and create a dementia-inclusive society; reduce the risk of dementia; guide diagnosis, treatment and care; provide information systems for dementia; provide support for dementia carers; and develop research and innovation.

Prevalence of dementia increases exponentially with increasing age and doubles every five years of age after age 65. In higher-income countries, prevalence is 5–10% in those aged 65+ years, usually greater among women than among men, in large part because women live longer than men. Within the US, higher prevalence has been reported in African American and Latino/Hispanic populations than in White non-Hispanic populations. Global systematic reviews and meta-analyses suggest that prevalence of dementia is lower in sub-Saharan Africa and higher in Latin America than in the rest of the world (Hugo and Ganguli, 2015). Regional differences may be due to underdiagnosis and limited resources, or general stigmatisation around the condition (Naylor et al, 2021).

It must be noted that dementia has tremendous consequences for individuals, their families, healthcare systems and the economy. Alzheimer's disease in particular is a leading cause of hospital admissions, skilled nursing facility admissions, need for home health care and of death. The costs of health services and the informal costs of unpaid caregiving for individuals with dementia are high and growing (Hugo and Ganguli, 2015). Family caregivers also experience increased emotional stress, depression and health problems (NHS, 2025; Victor et al, 2024).

**Best Practice Statement: All staff should know what dementia is and how it affects individuals and their carers.**

## OVERVIEW OF SKIN TEARS AND SKIN HEALTH

Skin tears can occur in all patient groups, but older people are at an increased risk. Skin tears are the most common wound among elderly people, as the normal skin ageing process means that elderly people will have at-risk skin (ISTAP, 2018; 2025).

Additionally, there is growing evidence that people with dementia, particularly those who exhibit agitation or resistance to care and who have fragile or ageing skin, are at increased risk for skin tears (ISTAP, 2025).

The populations at the highest risk of skin tears – particularly older people with vulnerable, aged skin – are also at the highest risk of developing infections and comorbidities, which can cause skin tears to be significant and often complex, hard-to-heal wounds.

Additionally, skin and tissue ageing are 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 (ISTAP, 2018; 2025).

### Definition of skin tears

Skin tears are defined as: traumatic wounds caused by mechanical forces, including removal of adhesives (ISTAP, 2020). Severity may vary by depth (not extending through the subcutaneous layer). Classification is based on the severity of "skin flap" loss. 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' (ISTAP, 2018; 2025). 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 (Van Tiggelen et al, 2019). In individuals with skin frailty, less force is required to cause a traumatic injury, meaning that the risk of skin tears is increased (ISTAP, 2018; 2025).

Skin tears can occur on any part of the body, but are most often found on the extremities, such as upper or lower limbs or the dorsal aspect of the hands (LeBlanc and Baranoski, 2011). They can be painful wounds, affecting the individual's quality of life, increasing risk of hospitalisation or increasing hospitalisation time (ISTAP, 2018; 2025).

In a review of patient and skin characteristics associated with skin tears, the most common patient characteristics were found to be a history of skin tears, impaired mobility and impaired cognition, while the skin characteristics associated with skin tears included senile purpura, ecchymosis and oedema (Rayner et al, 2015; Strazzieri-Pulido et al, 2017).

### Skin frailty

Skin frailty, causing the skin to be vulnerable and at risk, may be triggered by several factors (ISTAP, 2020). For example, the normal ageing process causes changes in the skin that make it more fragile and susceptible to damage (ISTAP, 2018; 2025), due to thinning of the epidermis, loss of collagen and elastin, and overall loss of moisture (Levine, 2020). Other factors that may contribute to skin frailty include ultraviolet (UV) radiation damage, genetic conditions such as ichthyosis (dry skin), some medications and irritants from dressings, maceration from incontinence, and repeated skin cleansing (Wounds UK, 2018; ISTAP, 2025).

Skin changes that make the skin vulnerable to injury can be classified as extrinsic, such as environmental damage (e.g. regular soap use, sun exposure or smoking) or pressure, or intrinsic, such as ageing, the effects of skin conditions (e.g. psoriasis or atopic eczema) or an underlying illness (Moncrieff et al, 2015; ISTAP, 2018; 2025). Additionally, these risk factors can also be modifiable or unmodifiable (ISTAP, 2020).

It is important to remember that skin frailty may be due to a number of different factors and affect different groups and individuals, but older people and those affected by dementia are likely to be at particularly high risk. Risk of skin frailty, and possible resultant issues, may change for different individuals at different times, meaning that it is vital to assess and reassess individuals, and reduce risk. Wherever possible, depending on the combinations of risk factors and their nature (i.e. intrinsic/extrinsic or modifiable/unmodifiable), steps should be taken to reduce the individual's risk (ISTAP, 2020).

