Wound Closure Skills: Teaching Suturing in Athletic Training Education

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Context: The examination, diagnosis, and intervention curricular content listed in the 2020 Commission on Accreditation of Athletic Training Education Standards for Accreditation of Professional Athletic Training Programs states that learners must be able to evaluate and manage wounds, including care and closure. Although many wound closure techniques exist in clinical practice, suturing may be a necessary skill for athletic trainers (ATs) and one for which they need proper training.

Objective: To describe the instructional format and step-by-step process for wound closure using the “simple interrupted” method of suturing.

Background: Athletic training has continued to evolve in terms of the skills that are permitted within the scope of an AT’s practice. The skill of wound closure via suturing has been omitted in athletic training programs due to the invasive nature of the technique. As state practice acts continue to adapt, many athletic training programs are adding suturing to their curricular content, and subsequently, a need exists to educate the credentialed AT.

Description: A multimodal approach to teaching suturing is recommended. This educational technique focuses on the cognitive introduction module that should occur before the skills lab. Step-by-step instructions are available to ensure that educators are able to properly train others in the task and for learners to gain a baseline understanding of the technique.

Clinical Advantage(s): Described herein are multiple strategies related to supplies and techniques to be mindful of the resources available for other athletic training programs. In addition, ATs who are trained and permitted to suture can provide improved patient outcomes through comprehensive interventions at the point of care.

Conclusion(s): Learners should be taught the skills of suturing including wound cleaning and anesthetizing and given opportunities to practice the skills over time. By providing budget-conscious options and alternative methods of instruction, this skill can be delivered for most programs.

Key Words: Simple interrupted, skin trauma, clinical skills

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KEY POINTS

- Using a multimodal approach provides a successful means to allow learners to gain the baseline knowledge, skills, and abilities to learn the process of suturing.
- Continual practice of the “simple interrupted” suturing technique must occur for the learner to maintain the skills learned in the initial educational session.
- Athletic trainers must ensure that proper administrative concepts including privileging documents and patient consent forms are used when suturing a wound.

INTRODUCTION

Wound care and closure have changed throughout the years in the technique and, subsequently, the materials used to treat a patient’s wound. Various invasive and noninvasive methods exist for wound closure including, but not limited to, adhesive skin tape, topical liquid adhesives, staples, and both absorbable and nonabsorbable sutures. In 2016, the National Athletic Trainers’ Association (NATA) published a position statement on the management of acute skin trauma that outlined the cleaning, debridement, dressings, identification of infections, and adverse reactions of wounds. Previously, invasive methods of wound closure such as staples and absorbable sutures were thought to be outside the scope of athletic training and therefore not commonly practiced by the credentialed provider. Patient cases that required invasive methods of wound closure resulted in referral to another health care provider, with additional cost incurred through transportation to a medical facility and financial burdens from additional medical expenses for the procedure. As a result, athletic trainers (ATs) commonly provided wound closure using adhesive bandages, commonly referred to as “steri-strips,” for small cuts and wounds.

Because wound closure with adhesive skin tape was typically viewed as common practice in athletic training, previous researchers developed an educational technique outlining the steps for debridement and wound closure for the budget-conscious educator. In addition, at the time of the previously written NATA position statement, the best available evidence supported the use of steri-strips. Although steri-strips are effective and necessary for wound care and closure, the changing landscape of the athletic training profession (eg, ATs provide care to rural and remote secondary schools, in the physician-practice setting, at industrial factories, and to the public safety sector for police and fire) require one to reconsider the wound closure techniques being taught and practiced in athletic training education. The reason for this reconsideration is that ATs in these emerging, nontraditional, and rural settings are often the only providers in the community who change their job responsibilities from those of a skilled provider in orthopedic and musculoskeletal care to those of a skilled provider in primary care. Athletic training education must emphasize ATs’ role in injury and illness prevention, as well as immediate and emergency care, through the lens of primary care for these underserved and emerging populations to best provide services including wound care and closure. As with most clinical skills used by ATs, the clinician relies on the training and preparation within their professional education. Although definitive statistics are not available, it is widely believed that the wound closure technique of suturing has been omitted by most professional athletic training programs due to state practice acts restrictions, like that of Pennsylvania, stating that athletic training practice does not include invasive procedures. With the release of the 2020 Commission on Accreditation of Athletic Training Education (CAATE) Standards for Accreditation of Professional Athletic Training Programs (referred to as “Standards” from this point), a need exists for athletic training educators to reexamine what and how the evaluation and management of wounds (Standard 70) is being deployed in the curriculum.

