Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West Community Care Access Centre contracted Community Nursing Agencies in the South West Local Health Integration Network.	
Title	**Procedure: Classifying Skin Tears using the Payne-Martin Classification System for Skin Tears**
Background	• To classify the degree of wounding when a skin tear occurs, Payne and Martin created the "Payne-Martin Classification System for Skin Tears" based on a pilot study in 1985 and a descriptive study in 1990[1] • The definitions used in the classification system were further modified in 1993[2] • The system consists of three skin tear categories and five skin tear types, based on the morphological characteristics of the epidermal injury • This tool has demonstrated internal and external validity
Indications	This procedure is intended to be used by front line registered health care providers, to assist with their assessment and management of individuals admitted/presenting with a skin tear.
Procedure	**NOTE: The use of the "Payne-Martin Classification System for Skin Tears" is but one part of the holistic assessment of an individual admitted/presenting with a skin tear.** **Assessment** 1. Review the person's medical chart for: a. Any previous skin tear classification documentation b. Current wound care orders **Planning** 1. Expected outcomes: a. Information from your assessment allows for the proper classification of the person's skin tear using the "Payne-Martin Classification System for Skin Tears" b. The person reports minimal discomfort associated with the dressing change and wound assessment c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound or their substitute decision maker (SDM)/power of attorney for personal care (POA C) (if applicable) are able to use the assessment information, in conjunction with your holistic person and wound assessment, to initiate/modify and implement an appropriate, person-centered, interdisciplinary plan of care which contains clear directions to staff and others who are providing the person with direct care 2. Explain the dressing change and wound assessment procedure and purpose to the person and/or their SDM/POA C (if applicable) and

obtain verbal or implied consent

3. Assess the need for pre-procedure pain medication as removal of dressings and/or the dressing change procedure itself can be painful. The person may require pain medication before the dressing change/wound assessment, and if so, they **must** be allotted enough time to allow the drug's peak effect to take place BEFORE initiating the dressing change/assessment

Implementation

1. Provide for privacy and ensure the person is in a comfortable position to facilitate assessment of the wound
2. Wash your hands and attend to the person with your assessment documentation and dressing supplies
3. If the person in bed, raise the bed (if you are able to) to an appropriate ergonomic working position to facilitate ease of assessment. Otherwise position yourself in an appropriate ergonomic position to allow for the wound assessment while preventing self-injury
4. Ensure adequate lighting
5. Don clean disposable gloves, and expose the person's skin tear by removing the existing wound dressing as per the manufacturer's instructions. You may consider the application of gown, goggles, and/or a mask if the risk for spray or splash back exists
6. Dispose of soiled dressings in the appropriate receptacle
7. Remove your gloves and dispose of them in the appropriate receptacle
8. Wash your hands and put on a new pair of clean disposable gloves, and cleanse the wound as ordered or as per the "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE" or "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE", as indicated. Gently pat the wound dry with gauze (if needed)
9. Assess the wound using the "NPUAP PUSH Tool 3.0" (see "Procedure: NPUAP PUSH Tool 3.0")
10. Assess the degree of tissue injury using the "Payne-Martin Classification System for Skin Tears":
    a. If there is a skin tear with NO loss of tissue, and the tear appears linear in nature, then you have a **category 1A skin tear**
    b. If there is a skin tear with NO loss of tissue, and the tear has a skin flap that can be completely or almost completely approximated (within 1mm of the wound edge), then you have a **category 1B skin tear**
    c. If there is a skin tear with partial but not complete tissue loss and 25% or less of the epidermal flap is lost, then you have a **category 2A skin tear**
    d. If there is a skin tear with partial but not complete tissue loss

	and more than 25% of the epidermal flap is lost, then you have a **category 2B skin tear** e. If you have a sin tear with complete loss of the epidermal flap, then you have a **category 3 skin tear** 11. Apply a new dressing as per the person's medical order or as per the "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE" or "South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE", using clean technique unless otherwise indicated, i.e. unless the wound is considered acute 12. Assist the person to a comfortable position as required 13. Lower the person's bed to an appropriate height (if applicable), and ensure the person's safety, i.e. apply side rails, personal alarm, restraints as per the person's care plan/medical orders 14. Clean reusable equipment/surfaces touched during the procedure with warm soapy water or detergent wipes and dry thoroughly to prevent cross infection, returning reusable equipment to the appropriate places. Dispose of any personal protective equipment and soiled dressing supply materials in the appropriate receptacle 15. Remove and dispose of your gloves in the appropriate receptacle and wash your hands 16. Discuss your findings and the implications of those findings with the person and/or their SDM/POA C 17. Share the results of your assessment with the interdisciplinary members of the person's wound care team 18. Complete documentation as required, i.e. document initial and on-going "NPUAP PUSH Tool 3.0" scores on the designated form according to your organization's policy, and document the persons NPUAP pressure ulcer stage in their medical records 19. Utilize the findings of your assessment in conjunction with your holistic person and wound assessment, to complete/update and implement an interdisciplinary, person-centered plan of care **Evaluation** 1. Unexpected Outcomes: a. The wound is not staged as per the "Classifying Skin Tears using the Payne-Martin Classification System for Skin Tears" guidelines b. The person complains of intolerable pain during your wound assessment/dressing change 2. Re-assess the wound using the "NPUAP PUSH Tool 3.0" at a minimum weekly
References	1. Payne R., Martin M. Skin tears: The epidemiology and management of skin tears in older adults. Ostomy Wound Management 1990; 26:26-37.

	2. Payne R., Martin M. Defining and classifying skin tears: Need for a common language ... a critique and revision of the Payne-Martin classification system for skin tears. Ostomy Wound Management 1993;39:16-20.
Related Tools (NOTE: these tools and their instructions can be found on the SWRWCP's website: swrwoundcareprogram.ca)	• Payne-Martin Classification System for Skin Tears • South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – HEALABLE • South West Regional Wound Care Program's Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE • NPUAP PUSH Tool 3.0 • Procedure: NPUAP PUSH Tool 3.0