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Improving Skin Tears Healing Time is Demonstrated by the Staff RN who Performs Early Initiation Treatment of the Skin Tear Protocol

Sharon Brazile
Jacksonville State University

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Department of Nursing

Chair: Dr. Lori S. McGrath

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Acknowledgement

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Abstract

Skin tears create numerous challenges for managing skin integrity for our aging population. Skin tears result from trauma, such as a patient bumping into a doorknob or rubbing against the wheelchair; they also occur because the epidermis and dermis lose elasticity and rub against each other, causing a shearing process that separates the outer skin layers from their protective under layers. Skin tears not only look terrible but can be painful and lead to infection if treatment is not initiated early by the nurse.

Purpose: The Chief Nursing Officer chose to focus on skin tear treatment at a southeast urban hospital since data existed that the current protocol was confusing, and the staff needed education on the new protocol and the importance of addressing skincare quickly. Informal discussions with the primary nurses found that nurses were not using a standard approach and often waited on the wound care team to handle skin tears. This delayed treatment and increased the patient's potential for infection. A standardized Skin Tear Protocol was needed to ensure the rapid assessment and treatment of skin tears.

Design Methods: This DNP project implements an evidence-based practice project with a quality improvement intervention that involves developing a standardized Skin Tear Protocol to assist the primary nurse in identifying skin tears and improving treatment initiation time for skin tears. A pretest and posttest were administered during the education course to each participant to assess their understanding of skin tears. Thirty-six randomly selected participants agreed to participate in the project.

Implications for Nursing: A statistician performed the data analysis and used the paired t-test and the two independent sample tests, which showed there was not a significant difference between the two groups. By utilizing the standardized Skin Tear Protocol, the DNP student and

the primary nurses can contain cost and decrease patient pain levels by implementing treatment while reducing the infection rate. By understanding and using the standardized Skin Tear Protocol, the primary nurse is ready to teach everybody about skin tears and skin tear care treatment. Education is the key to preventing skin tears.

Keywords: Skin tears, skin tear prevention, skin tear treatment, and skin tear protocol.

Improving Skin Tears Healing Time is Demonstrated by the Staff RN who Performs Early Initiation Treatment of the Skin Tear Protocol

Introduction

Many people wonder why elderly patients in institutional settings acquire skin tears; they occur in 1.5 million elderly patients a year. Elderly patients' skin is usually dehydrated, thin, and frail. As we age, the blood vessels become more sclerotic (Brouchard, 2019). Skin tears can take a toll on the patients and increase the healthcare workers' workload, and it can seem as if the healthcare worker is not delivering quality care to the patients (Herbert, 2019). Skin tears can be costly, with wound care costs for the aging population exceeding "15 billion dollars" (McCord, Hilsabeck, & Ray, 2017, p. 1). Research shows that 70% to 80% of skin tears occur on the patient's hands and arms and happens at peak activity hours (Herbert, 2019). Financial burden and length of stay in the hospital can overwhelm, leaving them with limited resources and increase clinician time and dressing costs (Vandervord et al., 2016). This paper reviews why skin tears occur, how to prevent skin tears, how to assess and classify skin tears, how to treat skin tears, how to properly document skin tears, and explain educating patients, families, staff, and other healthcare workers about skin tears. Overall, the goal is to implement educating the nurses about wound care products and starting early treatment in a standardized Skin Tear Protocol.

Background

The acute health hospital does not have a standardized treatment for skin tears; every nurse seems to do their own thing when treating skin tears. There are many ways treatment methods, but the best way is to use evidence-based practice and have a standing order in place. The prevention of skin tears is the key, but they cannot prevent all of them. However, one must take all necessary steps to minimize the risk (Herbert, 2019).

The primary prevention step includes performing routine skin assessments using a standardized

Skin Tear Protocol. The best-practice tool is the Payne-Martin Classification System. The Payne-Martin Classification System provides a method to describe wounds and guides the treatment methods for skin tears. This system offers a consistent approach for documenting skin tears to assure continuous monitoring to guarantee high-quality care and appropriate healing of the skin tear. Using this system provides a unified standing order protocol to meet the facility's quality assurance criteria. Also, it demonstrates that the patient is receiving quality care. Educating the patient and healthcare workers about skin tears is the way to implement a successful protocol. The goal is to achieve implementation of a standardized Skin Tear Protocol into the facility, educate the nurses about the products, and initiate early treatment for skin tears.