Standard 70: Evaluate and manage patients with acute conditions, including triaging conditions that are life threatening or otherwise emergent. These include (but are not limited to) the following conditions: Cardiac compromise (including emergency cardiac care, supplemental oxygen, suction, adjunct airways, nitroglycerine, and low-dose aspirin), Respiratory compromise (including use of pulse oximetry, adjunct airways, supplemental oxygen, spirometry, meter-dosed inhalers, nebulizers, and bronchodilators), Conditions related to the environment: lightning, cold, heat (including use of rectal thermometry), Cervical spine compromise, Traumatic brain injury, Internal and external hemorrhage (including use of a tourniquet and hemostatic agents), Fractures and dislocations (including reduction of dislocation), Anaphylaxis (including administering epinephrine using automated injection device), Exertional sickness, rhabdomyolysis, and hyponatremia, Diabetes (including use of glucometer, administering glucagon, insulin), Drug overdose (including administration of rescue medications such as naloxone), Wounds (including care and closure), Testicular injury, Other musculoskeletal injuries.

In the time between implementation of the 2012 CAATE Standards and the 2020 CAATE Standards into athletic training education, the profession of athletic training continued to advance while allowing ATs to work at the top of their scope of practice. Whereas the skill of suturing is not specifically mentioned in the 2020 Standards, the athletic training skills set should be elevated to match the changing state practice acts, needs of ATs’ professional role through primary care, and overall abilities to provide care to patients. The expansion of the 2020 Standards will directly affect the future AT going through a professional athletic training program, but it also creates a need for educators and practicing clinicians to seek professional development on wound closure techniques to be minimally competent within the professional scope of athletic training. Therefore, the purpose of this article is to discuss facilitating the instruction and skill practice of suturing, specifically the “simple interrupted” suture technique, for various learner groups including professional and postprofessional athletic training students, as well as professional development for the practicing clinician.
We recommend that both cognitive and behaviorist learning theories are integrated into wound closure education. One instructional strategy is to deliver the wound closure content to learners through a multimodal instructional strategy, a lecture portion followed by a hands-on simulated practice session, which is widely accepted in health and science education. Before the educational session, the athletic training educator should be considered proficient (ie, able to discern what must occur and able to formulate a care plan) by a medical professional such as a physician’s assistant or physician who has extensive hands-on training and practice with the skill of wound closure.

Within the lecture portion traditionally delivered through an interactive PowerPoint presentation, the focus should be on current literature surrounding the application of each wound closure technique globally within health care and specifically within athletic training. It is important that both the educator and the learners remember that suturing is an emerging skill within athletic training; thus, the current literature for athletic training–specific techniques and benefits is lacking. In addition, we suggest introducing current literature regarding practice recommendations and legal considerations within athletic training for best practices in wound closure.

When delivering this educational technique, it is important to tailor the conversation of legal considerations to the states where the learners will be practicing. Because this is not always possible, the educator should teach the learners ways to search their individual state’s practice acts to determine the steps for incorporating the use of sutures for wound closure. The key objectives for the lecture content can be found in Figure 1.

After the lecture, learners will begin a hands-on laboratory session on the skill, with directed and individualized feedback on their technique. Learners are expected to recall key components of cognitive knowledge and to demonstrate competent performance for completion. We recommend demonstration (video and in real time) and practice activities to teach wound closure skills. Providing learners with a closeup, video view of the suturing process at a reduced speed allows learners to receive visual guidance while the instructor may be helping others. The video should be played on a loop, allowing learners to see how each step of the suturing process is performed several times to capture important details of the technique. Practice sessions should include one-on-one guidance for each learner, with immediate feedback from the instructor.

We recommend that during the laboratory session, instructors present each individual step of the suturing technique rather than the entire skill at one time to allow for better technique development. The individual step-by-step process requires that the number of faculty, the number of learners, and the time allotted to the laboratory skill practice be considered when planning the session. We found that 10 learners for every 1 educator, with 2 to 3 hours of time for the entire learning experience, was sufficient for knowledge acquisition, skill critique, and individualized feedback. In addition, a handout for learners that listed the steps to be followed for wound closure was provided to use as a guide in the future (in the field or during additional practice) to ensure consistency and patient safety. Finally, after the skill practice, the educator should facilitate a discussion on how the wound closure technique could be integrated within current or future clinical practice with connection to learners’ existing knowledge, current literature, and practical skill development from the instructional technique. The following portion of the educational technique will detail the supply materials needed and examples of how to deliver the education.