**Best Practice Statement: Skin frailty and risk of damage should be assessed in all people with dementia and aged skin.**

### Overlap with other skin issues

If an individual's skin has an enhanced vulnerability, they are at increased risk of damage to the skin. This can encompass a range of issues, including (but not limited to; ISTAP, 2020):

- Skin tears
- Medical adhesive-related skin injury (MARSI)
- Pressure ulcers
- Moisture-associated skin damage (MASD)
- Skin changes at end of life.

There is growing evidence that these distinct skin conditions may be linked (e.g. MASD as a risk factor for pressure ulcers; Woo et al, 2017; Gray and Giuliano, 2018). The focus of this document is on skin tear prevention and treatment, but when working with individuals who are at increased risk of skin damage, it is useful for all staff to be aware of this overlap and vigilant for potential signs of skin damage beyond skin tears.

**Best Practice Statement: People with aged skin and dementia are at high risk of skin damage and should be monitored accordingly.**

### Links between skin health and dementia

Many of the risk factors for dementia overlap with risk factors and comorbidities that put individuals at increased risk of skin damage, particularly skin tears. Factors that increase the risk of developing dementia include (WHO, 2025a):

- Increased age (more common in those 65 or older)
- High blood pressure (hypertension)
- Poor nutrition and high blood sugar (diabetes)
- Being overweight or obesity
- Smoking
- Alcohol use (more than 21 units per week)
- Physical inactivity
- Social isolation
- Depression
- Head injuries.

There is evidence that people with dementia may also suffer from conditions that affect other parts of the body beyond the brain; for example, affecting peripheral tissue and potentially contributing to development of peripheral vascular disease (Jaul and Meiron, 2017).

There is evidence that several skin diseases are associated with forms of dementia, including bullous pemphigoid, hidradenitis suppurativa, psoriasis, skin cancer and cutaneous amyloidosis (Zhang et al, 2021) through common inflammatory, genetic and microbiological pathways.

Increasing attention is being paid to the parallels between the physical stages of wound healing and the biomarkers (such as amyloid-beta, tau and matrix metalloproteinases [MMPs]) associated with dementia: the suggested hypothesis is that changes in neural tissues as evidenced in dementia can be matched by corresponding biomarkers for the four stages of wound healing (haemostasis, inflammation, repair and remodelling; Lehrer and Rheinstein, 2016).

People with dementia are at higher risk for developing hard-to-heal wounds due to motor, sensory, autonomic, cognitive and behavioural impairments, which can contribute to difficulties in self-care, nutrition intake, mobility and communication, all of which in turn may exacerbate wound-related issues (Alam et al, 2021).

Having a chronic wound may also in turn put individuals at risk for accelerated cognitive decline, depression, recurrent infection, persistent pain and social isolation, all of which are commonly experienced by chronic wound patients (LeBlanc et al, 2025).

While dementia patients' skin may be vulnerable and at increased risk of damage, some behaviours typically associated with dementia – e.g. agitation, reduced ability to self-care, reduced nutrition and hydration, and polypharmacy – may also increase the probability of damage to the skin. Additionally, wound prevention and management in individuals with dementia necessitates specialised wound care practices tailored to their unique needs (LeBlanc et al, 2025).

Most of the current evidence exploring the link between dementia and wound development focusses on chronic wounds; however, it is crucial to focus on interventions to prevent skin injury in at-risk individuals,

helping to reduce the risk at the start, before skin breakdown that may potentially become chronic. Despite the known link between dementia and chronic wounds, current wound care guidelines do not adequately address the specific needs of individuals with dementia and guidance is urgently needed (Parker et al, 2019).

People with dementia may be at risk of incontinence-associated dermatitis (IAD), making the skin vulnerable to other forms of damage (Fletcher et al, 2025); additionally, manual handling and use of products such as incontinence underwear may increase the risk of skin tears, especially alongside co-existing behavioural symptoms and resistance. People with certain types of dementia are more likely to exhibit muscle rigidity and stiffness, spontaneous movements (e.g. restless leg syndrome) and tremors, presenting a challenge for personal care.

The links between dementia and skin health make it important to ensure that people with this condition are regularly assessed and monitored on an ongoing basis.

**Best Practice Statement: Staff should be aware of the links between dementia and the skin, making sure that individuals' skin is regularly assessed, monitored and documented.**

## STRATEGIES FOR INTEGRATED CARE

The optimal skin care of people living with dementia requires a holistic, evidence-based and interprofessional approach to meet the unique needs of each individual.

There is a need to examine the traditionally siloed approach to care and ensure all individuals are receiving the tailored specialist care they need that addresses all aspects of their health, as these are inevitably interconnected.

Every individual's general health, physical conditions, medical history, mental health and psychosocial wellbeing should be considered as part of a holistic person-centred approach to care delivery.

