

by Judy Bolhuis, BS, NHA

Evidence-based skin tear protocol

Don't neglect this important facet of wound care in your facility

A common experience:

A resident's daughter comes to the front office wanting to see the administrator. She reports her mother has very fragile skin, cannot stand on her own, and requires total assistance for all transfers. The daughter claims the nursing assistants hit her mother's lower leg on the retracted bedrail when they put her to bed, causing a skin tear. She says the nurses usually just put steri-strips across the skin tears and drainage from the skin tear gets onto her mother's sheets and clothes. The daughter doesn't like to see the bruises from the skin tears and she is concerned because she feels her mother's skin tears occur frequently and take a long time to heal.

The nurses put "nonstick" gauze over the steri-strips to address the drainage concerns. Still the daughter questions the treatment. When the dressing is changed, the nonstick gauze adheres to the dried blood from the skin tear, which hurts her mother and sometimes causes another skin tear or reactive bleeding. She says she believes the nurses are not taking her mother's skin tears seriously and more needs to be done.

The daughter may be correct in saying that skin tears are not taken seriously in the nursing home setting. Long-term care regulatory requirements classify skin tears as accidents, which may contribute to the perception that skin tears are not "real" wounds, even though they're the most common wound type among the elderly. Reports show that more than 1.5 million skin tears occur each year in nursing homes.

Skin tears occur when the layers of the skin separate from one another, forming an open wound. Often caused by shear and/or friction against the skin, skin tears tend to be very painful and often become

infected. Skin tears are common in the elderly because of thinning skin, flattened rete ridges, loss of natural skin lubrication, and increased capillary fragility. If a resident is on anticoagulants or corticosteroids, skin tears occur even more easily and take longer to heal. All clinical staff need training on the causes of skin tears to understand the necessary prevention strategies.

Facility wound care protocols often lack treatment guidelines for skin tears. When facilities have the benefit of a dedicated wound care nurse, it is generally not a part of the daily routine to treat skin tears; the treatment is done by the nurse at the bedside using what is available in the treatment cart.

Since skin tears are viewed as "accidents," often facility administration may not even know the true extent of the skin tear presence in the facility, how they are actually managed, or how long they can take to close.

In addition to collecting data on skin tears in the facility, an evidence-based protocol will provide for both the prevention and treatment of skin tears. A protocol should be scientific enough to be accepted by physicians, but practical enough to be used by all members of the clinical care team.

When discussing a skin tear protocol with clinicians, the goal is to maximize healing while minimizing the complications and pain associated with them. Implementation of the protocol should also result in cost savings due to a smaller number of occurrences and lower treatment costs.

Developing a skin tear protocol

There should be four primary criteria in evaluating an appropriate treatment option for skin tears—the dressing should (1) continuously cleanse the wound to eliminate the

need to cleanse during dressing changes, (2) fill and conform to the wound to maintain a healthy environment, (3) absorb exudate from the skin tear to increase wearing time, and (4) keep the wound bed moist and soothe the traumatized tissues to help reduce pain and provide comfort at the site of injury.

An ideal skin tear protocol goes beyond the specific treatment and addresses regulatory and in-servicing needs, facilitates the resident and family education offered by licensed staff, is evidence-based, and ensures outcomes consistent with the facility's quality of care standards.

Good facility communication about the process of evaluating and implementing an evidence-based skin tear protocol is very important. Prior to beginning to evaluate a skin tear protocol, staff should be trained in the primary preventive measures needed to reduce the opportunity for skin tears, which include improving skin health and reducing trauma. They should be educated on the steps that can be taken to minimize the potential for occurrence and to prevent recurrence, e.g., patting skin dry, applying moisturizing creams immediately after bathing, and correcting underlying dehydration and nutritional deficiencies.

An overview of the care planning steps to control recurrence of skin tears should include a review of the resident room and surrounding environment for safety hazards, as well as education of staff and family members related to lifting and turning techniques for nonambulatory residents. Care planning reviews for mobile residents should include the use of protective clothing and padding on wheelchairs and bedrails, as necessary, to prevent future injury. Also, facility requirements for documentation of skin tears should be reviewed with licensed personnel.

Protocol materials should include a review of the Payne-Martin Classification System, developed by R.L. Payne and M.L. Martin to identify the severity of a skin tear (figure); the classification code allows for a consistent description of the skin tear. This means that all clinical staff are communicating the assessment of the skin tear from the same frame of reference and no longer using subjective descriptions in their documentation.

Evaluating the skin tear protocol

The new protocol should be evaluated. This should not occur, however, until all licensed staff have been in-serviced on the protocol, its documentation requirements, and the products to be used. The development of a measuring tool meeting the requirements of skin tear documentation, follow-up, and care planning needs will allow the current process and the new protocol to be evalu-

ated for outcomes and costs. It is suggested that, depending on the size of the facility, four to 12 skin tears be evaluated on the current process before the new protocol is introduced. Collect data on skin tear classification; days to closure; pain level before, during, and after treatment; if bruising is present or absent; if edema or infection are present during treatment; number of dressing changes required; and number of minutes to complete each dressing change. To maintain consistency in the evaluation, all wounds should be assessed at the initial time of injury and treatment, and then with each successive dressing change.

