

## Payne-Martin Classification System for Skin Tears

In the late 1980s, the Payne-Martin Classification System for Skin Tears was developed to provide a common language for severity of skin tears. The classification defines a skin tear as a traumatic wound occurring primarily on the extremities of older adults because of friction alone, or because of shearing and friction forces that separate the epidermis from the dermis, or that separate both the epidermis and the dermis from underlying structures.

Elderly skin integrity has much to do with turgor (defined as the elasticity of the skin). Decreased turgor is present when the skin “tents” when pinched, taking more than 3 seconds to return to normal. With aging:

- There is a 20% loss in dermal thickness which can make the skin almost transparent in appearance.
- The subcutaneous fatty layer becomes thinner as well, especially on the face, neck, back of the hands and shins.
- Due to the flattening of the rete ridges, there is increased susceptibility to shear and friction injuries due to alterations in blood vessel networking and moisture retention.
- Elderly skin sags due to less elastin fibers which decreases skin recovery and increases purpura which then leads to 40% of the skin tears.
- Breaks in the skin can lead to infections as well as discomfort.
- Healing in the elderly takes longer due to decrease in epidermal cell turnover.



**Important Tip: Accurately assess and document the characteristics of the skin tear. The classification system is designed to categorize skin tears based on their severity and specific features. Key points to keep in mind are observing the skin tear carefully, assessing the level of tissue loss, considering the skin flap condition, documenting accurately and reassessing regularly.**



Nursing facilities are held to high levels of care standards and issues with impaired skin integrity can result in a federal tag or tags. Documentation needs to address any underlying conditions that may lead to skin tears as well as the wound assessment and if the ulcer was determined to be unavoidable with a prevention protocol in place. Risk factors for skin tears may include advanced age, cognitive impairment, trauma, issues related to transfers, blood tests, stocking donning/doffing, stiffness, spasticity, sensory loss, limited mobility, poor appetite, polypharmacy, assistive devices, ecchymosis and past history of prior skin tears. Skin moisture balance may require an emollient, lotion, creams, or ointment.

**Gentell Skin Tear Management Guidelines on reverse →**

References: <https://www.mcknights.com/print-issue/may-01-2009/>, Wound Management & Prevention. Skin Tears: A Review of the Evidence to Support Prevention and Treatment. March 2007, Wound Management & Prevention: Review of the Literature: Measures of Skin Turgor in Humans: A Systematic Review of the Literature April 2022; 68 (4): 14-24



## Payne-Martin Classification System for Skin Tears

Category I	Category II	Category III	Tissue Loss with Slough
<p><b>Skin Tear without Tissue Loss</b></p> <ul style="list-style-type: none"> <li>• Skin flap can be approximated so that no more than 1mm of dermis is exposed.</li> </ul>	<p><b>Skin Tear with Partial Tissue Loss</b></p> <ul style="list-style-type: none"> <li>• Scant tissue loss - Partial thickness in which 25% or less of the epidermal flap is lost and at least 75% or more of the dermis is covered by the flap.</li> <li>• Moderate to large tissue loss - Partial thickness wound in which more than 25% of the epidermal flap is lost and more than 25% of the dermis is exposed.</li> </ul>	<p><b>Skin Tear with Complete Tissue Loss (Full Thickness)</b></p> <ul style="list-style-type: none"> <li>• Epidermal flap is absent.</li> </ul>	<p><b>Skin Tear with Debridement Needed (Full Thickness)</b></p> <ul style="list-style-type: none"> <li>• Full Thickness wound with presence of slough or necrotic tissue.</li> </ul>
<ul style="list-style-type: none"> <li>• Use cotton tipped applicator to gently roll flap back into place and approximate edges. Apply steri-strips to approximated edges.</li> <li>• Cleanse with normal saline or wound cleanser. Pat dry.</li> </ul>	<ul style="list-style-type: none"> <li>• Use cotton tipped applicator to gently roll flap back into place and approximate edges.</li> <li>• Cleanse with normal saline or wound cleanser.</li> <li>• Partial thickness: Apply Hydrogel, Xeroform, Oil Emulsion, Petrolatum or Honey Gauze.</li> <li>• Full thickness: Apply Collagen, Hydrogel or Calcium Alginate.</li> <li>• Cover with secondary dressing</li> <li>• Change 2 to 3 times a week. Change daily when using Hydrogel.</li> </ul>	<ul style="list-style-type: none"> <li>• Cleanse with normal saline or wound cleanser. Pat dry.</li> <li>• Partial thickness: Apply Hydrogel, Xeroform, Oil Emulsion, Petrolatum or Honey Gauze.</li> <li>• Full thickness: Apply Collagen, Hydrogel or Calcium Alginate.</li> <li>• Cover with secondary dressing.</li> <li>• Change 2 to 3 times a week. Change daily when using Hydrogel.</li> </ul>	<ul style="list-style-type: none"> <li>• Cleanse with normal saline only. Pat dry.</li> <li>• Apply Collagen, Hydrogel, Calcium Alginate or Honey Alginate to achieve an autolytic debridement.</li> <li>• Or apply an enzymatic debridement agent.</li> <li>• Cover with secondary cover dressing.</li> <li>• Change daily.</li> </ul>
<p><b>Fragile Skin:</b> Secure with rolled gauze and tape.</p>	<p><b>Fragile Skin:</b> Secure with rolled gauze and tape.</p>	<p><b>Fragile Skin:</b> Secure with rolled gauze and tape or Silicone Foam.</p>	<p><b>Fragile Skin:</b> Secure with rolled gauze and tape or Silicone Foam.</p>
<p><b>Prevention Tips:</b></p> <ul style="list-style-type: none"> <li>• Assess/recognize fragile, thin, vulnerable, ecchymotic skin.</li> <li>• Caregivers, when providing direct care, should utilize extreme caution and a gentle touch when bathing and/or when transferring a resident.</li> <li>• Avoid wearing rings that could snag skin.</li> </ul>			