The general advice for those diagnosed with dementia to help manage symptoms are also useful in preserving overall health (WHO, 2025a), such as encouraging them to:

- Stay physically active
- Eat healthily
- Stop smoking and drinking alcohol
- Get regular check-ups
- Use memory aids (e.g. write down everyday tasks and appointments to help remember important things)
- Keep up hobbies and do things that they enjoy
- Try new ways to keep mentally active (e.g. reading)
- Spend time with friends and family and engage in community life.

Clinicians can also help by:

- Providing skin health tips
- Providing prompt continence care
- Minimise the use of incontinence underwear to avoid inadvertent skin injury from friction caused by rubbing of the skin.

**Best Practice Statement: Dementia and skin health must be part of a holistic approach to care, encompassing physical, mental and psychosocial factors.**

### Holistic assessment

Assessment of the individual should take a holistic view of individuals (e.g. their mobility, nutritional status, socio-economic and psycho-social factors), as well as their skin or risk of developing a wound (ISTAP, 2020).

Assessment of the skin should be conducted regularly, following individual assessment. A full holistic 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 an integrated and documented daily care regimen, to ensure any changes in the individuals' health/skin status are identified. It is important to note that clear, consistent and accurate documentation is a key part of this (ISTAP, 2020).

The individual's overall medical and skin-specific history (e.g. skin conditions and any history of skin issues or past skin damage) should be an important element of assessment, and action should be taken accordingly.

A comprehensive assessment should include the following elements (adapted from ISTAP, 2020):

- Full skin assessment (including hair, nail, mucosa); whether the skin is intact or has any damage
- Medical history
- The individual's intrinsic risk factors for vulnerable skin (e.g. old age, type of dementia, comorbidities such as diabetes, atopy or thin skin)
- The individual's wound-related risk factors such as neuropathy (or loss of protective sensation), venous insufficiency, infection, high exudate levels/excessive moisture, oedema (pitting and non-pitting)
- Any skin conditions, or unusual presentation of the skin (e.g. eczema, rash, blisters, scars, bruising, dryness)
- How the skin feels to the individual (e.g. pain or itching)
- Assessment of the individual's knowledge about his/her skin condition
- Skin condition history and any family history of skin disease
- Environmental factors that may affect the individual's skin (e.g. chemical exposure, repeated hand washing)

- Cultural practices for skin care and hygienic practices
- Urinary and bowel regimen (continence assessment)
- Medications, including over-the-counter products (particularly long-term medication such as corticosteroids)
- Any known allergies
- Physical activities/exercise and potential for trauma
- Exposure to any other extrinsic risk factors (e.g. increased sun exposure, tobacco, alcohol)
- Previous and past treatments and effectiveness
- Any treatments, actions or behaviours that may influence the condition.

Additional factors that may affect people with dementia include:

- Behavioural symptoms and triggers
- Understanding of instruction (e.g. for skin moisturising)
- Range of motion
- Involuntary tremors, muscle rigidity, twitching (myoclonus) and other repetitive motions
- Sundowning symptoms (late-day confusion).

When inspecting individuals' skin, the clinician should (ISTAP, 2020):

- Apply gentle touch/pressure to the skin to gather information about the skin's texture and turgor
- Check the temperature, tissue perfusion and oxygenation of the skin using fingertips (or use AI, Near-Infrared Spectroscopy (NIRS) and Long-Wave Infrared Thermography (LWIT), non-contact infrared thermography)
- Ideally, carry out the skin examination in a warm, private room (although it is recognised that this may not be possible).

**Best Practice Statement: All individuals should have a full skin assessment, with monitoring and documentation according to local policy.**

## COMMUNICATION AND ENGAGEMENT

Effective and respectful communication can be particularly important for individuals with dementia. In wound care, there has been a focus in recent years on self-care and engaging the individual in their care plan (WUWHS, 2020). It is important that care of people with dementia respects their dignity and wishes, with due consideration of their capacity to be involved with their own care if possible (van der Geugten and Goossensen, 2019).

Above all, it is important to remember that all people, regardless of their diagnosis or challenges, are different, so care should be tailored to meet the individual's needs.

### Communication

Communication for people with dementia and all those involved in their care (including family members, medical staff, therapists and members of the community) can be challenging, and it is often necessary to adapt communication to avoid stress and negative feelings in the person with dementia (Banovic et al, 2018).

Often caregivers and therapists will be working in situations where their communicative behaviour, nonverbal as well as verbal, needs to show support, compassion, care and desire to help (Banovic et al, 2018). It is important to remember that communication is more than just talking; non-verbal communication through gestures, movement and facial expressions can all convey meaning and/or help to get a message across. Body language and physical contact become significant when speech is difficult for a person with dementia, as well as remaining patient and calm in all interactions (NIH, 2024).