Problem Statement

The facility has documented a rise in the late treatment of skin tears. The staff has divulged that they feel unprepared to provide early intervention skin tear care and often consult the Wound Care staff, which can delay care. Healthcare providers admit that they do not know the appropriate way to treat skin tears. The Wound Care team knows an essential primary nursing skill involves knowing how and when to initiate early treatment for skin tears in the facility. A standard set of descriptive terms is a fundamental need for nurses to communicate and document skin tears to enhance patient care. The absence of a standardized Skin Tear Protocol impedes the nursing staff's ability to provide consistent, quality care. Registered nurses should be competent to answer the question, "Is the development and implementation of a standardized Skin Tear Protocol versus no protocol needed to assure the initiation of timely treatment for patients who have skin tears"? The PICO statement is as follows:

P- Registered nurses

I - Does the development and education about a standardized Skin Tear Protocol

C- Standardized Skin Tear Protocol Versus no protocol

O- Improve the initiation of treatment time for skin tears

T- Three months

Organizational Description of Project Site

The project site was a twenty-five-bed medical-surgical patient care unit in an urban acute care hospital setting. The hospital is licensed for 450-beds and is in the Southeastern region of the United States.

Review of Literature

Literature Search Methods

Evidence-based protocols identified through a systematic literature search between January 2014 to July 2019 found studies that guided how to treat skin tears. The technique included an electronic search of CINAHL, PubMed, and Cochrane Review. The search term differed slightly with each search engine, but it was comparable. The key search terms used were skin tears, skin tear prevention, skin tear treatment, and skin tear protocol. Limits of the studies included English, peer-reviewed, and free online articles.

Appraisal of Research Studies

Upon completing the literature review about skin tears, several articles found to support how to treat skin tears, as well as the best-evidence practice for the treatment of skin tears.

Many people wonder why elderly patients in institutional settings acquire skin tears. Skin tears occur in 1.5 million elderly patients a year. Elderly patients' skin is usually dehydrated, thin, and frail. As one age, the blood vessels become more sclerotic (Brouchard, 2019). Skin tears can take a toll on the patients and the healthcare workers, and it can seem as if the healthcare worker is not delivering quality care to the patients (Herbert, 2019). Skin tears are the most prevalent skin conditions in the extreme of age (Lichterfield et al., 2015). LeBlanc states that most skin tears are preventable, 2018.

A skin assessment tool is used on the initial visit, and follow-up visits can take place continuously (Idensohn et al., 2019). The prevention program should include emollient therapy, whereas the patient should receive emollient to the skin twice a day; a study was conducted by Carville that resulted in an intervention group of (n = 420). A control group of (n = 546) patients is in fourteen facilities in Western Australia; this resulted in a decrease in skin tears by almost 50% (Idensohm et al., 2019). A bathing regiment and the topical emollient is effective in reducing the risk for developing a skin tear. Soap substitutes, warm water, and soft cloths or towels are essential to skin integrity. The physical environment may consist of careful manual handling of the patient's padding furniture, and avoiding long, sharp fingernails. Always involve the patient about the skin tears. Allow the patient to choose which protective clothing to wear like long sleeves or trousers. Education is the key to successful skin tear prevention. Patients, families, staff, and other healthcare workers benefit from the training that focuses on maintaining skin integrity.

Education will consist of how to assess a patient with an initial skin tear. The main thing is to find out what caused the injury. After the full assessment of the wound, one can use the Payne-Martin Classification System to assess and classify the skin tear. The Payne-Martin Classification System provides a common language for all clinicians to communicate as to how they describe and treat the wound. There are three types of skin tears: Type 1: No skin loss, Type 2: Partial flap loss, and Type 3: Total flap loss.