**LABORATORY MATERIALS**

**Simulated Products**

The patient’s health status, age, weight, comfort, and the presence or absence of infection are as important as the properties of the suture itself, the wound characteristics, anatomic location, and clinician preference. It is typical for learners to practice suturing on either artificial skin pads or on

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**Figure 1. Key concepts for lecture content.**

| Concept | Details |
|---------|---------|
| Formulate the rationale for primary wound closure, i.e. the need to control the bleeding, facilitation of faster and successful healing, minimizing the risk of infection and scarring. |
| Prepare a sterile field for the wound closure. |
| Synthesize the steps involved in the preparation of wound for closure, like making patient comfort, performing a thorough inspection of the wound, wound irrigation, control of bleeding and anesthesia. |
| Demonstrate the basic approach to wound anesthesia by using injectable lidocaine. |
| Identify sutures most commonly used for superficial wound closure. |
| Outline the suturing method focused on simple interrupted technique. |
| Formulate patient education, like tetanus prophylaxis, signs of infection, wound care at home, and removal of sutures. |

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pig feet because these 2 options provide the closest replication of actual human skin. It is important for educators who are designing these courses to consider the religious and cultural beliefs of those who are taking the course because some learners may not be able to use the pig feet for skill practice.\textsuperscript{15} There are also alternatives to artificial skin pads and pig feet that can be used such as a full suturing practice arm and synthetic skin models that mimic the layers of the skin more realistically, as well as low-cost alternatives such as oranges or bananas because these fruits have sufficient thickness to hold the suturing technique.

**Selecting the Suture Material**

Because skin varies in thickness, elasticity, speed of healing, and tendency to scar, the selection of specific sutures varies greatly.\textsuperscript{1,14} When selecting suture materials, clinicians should consider tensile strength, tissue absorption, cross-sectional diameter, coefficient of friction, knot security, elasticity, plasticity, linear configuration, handling, tissue reactivity, materials, physical configuration, fluid absorption, ease of removal, and color.\textsuperscript{1,14} Typically, we have used the 3-0 or 4-0 nylon suture for novice clinicians because it is the standard thickness of suture used on most wounds and nylon is an easier material to use when teaching the skill. Options are also available for purchasing expired or close-to-expiration materials or veterinary-grade sutures that are still good enough to use from an educational standpoint but come at a cheaper cost. If obtaining suturing materials is a concern, we recommend that educators explore using sewing thread and curved needles as an option to reduce the cost burden while still offering a realistic experience with the technique.
The demonstration of the suturing skill is given time to see the skill completed and to practice (cognitive theory) and application of suturing but also imperative that the learners not only gain knowledge about within the knowledge of a multimodal approach, it is recommended exploring demo-dose sterile vials that contain a such as lidocaine, may not be the best use of the drug, we recommend one option to obtaining a large bulk of the supplies can be accomplished through purchasing preconstructed suturing kits that are available through any medical supply distributor. These kits vary in what they contain; however, most include basic suturing instruments such as scissors, forceps, and the hemostat needle holder. For the budget-conscious educator, we recommend saving the suture kits and reconstructing them for future educational sessions. Unfortunately, most suturing kits do not include the necessary supplies for anesthetizing the wound. To practice preparing injections, the educator will need to obtain necessary supplies such as needles and a local anesthetic. Given that using a local anesthetic, such as lidocaine, may not be the best use of the drug, we recommend exploring demo-dose sterile vials that contain a simulated drug. A comprehensive list of all supplies needed are provided in Table 1, with purchasing options available in Table 2.

### Suturing Kits and Injections

One option to obtaining a large bulk of the supplies can be accomplished through purchasing preconstructed suturing kits that are available through any medical supply distributor. These kits vary in what they contain; however, most include basic suturing instruments such as scissors, forceps, and the hemostat needle holder. For the budget-conscious educator, we recommend saving the suture kits and reconstructing them for future educational sessions. Unfortunately, most suturing kits do not include the necessary supplies for anesthetizing the wound. To practice preparing injections, the educator will need to obtain necessary supplies such as needles and a local anesthetic. Given that using a local anesthetic, such as lidocaine, may not be the best use of the drug, we recommend exploring demo-dose sterile vials that contain a simulated drug. A comprehensive list of all supplies needed are provided in Table 1, with purchasing options available in Table 2.