Equally, as dementia progresses, the individual is likely to experience difficulties with communicating, which will require compassion and specific tailored care. Dementia will gradually affect the way a person communicates, as their ability to present rational ideas and to reason clearly will change. Their ability to process information gets progressively weaker and their responses can become delayed (NHS, 2023).

It is important that you encourage the person to communicate in whatever way they are able. Remember, we all find it frustrating when we cannot communicate effectively or are misunderstood. Communication is a two-way process and the carers of someone living with dementia will probably have to learn to listen more carefully (NIH, 2024). You may need to be more aware of non-verbal communication through facial expressions and body language, or use more physical contact, such as reassuring pats on the arm or smile as well as speaking (NIH, 2024).

See **Box 1** for practical tips that may help when adapting communication for people with dementia.

**Box 1. Communication tips (adapted from NHS, 2023; NIH, 2024)**

**When someone has difficulty speaking or understanding, it may help to try to:**

- Speak clearly and slowly, using short sentences
- Make eye contact, call the person by name and tell them your name
- Give them time to respond, don't interrupt or pressure them to speed up their answers
- Encourage them to join in conversations with others, where possible
- Let them speak for themselves during discussions about their welfare or health issues
- Try not to patronise them, talk about the person like they are not there or use a 'baby voice'
- Acknowledge what they have said, even if they do not answer your question, or what they say seems out of context – show that you've heard them and encourage them to say more if they can
- Give them simple choices – avoid creating complicated choices or options
- Use other ways to communicate – such as rephrasing questions because they cannot answer in the way they used to
- Be aware of your tone, volume, facial expressions and body language; show a warm, loving and matter-of-fact manner
- Encourage two-way conversation if the person is able
- Be open to the person's concerns, even if they are hard to understand or address
- Be patient with angry-seeming outbursts; if you become frustrated, take some time to calm down
- Use methods other than speaking to help the person, such as gentle touching to guide them or holding the person's hand while you talk
- Use active listening: if possible, stop what you are doing so you can give the person your full attention; minimise distractions that may get in the way of communication, such as the television or the radio playing too loudly, but always check if it's OK to do so; repeat what you heard back to the person and ask if it's accurate or ask them to repeat what they said.

**Best Practice Statement: Individual strategies may need to be developed to aid respectful communication.**

### Capacity and decision-making

Capacity to make one's own decisions is fundamental to the autonomy of every individual. In a medical setting, capacity is required for valid informed consent. Capacity, though dependent on cognition, is not the same as cognition and is also different from functional activities. A person unable to do a task may be capable of deciding who can assist her or him to do the task. While dementia may affect individual capacity, people with dementia cannot be assumed to be incapable of making decisions (Hegde and Ellajosyula, 2016).

It is important to remember that capacity is not static; capacity for decision-making can change and can improve as well as deteriorate (e.g. if a reversible condition is effectively treated).

It is crucial to strike a balance between respecting the autonomy of the person living with dementia and acting in his/her best interest. Assessment of individuals' capacity overlaps with the law and will vary depending on local guidelines. However, it is important that all clinicians working with people living with dementia help to provide the conditions for the optimal level of functioning of the individual to enable them to make their own decisions if possible (Hegde and Ellajosyula, 2016).

### Safeguarding and human rights

Unfortunately, people living with dementia may be denied the basic rights and freedoms available to others. In some geographical areas and healthcare systems, physical and chemical restraints are used in care homes and acute care settings, even when regulations are in place to uphold the rights of people to freedom and choice (WHO, 2025a).

An appropriate and supportive legislative environment based on internationally accepted human rights standards is required to ensure high-quality, respectful care for people with dementia and their carers (WHO, 2025a).

People living with dementia become increasingly vulnerable and gradually more dependent on others as this condition progresses; therefore, over and above safeguarding basic human rights, it is important to maintain individuals' dignity. Dignifying aspects of care have been identified as forming 'a process of adjusting and attuning to the changing abilities, personality, preferences and care needs of the person with dementia', particularly in those with severe dementia due to their increased care dependency (van der Geugten and Goossensen, 2019).

## SKIN TEAR PREVENTION

Prevention of skin damage in people with dementia falls into two general themes: protecting the skin and reducing the risk of manual damage or injury. Optimising skin integrity outcomes should be underpinned by addressing individual needs and preferences, identifying and addressing intrinsic and extrinsic risk factors, ongoing assessment and evaluation, and developing and delivering evidence-based, person-centred care (ISTAP, 2020).

### Risk assessment

At assessment stage, as well as the individual's skin and overall health, a risk assessment should be made, so that environmental and physical risk factors can be reduced as much as possible (ISTAP, 2018; 2025).