Classification of the skin tear will determine which treatment to use. The Skin Tear Advisory Panel recommends controlling the bleeding first, cleansing the skin with normal saline or wound cleanser, patting the skin dry, approximating the wound edges, and classifying measure, and documenting the wound. Treatment of the wound consists of a non-adherent mesh dressing for skin types 1, 2, and 3 (LeBlanc, 2019). The goal of therapy is to keep the wound

bed moist, utilize atraumatic removal, and minimize maceration. The Xeroform gauze is the first recommendation for Type 1, 2, and 3 skin tears. One must document treatment placement. Of utmost importance, educating the patient, family, staff, and healthcare workers about skin tears. The authors of the articles agreed that skin tears are significant problems in institutional facilities but are preventable (Idensohn et al., 2019). All healthcare workers should be taught skin tear prevention techniques during orientation and reviewed annually. An assessment tool needs to be in place to help decrease the risk of skin tears. Healthcare workers must use the same standardized tool to classify skin tears. The treatment goal for managing skin tears is to maintain a moist wound bed, to avoid traumatic irritation to the skin when removing a dressing, and to avoid infection and pain to the wound site. The treatment steps are the same to control the bleeding first. An approved skin tear product is placed on the skin tear per the type of skin tears injury. Sometimes there may be a need for a secondary dressing. Initiating early treatment by the nurse is a way to decrease the delay in healing time and to decrease the possibility of infection.

Besides, the articles mentioned some differences in treatment when it came to dressing selection. One author thought that the skin tear treatment should include covering the wound with a dressing, such as Mepilex Border, while another author stated it is all right to cover the primary treatment site with 4X4, roll gauze, and tape.

Evidence-Based Practice: Verification of Chosen Option

The doctorate of nurse practice (DNP) project will be a quality improvement intervention, and there will be a protocol for skin tears implemented at the acute health hospital that utilizes evidence-based practice.

Theoretical Framework/Evidence-Based Practice Model

Virginia Henderson believes that the nurse should act independently when it comes to assisting the patient, especially when the patient lacks knowledge. There were four major significant need concepts theorists: individual, environment, health, and nursing. Virginia Henderson described fourteen components of practical nursing. Under the physiological needs, she spoke of having the patient move and maintain desirable postures, which help prevent pressure ulcers. She also spoke about keeping the body clean and protecting the integument (Gonzalo, 2019). When a wound care nurse treats a wound care patient, they must make sure that the skin or wound is clean, pat the skin dry, and always protect the peri skin by using a skin protector. Usually, when a patient has a wound, the patient does not still understand the disease process because of a lack of knowledge. Therefore, the wound care nurse must educate the patient, family, and staff about the disease process and how to take care of the wound. As a DNP leader, one could uphold utilizing Virginia Henderson concepts and implement them into the everyday clinical setting.

Goals, Objectives, and Expected Outcomes

The goal is to enhance compliance among nurses to initiate early treatment of skin tears because skin tears need immediate attention. If one treats skin tears as early as possible, this will mean a decrease in the delay in healing time as well as a reduction in the infection rate.

Generally, it takes about seven to fourteen days for a skin tear to heal per research. Implementing an evidence-based practice skin/ wound protocol into the facility will help the nurses comply. A skin tear protocol about the prevention and treatment of skin tears is beneficial to any facility (Hovan, 2019). Utilizing an evidence-based practice (EBP) educational tool to teach nurses about skin tear products and how to identify skin tears and initiate early treatment of skin tears should enhance treatment and compliance of skin tears.

Objectives

- Describe the history of skin tears by the wound care nurse in one week
- Identify the cause of skin tears by the wound care nurse in one week
- Explain how the wound care nurse can prevent skin tears in two weeks
- Categorize how to assess and classify skin tears by the wound care nurse in two weeks
- Explain how to treat skin tears by the wound care nurse in three weeks
- Explain how to document skin tears by the wound care nurse in three weeks
- Explain that the success of any skin tear protocol is to educate the patient, families, staff, and healthcare team by the wound care nurse in four weeks

Expected Outcomes

- To introduce an educational project that the primary nurse can use in the facility to treat skin tears
- To train the nurses to understand which products to use to treat skin tears
- To be sure the nurses use the standardized Skin Tear Protocol
- To be sure that the nurses increase compliance for initiating early treatment for skin tears than waiting on the wound care team
- To be sure that the nurses educate patients, families, staff, and other healthcare workers about skin tears, prevention, assessing, treatment, and documentation of skin tears

- To utilize EBP to teach and treat skin tears
- To improve patient's outcome

Project Design

The project consisted of a quality improvement project that included enhancing compliance among the nurses to initiate early treatment for skin tears. The nurses received training about wound care products for skin tears. After attending the education course, the nurses were trained by the wound care nurse to use evidence-based practice (EBP) documented in the Skin Tear Protocol. Utilizing the validated EBP educational tool enhanced compliance of standardized Skin Tear Protocol by the primary nurse. The method was to be a Quantitative and outcome research evidenced-based practice project.