### Table 2. Supplies Costs and Options for Wound Closure

| Sutures | |
|---|---|
| Medco Sports Medicine, $98.95/12 sutures ($8.25/suture) | |
| ShopMedVet, $39.95/100 sutures ($0.40/suture) | |
| Amazon, $9.99/20 sutures ($0.50/suture) | |

Our tip: Plan for approximately 3–5 sutures per learner

| Suture pads | |
|---|---|
| Surgireal, base $29.99 and pad $39.99 | |
| Amazon, $13.45–$29.95 | |

Our tip: These pads can be reused through many learning experiences. Investing in a better suture pad can allow for more authentic experiences and a longer product life.

| Wound closure kits | |
|---|---|
| MedCo, $37.45 | |
| ShopMedVet, $9.95 | |
| Amazon, $25.99 | |

Our tip: These can be reused and re-created to be used many times.

| Combination wound closure kit and suturing pad | |
|---|---|
| Amazon, $31.97 | |

Our tip: If possible, consider adding these to the student fees for the course or to the operating budget to allow each learner to keep the kits for future practice.

| Injection | |
|---|---|
| ShopMedVet, $6.99/100 needles ($0.07/needle) | |
| Allegro Medico, $17.94/100 needles ($0.18/needle) | |
| Delasco, $1.50/saline bottle | |

Our tip: Consider asking a hospital for expired medication to use for practice.

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### Determining the Most Appropriate Wound Closure Technique

The AT must first determine which method of wound closure would benefit the patient the most, whether that be through steri-strips, suturing, or other available methods. Suturing is advised if the laceration is greater than 0.75 inches (2 cm) long or 0.25 inches (0.6 cm) deep. Currently, it is recommended that if suturing is to occur, it happens within 6 hours of the injury. The literature is inconclusive for time frames greater than 24 hours postinjury. It is important that the AT use discretion when determining whether to suture a wound rather than send the patient for additional advanced medical care.

### Creating a Sterile Field

Before suturing, the AT needs to create a sterile field. Unlike other wounds ATs may treat, wounds that require suturing must be treated on a sterile field for safest protocol. A complete explanation that should be followed for achieving a sterile field can be found in Clinical Procedures for Safer Patient Care. If a suture kit is purchased, the sterile field will be included in the kit. Although each suture kit is slightly different, most kits contain drapes that can be used to cover and protect the patient and create the sterile field. Learners should practice the technique with proper gloving to mimic real-life scenarios. When opening the suturing kits, it is imperative that the sterile field be maintained. All materials used should be placed on the sterile drapes; a sterile pad should be used to cover the area surrounding the wound. The steps for creating a sterile field and preparing for suturing can be found in Table 3. For educators who do not have sterile gloves available for their program, a cost-effective alternative is to create sterile glove packs with regular, boxed latex gloves using a sandwich- or gallon-sized zipped bag as mock sterile glove packs that are laid out similarly to a sterile glove pack. The process can be replicated for sterile draping.

### Wound Cleaning

The most important aspect of treating minor wounds is irrigation and cleaning. Specifically, normal saline or tap water should be used to irrigate the area to provide a moist wound-healing environment. Artificial skin pads that are traditionally used for this skill practice cannot withstand the irrigation technique. We recommend that educators use other methods, such as the debridement examples noted in the previous “Educational Technique” article regarding wound care, to practice properly irrigating a wound. In addition, we recommend that the practice of wound cleaning be learned as practice during the laboratory portion of the education session must involve 5 key component areas: determining the most appropriate wound closure technique, creating a sterile field, wound cleaning, preparing the injection, and suturing a wound. For this educational technique, we will describe the simple interrupted technique for suturing. We will detail the key information and recommendations for skill practice for each of these component areas. The educational technique should be taught in totality in this specific order to replicate the procedures the health care provider should take when performing the skill in the field.
a stand-alone skill as well as be integrated into a comprehensive approach to wound closure after successful completion of the suturing-technique steps. For example, the learner should practice irrigating and debriding a wound of grass, turf rubber, or gravel to prepare the wound for suturing. Next, the educator should scaffold the technique by combining the components for the learner to transition from finishing the wound cleaning to the injection and suturing techniques.