This may involve factors such as (ISTAP, 2018; 2025):

- Avoiding friction and shearing – ensuring to use good manual handling techniques and using products such as hoists and glide sheets where required
- Using padding for equipment and furniture where required or as per health protocol
- Ensuring a generally safe environment – e.g. ensuring adequate lighting and removing any manual obstacles – particularly in individuals who may have severe cognition issues or impaired vision
- Conducting falls risk assessment where suitable
- Encouraging use of protective clothing/devices where required, such as shin guards, long sleeves and/or tubular bandages/stockinette
- Avoiding sharp fingernails or jewellery in patient contact.

Additional strategies that may be helpful to address behavioural factors include:

- Access to specialised behavioural management services and interventions to assist in the management of any behavioural difficulties
- Music therapy, simulated presence therapy, supportive interventions, pet therapy, light therapy, exercise, dance-based interventions, arts-based interventions, touch
- Education and training for family, caregivers and healthcare professionals
- Identifying and modifying precipitating factors or triggers possibly leading to the behaviour and reinforcing events.

Creating a safe and comfortable environment is important for people with dementia. Familiarity and routine may be helpful to avoid confusion or distress. Knowing the individual and tailoring their environment and care as much as possible can make a significant difference in quality of life and health outcomes.

**Best Practice Statement: Risk assessments should be made for all people living with dementia and those with frail skin to avoid damage.**

**Scan the QR code above to access existing ISTAP guidance on risk reduction.**

### Skin care

Looking after the skin to preserve its integrity is a vital part of reducing the risk of damage. A regular skincare routine should be caried out for all individuals, using emollient therapy.

Use of emollients promotes general skin health and twice-daily application has been proven to reduce incidence of skin tears by 50% (Carville et al, 2014). Emollient products are available as moisturisers (creams, ointments and lotions), bath oils, gels and soap substitutes. Product choice should be guided by practicality and, where possible, individual preference. For example, ointments contain more oil than cream emollients, which can make them more effective, but they are greasier and may be more difficult to remove; however, emollients containing humectants produce similar rehydration effects but are less 'heavy' and can be more cosmetically acceptable for the individual (Wounds UK, 2015).

The person's bathing regimen should be considered, with emollient products used as soap substitutes and pH-balanced products used where required. Frequency of bathing should be minimised where possible; water temperature should not be too hot, care should be taken to pat the skin dry (not rub), and soft cloths and towels should be used that will not be abrasive on the skin (ISTAP, 2018; 2025).

**Best Practice Statement: All individuals should have a skin moisturising regimen to help preserve skin integrity and protect the skin from damage.**

| Table 3. Types of interventions addressing agitation/aggression in dementia (adapted from NIH, 2016) | | | | |
|---|---|---|---|---|
| Setting | Intervention Level | Intervention Type | Goals | Examples |
| Nursing Homes and Assisted Living Facilities | Resident/patient level | Sensory | Preventing incidents | Music therapy (listening), aromatherapy, bright light therapy, multisensory stimulation |
| | | Structured Activities | Preventing incidents | Dancing, exercise, social interaction, music therapy (playing, singing), art therapy, outdoor walks |
| | | Complementary and Alternative Medicine | Preventing incidents; treating incidents | Aromatherapy, reflexology, acupuncture, acupressure, massage, Reiki |
| | | Psychological | Preventing incidents | Validation therapy, reality orientation, reminiscence therapy, support groups |
| | Care Delivery Level | Care Delivery Models | Preventing incidents; treating incidents | Dementia care mapping; patient centred care |
| | | Staff Training and Education | Preventing incidents; treating incidents | Specific curriculums for communication, managing behaviours |
| | | Environmental | Preventing incidents | Walled in areas, wandering areas, wayfinding enhancement, reduced stimulation areas, enhanced environments |
| Acute care | Client/patient level | Staff training and education | Reducing potential distress | Reduced stimulation, reassurance, managing agitation or distress |
| | | Environmental | Preventing incidents | Walled in areas, wandering areas, wayfinding enhancement, reduced stimulation areas, enhanced environments |
| Rehabilitation settings | Client/patient level | Caregiver education and training with psychosocial support | Preventing incidents; treating incidents | Specific curricula to educate caregivers about dementia and build skills to manage behaviours with additional components such as support groups or counselling. |
| | | Environmental | Preventing incidents | Walled in areas, wandering areas, wayfinding enhancement, reduced stimulation areas, enhanced environments |

### Staff education

All staff should be made aware of the importance of a person's skin health on their quality of life. Everyone caring for those living with dementia needs to be informed about good skin care, aware of the risk factors for skin damage and how these can be minimised in the people that they are looking after.