Project Site and Population

The acute care hospital setting in the Southeastern region of the United States is licensed for four hundred and fifty beds. The project took place on the Medical-Surgical floor, which had twenty-five beds in one location. During an informal review of quality issues, the staff revealed a lack of knowledge about a standardized Skin Tear Protocol. Furthermore, the staff had numerous and inconsistent approaches to identifying and treating skin tears. An informal nursing staff survey gathered data from the bedside nurses about how they treated skin tears. The results of the data revealed that nurses were treating skin tears in many ways. Some nurses were not initiating early treatment. Some nurses were waiting on the wound care nurses to provide treatment that delayed treatment for several hours or days before the wound care nurse could see the patient. An acute health hospital, because of the large capacity of patients, could greatly benefit from having a standardized Skin Tear Protocol in place to improve early treatment, decease the delay in healing time, reduce cost and reduce the infection rate. The standardized Skin Tear Protocol is easy to use.

The patient population consisted of admitted patients from 19 years old and older with skin tears. The participants were all patients admitted to the designated unit with skin tears that required treatment. The primary nurse on the Medical-Surgical floor was responsible for initiating early treatment for skin tears. If the primary nurse did not start treatment for the skin tears, the primary nurse could refer the participant to the wound care team to treat the patient. The goal is for the primary nurse to treat more skin tears than the wound care team. The wound care team consisted of the certified wound care nurse, the wound, ostomy, continence nurse (WOCN), and the wound care nurse. There were twenty-five patients on the Medical-Surgical floor, and four nurses had seven to eight patients each per shift. There were two twelve-hour shifts in a day. There were at least eight nurses per day that took care of the patients within twenty-four hours. The wound care nurse conducted the project and determined how many patients were treated by the primary nurse compared to the wound care team. The DNP project site's administration approval is in Appendix A. In Appendix B, the writer presented the proposal for the skin tear project, which she presented to the performance improvement council at their meeting. In Appendix C, she received permission from Dr. Finlayson, PhD., RN., to use the educational tools of module 2 and the attached Quiz to evaluate the primary nurses learning about managing skin tears. Appendix D is the pre/posttest given to the participants, which consisted of nine questions. Appendix E presents the methods used to teach participants how to classify skin tears using the Payne-Martin Classification system for skin tears. Appendix F contains a copy of the standardized Skin Tear Protocol, used to teach skin tear treatment to the primary nurses. The following are the inclusion and exclusion criteria used to select skin tear patients for the comparison study.

Inclusion	Exclusion
1. Skin tear present	1. No skin tear present
2. Inpatient admission on designated Medical/Surgical Unit.	2. An outpatient admission.
3. The primary nurse must treat the skin tear.	3. Staff other than primary nurse treated the skin tear.
4. The primary nurse used the new standardized Skin Tear Protocol.	4. The primary nurse did not use the standardized Skin Tear Protocol.

Setting facilitators and barriers

The quality improvement project occurred at an acute health hospital located in the Southeastern region of the United States.

Barriers	Facilitators
1. Difficulty completing clinical priorities.	1. Contact with preceptor and mentor.
2. Lack of time to accomplish tasks.	2. Discussions with the CNO, ACNP, and the QA personnel about study findings.
3. Organizing the weekly schedule for implementation.	3. We are receiving positive feedback from the Administration for using an EBP protocol to improve patient care.
4. Challenges with internal obstacles with getting the project approved.	
5. Not having a skin/wound protocol in place.	

Tools

The Promoting Healthy Skin: A Self Directed Learning Resource for Residential Aged Care Workers (PHS) (Edwards, Courtney, and Finlayson, 2010) provides the training materials, videos, and a pretest and posttest to assess the nurse's understanding of skin tear care. The Payne-Martin classification system and the STAR system provided additional tools for training the nursing staff about skin tear care. The standardized Skin Tear Protocol provided the new policy and procedure for evidence-based skin tear care.

Intervention, Implementation, and Data Collection

The plan consisted of talking to the Assistant Chief Nursing Officer and the quality improvement department about what is needed to help the wound care patients. Data and feedback revealed that the acute health hospital lacked compliance from the primary nurse with the process of initiating early treatment for skin tears instead of waiting on the wound care team. The wound care nurse completed the DNP project, searched the literature, and found the best evidence-based practice, which was to develop a standardized Skin Tear Protocol and provide teaching to the staff. A data collection template was developed in the electronic medical record, and the skin tear educational session was designed by the providers and staff using the Promoting Healthy Skin program. The stakeholders reviewed the template and teaching materials. With a few minor changes, the study was approved for implementation on the chosen Medical-Surgical Unit.