Preparing Injections

For injections, we recommend using fruit such as a clementine for skill practice because the peel of the fruit provides a simulated experience for moving through the tissue structures of the human body. As with wound irrigation, most of the artificial skin pads cannot withstand the injection; however, if your laboratory sessions are using pig feet, then the injection can happen at the laceration site created on the tissue. Learners should be exposed to the entire process including drawing the injection with a blunt needle, changing to an injectable needle, and fully anesthetizing the area. Options such as vials of saline can be used to mimic a local anesthetic draw. Table 4 provides a visual handout of the steps necessary for preparing and providing injections for suturing.

Simple Interrupted Technique

With any new skill, one must first learn the steps and become confident with them before being able to implement the skill in totality, a process known as the chunking mechanism.21 Although there are many types of suturing, we recommend that learners first learn and master the simple interrupted suture technique.14,22,23 We chose the simple interrupted technique because it is known as the easiest suturing technique to master as well as the most translatable technique to any

Table 3. Preparation Procedures

| Sterile Field and Wound Cleaning |
|----------------------------------|
| 1. Wash hands using proper hand-washing protocol |
| 2. Ask the patient about known allergies (particularly latex). Open suturing kit. |
| 3. Properly drape the patient and prepare the sterile field. Using proper protocol, put on gloves that come in the suturing kit. |
| 4. Before wound closure, ensure that the wound is cleaned. It is imperative to inspect the wound for foreign bodies or any additional injuries that may have resulted from the wound. |
injury type and site. The specific step-by-step process of the simple interrupted technique is provided in Table 5.

The skill of suturing can be difficult for some due to the small size of the instruments in combination with the thin suturing material. If educators have learners who are struggling with the suturing knots, hand placement, or the movements, we recommend creating larger-than-life replicas of the suturing method. To do so, educators can use wooden blocks with drilled holes and large rope for the learner to see on a large-scale version how to properly tie the knots so they lie down smoothly.25

### TRANSLATING SKILLS INTO CLINICAL PRACTICE

Although ATs manage wounds frequently, wound closure techniques such as suturing will typically not be practiced at the same rate. As important as suturing is for both ATs and athletic training students alike, we must reiterate that when this skill is learned, it is imperative to not immediately implement this into clinical practice until further practice on multiple occasions has occurred and one has obtained privileging documents from a physician. Another component to consider with using suturing as a form of wound closure is skill decay.26 Skill decay, or the decrease of the knowledge of skill application, occurs as early as 6 months after a training...
Table 5. Wound Closure Procedures

| Simple Interrupted Suturing Technique |
|---------------------------------------|
| 1. Grasp the needle driver in your dominant hand. |
| 2. Pull the suture out of the packing by grasping it with the needle driver two-thirds of the distance from the tip to the end of the needle and locking the needle driver so that it holds the needle in place. |
| 3. Grasp the edge of the wound with the forceps (gently) with your non-dominant hand. |
| 4. Position the needle at 90° angle to the surface of the skin. |
| 5. Apply pressure on the needle driver to push the needle through the tissue. The distance from the wound to the periwound tissues needed is situation and dependent on the size of the wound and the size of the suture. |
| 6. Unlock the needle driver. |
Table 5. Continued

| Step | Description |
|------|-------------|
| 7.   | Pull the tip of the needle with the forceps leaving 1/3-in-long suture above the skin. |
| 8.   | Grasp the needle with the needle driver and lock the needle in place. Pick up the other side of the wound with the forceps. |
| 9.   | Drive the needle through the skin from the inside of the wound to the surface. Unlock the needle driver |
| 10.  | Pull the end of the needle with the forceps (try not to pull the suture out of the other edge of the wound). |
| 11.  | Hold the end of the suture carefully in your nondominant hand. |
| 12.  | Wrap the suture around the closed needle driver 2–3 times. |
| 13.  | Grip the free end of the suture with the needle driver and pull both ends of the suture to tie a knot. |
session for other clinical skills such as the use of airway adjuncts and other rarely used emergency skills. ATs must continue to perform these skills on live patients through continued professional development to avoid skill decay from occurring.

An additional concern is the legal considerations of performing this skill of wound closure via suturing. To ensure the learners can appropriately understand the legal implications, this topic is taught in the lecture portion of the educational session and is reiterated throughout the practice component. When considering athletic training skills such as suturing, it is important that the AT know each individual state’s practice act, which may be restrictive in allowing the AT to use these newly acquired skills in clinical practice. In addition, ATs must have legal documents such as privileging documents, which go beyond that included within standing orders, from a physician before completing the task. Before gaining these

14. Cross your hands while holding both ends of the suture and pull on the ends of the suture to stabilize the knot.

15. Wrap the suture around the closed needle driver one time in direction opposite to the one you used before.

16. Grasp the free end of the suture with the needle driver and pull both ends of the suture to tie a knot.

17. Repeat the previous 2 steps twice more.
18. Cut each end of the suture leaving about one-third of an inch from the knot.