Skin tears can be distressing and painful for patients; but equally skin tear prevention and treatment can be just as challenging for caregivers. For people living with dementia, there are many common issues that increase risk of skin damage and can be difficult to manage. For example, helping individuals to dress and carry out daily activities may be more challenging in those with dementia, particularly if they are agitated or distressed; extra resources may be needed for some care activities (e.g. trimming nails or bathing). Physical restraints are strictly regulated to ensure they are used only as a last resort to prevent imminent, serious injury when all alternative interventions were unsuccessful. Restraint use should be continually assessed by the health care team and reduced or discontinued as soon as possible.

Caregivers may experience guilt or shame if skin damage occurs as care is delivered, particularly if it is difficult to keep the environment calm. Distraction or calming techniques for the individual may be useful but are not always possible or effective. Knowing the individual is key and it may be necessary to 'think outside the box' or seek extra support.

**Best Practice Statement: Staff at all levels should have an awareness of the importance of all individuals' skin health.**

### Family, friends and informal carers

People living with dementia will often require care from family members, friends or informal carers. It is important to consider support both for people being cared for at home and the people helping with their care.

If possible, carers and family members should be included in care and may need to be signposted to support for them as well as the patient. Depending on geographical area, there may be resources or charity support available to support informal carers. Carers and family members should be encouraged to seek support, take breaks and care for themselves if possible (NHS, 2025).

For people living with dementia and their carers, communication is crucial, breaking down stigma and ensuring that appropriate support is available and accessible. Some behaviours associated with dementia may be particularly challenging to deal with and difficult to talk about, particularly those relating to agitation or disinhibition. In minoritised ethnic groups in particular, the burden on families may be considerable and care needs to be inclusive for all, with diverse cultural needs considered (Victor et al, 2024).

**Best Practice Statement: Family, friends and informal caregivers should be involved in care whenever possible and may need to be signposted to support for carers.**

## TREATMENT AND PRODUCT SELECTION

If a skin tear does occur, it is important that the wound is appropriately treated with consideration of the person and their individual needs. Individuals living with dementia may have specific needs and preferences that need to be taken into account; these may not be immediately obvious and may require time, patience and 'thinking outside the box'.

### Treatment of skin tears

Where possible, treatment of skin tears should aim to preserve the skin flap and maintain the surrounding tissue, re-approximate the edges of the wound (without stretching the skin), select a gentle, non-adherent dressing and reduce the risk of infection and further injury while considering any comorbidities.

Starting the appropriate treatment as soon as possible improves patient outcomes; therefore, staff and caregivers should be educated to perform first aid when a skin tear occurs, to preserve the viability of the skin flap where possible (ISTAP, 2018; 2025).

See **Figure 1** for the ISTAP skin tear decision algorithm for more information on goals of treatment when dealing with skin tears. The skin tear decision algorithm is designed to help all practitioners in the assessment and treatment of skin tears, maintaining a continuous link between prevention, assessment, and treatment (ISTAP, 2018; 2025).