Care for patients identified with skin tears was conducted through a chart review. The critical areas reviewed included the time and date of the initial skin tear treatment, the name of the provider, and whether the new standardized Skin Tear Protocol was used. Data was collected for three months after the protocol and education were delivered to the staff.

Implementation Plan/Procedures

After the Institutional Review Board (IRB) approved the project, the DNP student presented a PowerPoint presentation with ten slides to the performance improvement committee about skin tears. She also went over the skin/wound protocol to be implemented into the facility. At the end of the presentation, there was a question and answering section. The group disapproved of one statement on the protocol; about the nurses trimming the dead tissue from the wound. After the protocol was revised, the rest of the project was approved.

A thorough search of the literature yielded an evidence-based practice skin/wound protocol. This information helped develop the standardized Skin Tear Protocol. An excellent educational tool, *Healthy Promoting Skin: A Self-Directed Learning Resource for Residential Aged Care Workers,* was found during the literature search. Dr. Kathleen Finlayson, RN, Ph.D., who works for the School of Nursing at the Institute of Health and Biomedical Innovation, Queensland University of Technology provided permission to use the education Module 2 and Quiz. The project participants who volunteered to participate in the study signed a consent form and completed demographic data about themselves, of ordinal, nominal, and interval-ratio data. The pretest was administered; the educational session was presented, followed by the posttest.

Measurement Instruments

The Payne-Martin classification system of skin tears and the STAR classification system was presented in the educational session. The staff education course consisted of how to assess for skin tears, how to manage skin tears, and how to prevent skin tears. After training and teaching were performed, and the participants had an opportunity to ask questions, they participated in the posttest. The standardized Skin Tear Protocol study began on January 1, 2020, until March 31, 2020.

Strengths/Weakness of Tools

The PHS Quiz and Payne-Martin Classification of skin tears are valid and reliable evidence-based tools. The Payne-Martin Classification of skin tears is an evidence-based practice tool, and the authors support the instrument's validity. Retrieval of data for the chart audits from the electronic health record was difficult and time-consuming. Evidence collection may be weak due to these difficulties with collecting complete data.

Data Collection Procedures

Each week the DNP student collected data about how many skin tears occurred in the selected nursing unit. The information was kept in a locked file until the DNP student gave the information to the statistician. The DNP student held a record of how many skin tears were treated by the primary nurse and how many skin tears were treated by the wound care team. The study was conducted for three months. The data was collected and reviewed for the implementation of treating skin tears on time. The DNP student took the information to the statistician, where the statistician conducted a paired t-test and two independent sample tests. The results showed that after completing the Fisher's Exact method test that there was no change in the proportion of cases that were initially assessed by the wound care team (p-0.644). Also, the pre/posttest was administered to see if the primary nurses felt confident with teaching about skin tears and whether the primary nurse training improved after teaching. After training, the test results indicated that 32 nurses out of 36 gained an improved knowledge of the appropriate Skin Tear Protocol by 88.9%. The primary nurse is at the forefront of teaching and treating skin tears.

Data Analysis

A statistician performed the data analysis and used the paired t-test and the two independent sample tests, which showed there was not a significant difference between the two groups. Chart

reviews were conducted. Data were collected on all adult populations admitted to the designated unit from nineteen years old and older. Data were examined over three months. Each participant documented the skin tears in Cerner. A calculated total was kept as to how many skin tears the primary nurse treated versus how many skin tears were treated by the wound care team. Demographics collected on the subjects were age, race, and when the treatment was initiated.

Cost-Benefit Analysis/Budget

The cost was minimum. The DNP student had to make copies of the Quiz for the pre/posttest. Copies of the Payne-Martin classification of skin tears, the nurse's datasheet, and copies of the skin/wound standing order protocol (at least 44 copies for each task) approved for this study. The benefit to the acute care hospital is that the hospital received a standardized Skin Tear Protocol, the patients received early treatment for their skin tears by the bedside nurse.