19. For each additional knot, repeat approximately 4 mm apart, evenly spaced with the knots lined up on one side. The total number of knots are determined by dividing the length of the wound by 4 mm as that is the recommended distance for each knot to be placed.
Over the 4 years that the research team has instructed the skill of wound closure to learners in professional and postprofessional (at both the masters and doctoral level) athletic training programs and during professional development sessions at regional conferences, the learners have expressed how the format of lecture and laboratory sessions with immediate feedback improved their confidence and enhanced their skill development. Throughout the previous teaching experiences, necessary improvements have been made such as including injections, providing a live video feed of the suture skill demonstration in large classroom spaces for learners to see from an aerial view, and incorporating learner feedback about

documents, the AT must demonstrate competence in advanced wound closure to their collaborating physician with evidence of education and training or with continued patient care with the skill for a predetermined number of patient encounters in a specific time frame to maintain their competence. An example of a clinical privileging document adapted from Stanford Health27 is available in Figure 2. Some other considerations for ATs before the integration of suturing at their clinical site includes maintaining active professional liability insurance as well as obtaining and documenting consent specific to the procedure. An example of an authorization form28 is provided in Figure 3.
the "next steps" to clinical integration of the skill. In addition, we have strengthened the educational handouts to allow the learners the opportunity to reflect when practicing the skill. We suggest that future education experiences continue to develop advanced clinical skills such as additional suture techniques with varying levels of difficulty. A montage of 3 learners from various levels of education shared a short testimonial about their experiences with the educational technique found in the Supplemental Video (available online at www.nataej.org). We believe these testimonials show the connection of the lecture content and skill development with future thought about how suturing may be integrated into their clinical practice.

FUTURE EDUCATIONAL CONSIDERATIONS

As the skill of wound closure occurs more frequently within athletic training clinical practice, ATs must be assessed with clinical scenarios such as simulations. In addition, with all the regulations regarding suturing, there may not be opportunities for athletic training students to immediately implement their knowledge into clinical practice. By using simulations through hybrid standardized patients with the addition of a part-task trainer such as an arm or leg with a laceration, learners will be able to practice these skills with a live patient-actor in a situation that incorporates evidence-based practice and patient-centered care such as communication, education, and empathy.

CONCLUSIONS

When ATs are able to perform wound closure skills such as suturing, patients who may not have access to a physician, such as those in rural communities or those who are uninsured, are able to get quality patient care from the same ATs who began their care plan. With the adoption of advanced athletic training skills including that of wound closure, it is imperative that both athletic training students and ATs learn and practice the skill of suturing. Practicing clinicians should seek out opportunities to fill their educational and practical needs, especially if they will be mentoring future clinicians. In addition, when determining to incorporate this skill into clinical practice, ATs must ensure that the

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**Suturing Authorization Form**

This form facilitates the opportunity for consultation for completing wound closure via suturing. Wound closure is best performed within 6 hours of initial injury. Wounds greater than 0.75 inches or deeper the 0.35 inches are recommended for wound closure via sutures.

| Patient Name | Clinical Site | Physician Name |
|--------------|--------------|----------------|

| OR | Physician Name |
|---|----------------|

**Authorization**

By circling a choice and signing below, I, __________ (patient name), am directing the above stated athletic trainer(s) at __________ (clinical site) to:

- Have permission to perform wound closure via suturing in cases where sutures are recommended
- Not have permission to perform wound closure via suturing in cases where sutures are recommended

When sutures are not used in the athletic training facility, I understand that I will need to receive further medical care at another healthcare facility within 24 hours from the time the injury is sustained.

Patient Signature: ____________________________
Date: __________

Parent/Legal Guardian (if minor) Signature: ____________________________
Date: __________

Athletic Trainer Signature: ____________________________
Date: __________

Adapted from the National Athletic Trainers’ Association Heat Stroke Treatment Authorization Form. [https://www.nata.org/sites/default/files/heat-stroke-treatment-authorization-form.pdf](https://www.nata.org/sites/default/files/heat-stroke-treatment-authorization-form.pdf)
proper legal procedures have been followed as well as plan for continued and constant skill practice.

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