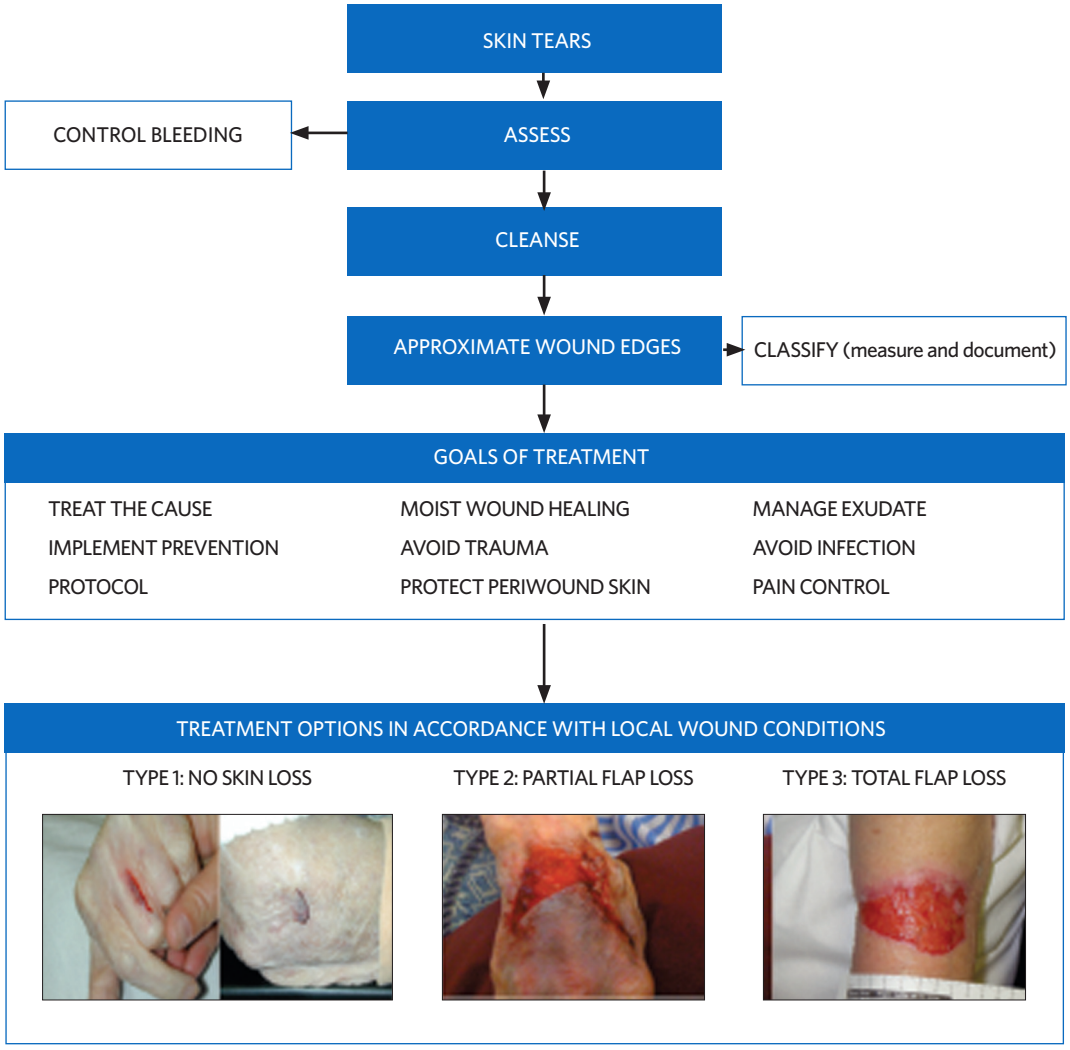


**Figure 1.** International Skin Tear Advisory Panel skin tear decision algorithm (adapted from ISTAP, 2018; LeBlanc et al, 2013).

**Best Practice Statement: Identification and treatment of skin tears should start as soon as possible, so all staff need to be educated on checking for signs of skin damage and how to carry out initial first aid when required.**

### Consideration of fragile skin

Skin tears are acute wounds that have the potential to be closed by primary intention. Traditionally, wounds closed by primary intention are secured with sutures, staples or adhesive strips; however, given the fragility of aged and/or frail skin and that skin tears are not usually deep wounds, these are not viable options and other methods are required (e.g. topical skin glue).

When a skin tear occurs, it is vital that all wound care products chosen will optimise healing and not increase the risk of further skin damage. This should include specialist dressings, and products to cleanse and moisturise the skin (ISTAP, 2018; 2025).

### Dressing selection

In managing skin tears on fragile skin, it is crucial that dressing choices are made that do not further damage the skin (i.e. the lowest suitable adherence should be selected).

Other factors to consider when selecting a dressing should include (ISTAP, 2018; 2025):

- The ability to control bleeding if necessary
- Ease of application and removal
- Removal without causing trauma to the skin
- Providing a protective anti-shear barrier
- Optimising the physiological healing environment (e.g. moisture, bacterial balance, temperature, pH)
- Flexibility and ability mould to anatomical contours
- Providing secure, but not aggressive, retention
- Extended wear time to minimise dressing changes while effectively managing the wound
- Optimising quality of life
- Non-toxicity
- Cost-effectiveness.

Additionally, strategies and techniques may be used during dressing changes, such as:

- Distraction during care
- Low sensory environment for dressing changes
- Consistent staff when possible, to increase familiarity and trust
- Involving family/caregivers in care
- Determining the best time of day for dressing changes based on bath times, and individual routines and behaviours
- Pre-medication as required for pain or behavioural issues
- Using camouflage to minimise patient 'picking' at dressing
- Using bandages to secure dressing
- Premoistening the dressing where necessary to promote dressing detaching from the skin
- Selecting dressings with long wear times to minimise change frequency
- Considering antimicrobial dressing for infected wounds.

When selecting and applying dressings, avoid alcohol-based products or using emollients or creams under dressings. Bulky dressings should also be avoided, as they may agitate the individual or result in 'picking' at the dressing.

**Best Practice Statement: Products should be selected that effectively manage the skin tear while reducing the risk of further damage.**

### Additional considerations for individuals with dementia

In managing skin tears, the same basic principles apply, but individuals living with dementia may require additional factors to be considered around product selection and particularly dressing choice, some of which may not be immediately obvious.

Adherence is a key issue in dressing selection, ensuring that the dressing can stay in place effectively while not damaging the skin. In dementia, mobility is frequently a factor – affected individuals may become

either less mobile, or sometimes more mobile (e.g. movements associated with agitation) – so dressings will need to stay in place and contour to the person's skin, particularly if they are in hard-to-dress areas such as the hands or over joints.