Timeline

After the hospital's IRB committee approved the project, teaching began on October 7, 2019, until December 31, 2019. The project started on January 1, 2020, to March 31, 2020. Did the study show significant statistical differences? There was no significant statistical difference demonstrated between the two groups.

Ethical Considerations/Protection of Human Subjects

The Jacksonville State University IRB approved the initiation of the DNP project. All participants and subjects are protected by the Health Insurance Affordability and Accountability Act (HIPAA). The DNP student signed the form that she had been educated about the rules and regulations of the patient's personal information. The DNP student informed all the participants and subjects about the project, and all the participants signed an informed consent voluntarily. The participants could withdraw from the study by verbally stating that they no longer wanted to

participate in the study. Data collected by the participants and the subjects were unidentifiable because codes did not identify them. There were minimal risks associated with participating in the project. The DNP investigator secured the data in a locked file cabinet. All electronic data from Cerner were encryption; only authorized users had access to the records.

Conclusion

This evidenced-based practice improvement project has been useful to the primary nurse. The primary nurse was taught everything about skin tears, how to identify skin tears, and how to treat and document skin tears. The primary nurse is more confident about managing skin tears and initiating early treatment. This project can be utilized in many different settings, such as the cardiac floor, orthopedics, and the units anywhere in which skin tears occur. The Chief Nursing Officer (CNO) will serve as the champion for the project moving forward. The goal is to disseminate the new protocol throughout each department in the acute hospital setting. The education team will teach the project to each department in the acute health hospital setting. The primary nurses are more knowledgeable about skin tears and treatment options using the new standardized Skin Tear Protocol.

The Doctorate of Nurse Practice (DNP) student believes that this protocol is the beginning of many evidence-based practice projects that could improve the quality of care by using simple interventions in the acute hospital setting. After finding a problem and presenting evidence-based support, the DNP student, along with the primary nurse, could accomplish the skin tear treatment. By utilizing the standardized Skin Tear Protocol, the DNP student and the primary nurses can contain cost and decrease patient pain levels by implementing treatment while reducing the infection rate. Also, the primary nurses were able to use the same standardized treatment protocol to identify skin tears and to initiate early treatment of skin tears effectively. Finally, the DNP student was able to educate the primary nurses about skin tears. Their

knowledge was tested by using a pretest and posttest quiz, giving out informational handouts, and showing them a video about skin tears. Adherence to the standardized Skin Tear Protocol has improved initiation treatment time. The wound care nurse now feels that the primary nurse is an advocate for the patients and can teach other staff, patients, and families about skin tears. Education is the key to the prevention of skin tears.

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Appendix A

Removed for Confidentiality

Appendix B

Removed for Confidentiality

Appendix C

Removed for Confidentiality

Appendix D

Letter of Approval to use module and Quiz

From: Kathleen Finlayson sent: Tuesday, August

20, 2019 4:36 PM To: Sharon

Brazile

Subject: RE: Need permission to use your skin tear quiz

Hi Sharon,

Thank you for your query, it's good to hear the modules are being used. You are free to use the Quiz and modules on this site, with the appropriate copyright acknowledgment as below, I hope you find it useful.

Edwards H, Courtney M, Chang AM, Finlayson K, Gibb M, Parker C. (2010) Promoting Healthy Skin: A Self-Directed Learning Resource for Residential Aged Care Workers. (web based interactive DVD). Brisbane: Queensland University of Technology.

Kathy

Dr Kathleen Finlayson, RN, PhD
School of Nursing
Institute of Health and Biomedical Innovation
Queensland University of Technology
Ph: 61 7 3138 6105
Email: k.finlayson@qut.edu.au
CRICOS No 00213]

Appendix E

Pre/Post-Test

QUESTION 1

In what location do skin tears most commonly occur?

i) Any area of the body. ii) Arms and hands. iii) Shin or lower leg. iv) Head.

Answer(s):

.....

QUESTION 2

Which of these features characterise a skin tear?

i) A break in the skin as a result of an injury. ii) A traumatic wound that occurred because of friction or shearing and friction. iii) The epidermis is torn from the dermis (known as a "partial thickness wound").

iv) The epidermis and dermis have torn away from the underlying tissue (known as a "full thickness wound").