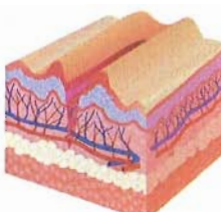
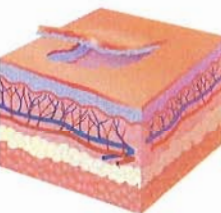
It is helpful to begin this evaluation of the current process early, while gathering information and learning about potential new strategies and products for the new protocol. To decrease the time required for the evaluation of four to 12 skin tears on both the current process and the new protocol, facilities can be divided into two sections: one area for the current process and one area for the new protocol. True, it may be difficult to persuade clinicians to complete the evaluations if the new protocol appears clearly superior, but it is necessary to have complete data to make sound and objective decisions.

Skin tear protocol results

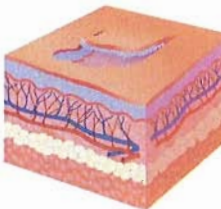
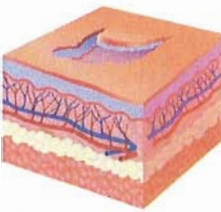
In a recent study conducted by the author, with data collected by facility-based clinicians, valuations were initiated in more than 450 facilities by the nurses who usually treat their residents' skin tears. The tested protocol covered the key areas of prevention, education, documentation, and treatment, as described above. The nonadherent dressings that are the core of the treatment component in this tested protocol met four primary criteria:

- They continuously cleanse the wound bed so that manual cleansing during dressing changes is usually not necessary—which saves significant nursing time.
- They fill and conform to the wound to maintain a clean, soothing, moist wound healing environment to promote optimum moist wound healing conditions.
- They absorb excess exudate from the

Category I: Skin tears without tissue loss

A. Linear type	A linear skin tear is a full thickness wound that occurs in a wrinkle or furrow of the skin. Both the epidermis and the dermis are pulled apart as if an incision has been made, exposing the tissue below.	
B. Flap type	A flap type skin tear is a partial thickness wound in which the epidermal flap can be completely approximated or approximated so that no more than one 1 mm of dermis is exposed.	

Category II: Skin tears with partial tissue loss

A. Scant tissue loss type	A skin tear with scant tissue loss is a partial-thickness wound in which 25% or less of the epidermal flap is lost and in which at least 75 % or more of the dermis is covered by the flap.	
B. Moderate-to-large tissue loss type	A skin tear with moderate-to-large tissue loss is a partial-thickness wound in which more than 25 % of the epidermal flap is lost and in which more than 25 % of the dermis is exposed.	

Category III: Skin tears with complete tissue loss

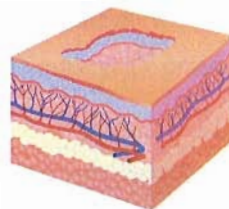
A skin tear with complete tissue loss is a wound in which the epidermal flap is absent.	
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Figure. PAYNE-MARTIN CLASSIFICATION SYSTEM (revised 1993):1

skin tear to increase dressing wear time without increasing the risk of maceration.

- They provide continuous comfort at the injury site by keeping the traumatized tissues warm and moist and by directly helping reduce pain and bruising.

The evaluation tool used included data on skin tear classification; days to closure; pain level before, during, and after dressing changes; presence or absence of bruising, edema and/or infection during treatment; number of minutes to complete each dressing change; and number of dressing changes to skin tear resolution. To maintain consistency in the evaluation, wounds were assessed at the time of initial injury and treatment and then at each successive dressing change. The nurses were instructed to evaluate four to 12 skin tears using the facility's current treatment process and an equal number using the new treatment protocol so that comparisons of outcomes and costs could be made.

Whether this was done simultaneously in two areas of the facility or sequentially depended on the facility's choice.

Despite the efforts of the implementation teams, clinicians assigned to evaluate the facilities' current process of treating skin tears frequently ended their portion of the evaluation prematurely and adopted the new skin tear protocol.

When compared to the facilities current best practices, use of the new skin tear protocol provided 90% faster dressing changes, 60% improvement in healing times and, on average, 76% fewer dressing changes, with a reduction in both episodes of bruising with injury and episodes of swelling in the area of injury. Residents reported decreased pain during dressing changes and decreased pain associated with the injury site overall. Clinicians reported that the new protocol decreased the average nursing time spent dressing a given skin tear to resolution from a total of more than 30 minutes to a total of less than four minutes.

A review of the documentation provided in the protocol also indicated more consis-

tent use, over time, of the Payne-Martin classification system and pain indicators, as well as clinical staff awareness of the need for follow-up documentation to resolution of the skin tear. Communication between clinicians became focused on the Payne-Martin classification of the skin tear, allowing for better tracking of outcomes.

Of the 72 facilities whose evaluations are complete at the time of this writing, 88% have adopted the new skin tear protocol for their entire facility. ■

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Reference

1. Payne RL, Martin ML. Defining and classifying skin tears: Need for a common language. *Ostomy Wound Management*. 1993;39:16-20, 22-24, 26.



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