For people living with dementia, comfort is crucial. If a dressing causes discomfort or is too obtrusive, this may exacerbate the distress or agitation associated with dementia that a person experiences. Additionally, if a dressing is visually obtrusive or too noticeable to the individual, it may cause distress or confusion, with patients potentially trying to remove the dressing or 'pick' at it, risking further damage to their skin.

Depending on the individual's unique symptoms and experiences, issues may arise that are different to 'usual' considerations with other people living with dementia. For example, anecdotal evidence has been highlighted that individuals living with dementia may engage in actions such as eating or chewing dressings. This may mean that measures need to be taken to make the dressing less visible or intrusive for the individual (e.g. matching the dressing to the individual's skin tone, covering the dressing with a bandage or garment), and that dressings are not selected that may contain ingredients that are toxic poisonous to ingest.

It may be necessary to modify dressings or garments or find novel ways of making dressings more tolerable for the individual. This may include cutting dressings (refer to manufacturers' instructions for use) or modifying clothing to cover or camouflage them or make them more comfortable.

**Best Practice Statement: Wound care must be tailored to the individual, and their unique needs and preferences.**

### Risk of medical adhesive-related skin injury

Medical adhesive-related skin injury (MARSI) may be a particular risk in individuals living with dementia, so particular care should be taken in dressing removal technique.

When applying and removing dressings for people with vulnerable skin, the following should receive particular attention (ISTAP, 2018; 2020; 2025):

- Using dressings that are atraumatic on removal
- Taking the time to remove dressings slowly ('low and slow')
- Marking the dressing with an arrow to indicate the correct direction of removal; making sure this is clearly explained in the notes where relevant (e.g. in skin tears)
- Using adhesive removers when removing the dressing to minimise trauma
- Selecting a dressing that is designed to be in direct contact with the periwound skin
- Alternatively, considering use of a skin barrier product to protect the surrounding skin (e.g. to prevent maceration if a wound has high exudate levels or prevent skin stripping when removing adhesive/ dressings or securement devices)
- Using calming or distraction techniques that are tailored to the individual if necessary
- Considering external securement bandage to secure dressings on areas such as joints and limbs; appropriate tension should be applied to minimise trauma and circulation problems.

### Pain associated with dressing changes

Dressing changes and removal can be painful for any individual, and can potentially cause distress or fear of dressing change (WUWHS, 2020). For people living with dementia, communication may be difficult, so it is vitally important for all caregivers to be attuned to the individual and any pain or distress they may be experiencing. It is also important to look out for and notice non-verbal cues, which may be especially necessary when the person living with dementia is no longer able to communicate verbally (van der Geugten and Goossensen, 2019).

Awareness of individuals' potential pain and associated distress is crucial. Therefore, extra time may need to be taken to ensure every individual is free of pain and is also treated with respect and dignity (van der Geugten and Goossensen, 2019).

Topical pain management measures may be necessary in wound care. For example, Lidocaine hydrochloride is frequently used for management of painful wounds. This may be a useful option in practice, having been found to result in reduced pain intensity, and show high safety and tolerability (Janowska et al, 2022).

**Best Practice Statement: Pain management should be a key consideration in people with dementia, especially those who may struggle with communication, and additional resource and support may be needed.**

Scan the QR code above to access existing ISTAP skin tears guidance tools.

## CONCLUSIONS AND THE FUTURE

All staff need to be aware of the links between dementia and skin damage, which are physiological, psychosocial and environmental (Zhang et al, 2021). The most prevalent risk factors for skin tears have been identified as old age, followed by impaired mobility, falls and accidental injuries, previous skin tears, cognitive deficit/dementia, dependence in transfers, and upper limbs (Strazzieri-Pulido et al, 2017).

People living with dementia are often excluded from wound-related studies, so there are key gaps in the evidence at hand. Further wound research and more work that includes these members of the population is needed to explore these links and develop guidance for clinicians on the beat ways to working with people living with dementia (Parker et al, 2019). Further work by LeBlanc et al (2025) will focus on inclusion criteria based around people with dementia and will help to inform further guidelines.

The ISTAP principles and guidelines for prevention and management of skin tears should underpin practice (ISTAP, 2018; 2020; 2025), with additional consideration of the individual and their unique needs and preferences; time, patience and 'thinking outside the box' will often be needed, particularly where communication is an issue.

Dementia is a rapidly growing issue with a huge impact and as society is getting older, we can expect an increasing number of people living with dementia. As caregivers, we need to have the knowledge and awareness to help to provide dementia-friendly services that improve experiences and outcomes for individuals living with dementia, particularly in later stages of the disease (Banovic et al, 2018).

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## NOTES