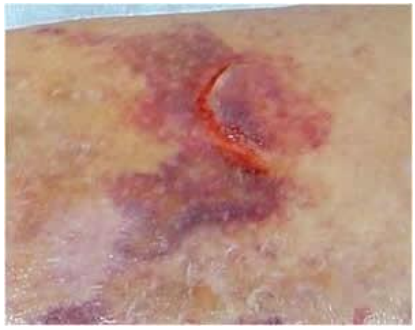
v) An injury commonly caused by bumping into furniture or a fall.

Answer(s):

.....

QUESTION 3

Using the STAR classification system, which category is this skin tear?



i) Category 1a
ii) Category 1b
iii) Category 2a
iv) Category 2b
v) Category 3

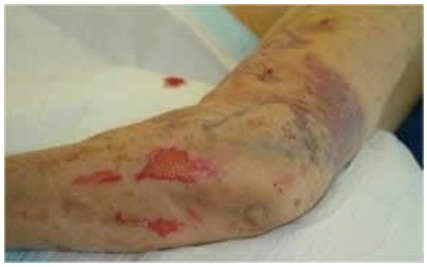
Answer(s):

Pre/Post-test

QUESTION 4

Using the STAR classification system, which category is this skin tear?

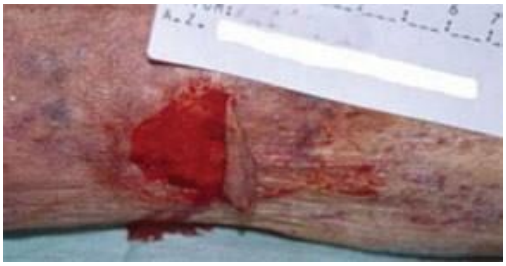
i) Category 1a ii) category 1b iii) Category 2a iv) Category 2b v) Category 3 Answer(s):



QUESTION 5

Using the STAR classification system, which category is this skin tear?

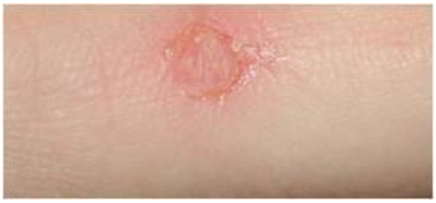
i) Category 1a ii) Category 1b iii) Category 2a iv) Category 2b v) Category 3 Answer(s):



QUESTION 6

Using the STAR classification system, which category is this skin tear?

i) Category 1a ii) Category 1b iii) Category 2a iv) Category 2b v) Category 3 Answer(s):

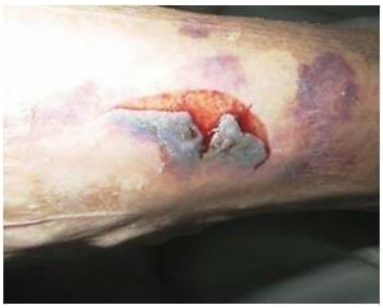


Pre/Post-test

QUESTION 7

Using the STAR classification system, which category is this skin tear?

i) Category 1a
ii) Category 1b
iii)Category 2a
iv)Category 2b
v) Category 3



Answer(s):

QUESTION 8

You should manage skin tears by:

i) Controlling the bleeding and cleaning the wound.

ii) Leaving any separated or lifted skin flaps where they are. iii) Assessing tissue loss. iv) Leaving the wound open to the air to dry. v) Assessing the client's general health.

vi) Applying a dressing. vii) Using an adhesive to secure the dressing.

Answer(s):

.....

QUESTION 9

Which of the following strategies help prevent skin tears?

i) Using pH neutral products to cleanse and moisturise the skin. ii) Gentle handling. iii) Covering and padding walking frame supports and wheelchair arms/footrests. iv) Ensuring some clients wear limb protectors.

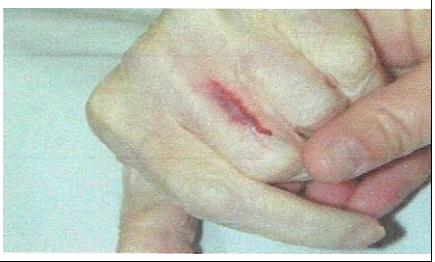
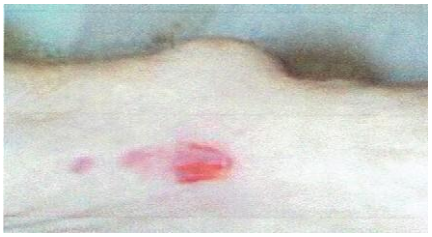
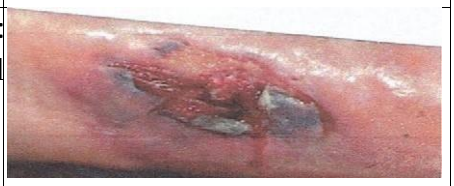
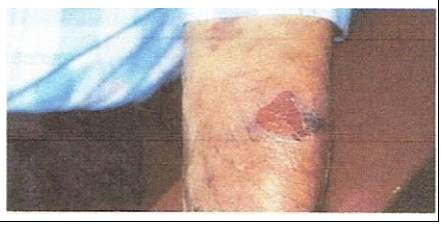
v) Ensuring good lighting in bedrooms and living areas.

Answer(s):

.....

Appendix F

Payne-Martin Classification System for Skin Tears

Skin Tear Category	Sub-Category and Description	Photograph
Category 1+: Skin tears without tissue loss	IA — Linear: Full-thickness or flap partial thickness	
	1B - Flap Type: Partial-thickness Epidermis and dermis are separated Flap can be approximated or Approximated to expose no more than 1mm of the dermis	
Category 2+: Skin tears with partial tissue loss	2A - Scant Category II Skin Tear: 25% or less of the epidermal flap is lost	
	2B - Moderate Category II Skin Tear: More than 25% of the epidermal flap is lost	
Category 3: Skin tears with complete tissue loss	Epidermal flap is absent	

+ Category I and 2 photographs are courtesy of Kim LeBlanc, Dawn Christensen and Wound Care Canada. Used with permission.

Resource

LeBlanc K, Christensen D, Orsted HL, Keast DH. Best Practice Recommendations for the Prevention and Treatment of Skin Tears. Wound Care Canada. 2008;6(1):14-30. Used with Permission.

Appendix G

Skin/Wound Standing Order Protocol

Effective October 2019

SKIN TEARS

1. **Prevention:**
    a. Educate the staff, patients, and families about skin tears.
    b. Pad equipment/furniture as needed.
    c. Keep nails short and glove if necessary, the staff according to policy.
    d. Apply tape without tension.
    e. Use a porous type to allow moisture to evaporate.
    f. To remove the tape, slowly peel the tape away from the skin.
    g. Secure extremity dressings with roll gauze or tubular stockinette.
    h. Use skin sealants or solid-wafer skin barriers under adhesives.
    i. Encourage the patient to wear long sleeves and socks/stockings to protect extremities.
    j. Use No-Rinse, self-sudsing disposable washcloths on patients.
2. **Assess:**
    a. Control bleeding.
3. **Treatment:**
    a. Use aseptic technique.
    b. Cleanse the area with normal saline or noncytotoxic wound cleanser (ex. SAF-Clens AF).

c. Pat dry.
d. Apply skin protectant to peri-wound skin (ex. Cavilon).

4. **Skin present:**

   a. Slide edges together or approximate.

   b. Steristrip edges in place.

      Cover with:

      a. Non-adherent mesh dressing (ex. Xeroform Petrolatum Dressing) and use 4X4 gauze, secure with a rolled gauze bandage and tape on dressing or cover with Mepilex Border. (Date, time, and initial tape or Mepilex Border)

      b. Dressing should be changed every other day, and document daily about the skin tear in Cerner by lifting the bandage and exam the wound and replace the bandage over the wound until next dressing change.

5. **Skin absent:** Cover with:

   a. Non-adherent mesh dressing (ex. Xeroform Petrolatum Dressing) and use 4X4 gauze, secure with a rolled gauze bandage and tape dressing or cover with Mepilex Border. (Date, time, and initial tape or Mepilex Border)

   b. The dressing should be changed every other day and document daily about the skin tear in Cerner by lifting the bandage and exam the wound and replace the bandage over the wound until the next dressing change.

   c. If large deep skin tear/laceration needing sutures, notify the physician.

   d. Notify the healthcare provider of signs and symptoms of infection:

      Treatment: Mepilex Ag. with dressing change every other day.

e. Discontinue dressing, when healed, must notify the wound care team to assess that wound has healed.

6. **Evaluation:**

a. The nurse is to monitor the area of skin tears daily and document in Cerner in the free text section, describe the skin tear in detail every shift. (Type, location, appearance, amount of drainage, odor, discomfort, or pain).

Design by Sharon Brazile