Inpatient Wound, Ostomy, & Continence Care, University of Maryland Upper Chesapeake Medical Center, Bel Air, MD

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Four Eyes: Improving Admission Skin Assessment with Two-Nurse Co-Sign

OBJECTIVES

- To improve nursing accountability in performing admission skin assessments on all patients within 24 hours of admission.
- To improve the presence of and accuracy of documentation of wounds present on admission (POA).
- To increase the rate of head-to-toe skin assessments on admission.
- To eliminate missed opportunities to identify wounds on admission.

METHODS

- **The Four Eyes Assessment Tool** was implemented on the 25-bed Intermediate Care Unit (IMC) and 14-bed Intensive Care Unit (ICU) at the UM UMC between March 19, 2019, and April 25, 2019.
- Transcripts included RNs present during patient admissions or transfers to either unit, patients admitted or transferred to either unit, the inpatient Certified Wound Ostomy Continence Nursing (CWOCN) team, and the nurse manager of the IMC.
- All patients admitted or transferred to either unit received a complete head-to-toe skin assessment within the first 24-hours of admission under the observation of two RNs who then completed and co-signed the Four Eyes Assessment Tool.
- All completed Four Eyes Assessment Tools were submitted and analyzed by the inpatient CWOCN team over a five-week period.

RESULTS

- **IMC Results**

  - 221 wounds total identified on admission to the IMC.
  - Total Patients with Wounds = 93 patients
  - Percentage of Patients with Wounds by Stage of Pressure Injury:
    - Stage 1: 25.60%
    - Stage 2: 32.00%
    - Stage 3: 13.00%
    - Stage 4: 20.50%
    - Surgical Ulcer: 2.50%
    - Trauma Ulcer: 4.00%
    - Deep Tissue Injury: 1.90%
    - Mucosal Injury: 3.40%
    - Moisture Injury: 2.30%

- **ICU Results**

  - 99 wounds total identified on admission to the ICU.
  - Total Patients with Wounds = 6 patients
  - Percentage of Patients with Wounds by Stage of Pressure Injury:
    - Stage 1: 25.00%
    - Stage 2: 40.00%
    - Stage 3: 15.00%
    - Stage 4: 10.00%
    - Surgical Ulcer: 0.00%
    - Trauma Ulcer: 0.00%
    - Deep Tissue Injury: 0.00%
    - Mucosal Injury: 0.00%
    - Moisture Injury: 0.00%

- **HAPI Results**

  - In the month prior to implementing the Four Eyes Assessment Tool, two HAPIs were identified.
    - IMC: one deep tissue pressure injury
    - ICU: one pressure ulcer injury
  - Neither were reportable to the state.
  - Both were identified due to the completion of the tool.

- **Post-ASSESSMENT STAFF SURVEY DATA**

  - **Pre-assessment Staff Survey Data**
    - **Pressure Injury Staging**: Confident
    - **POA Documentation Confidence**: Average
    - **Admission Skin Assessment Confidence**: Average

  - **Positive Feedback**:
    - Two of seven respondents noted that the tool
    - Two of seven respondents felt that the tool
    - Three of seven respondents felt that the tool

  - **Negative Feedback**:
    - One of seven respondents noted that the tool
    - One of seven respondents noted that the tool
    - One of seven respondents noted that the tool

- **REFERENCES**


CONCLUSIONS

- Pre-survey data indicated that nursing staff had moderate confidence in performing head-to-toe skin assessments on admission, identifying pressure injuries, and capturing the presence of all wounds on admission; however, contrary to the above, most nurses noted that they did not have the ability to perform a head-to-toe skin assessment on every patient on admission, citing time as the primary reason.
- A total of 184 patients were evaluated and determined to have a cumulative total of 230 wounds present on admission (POA).
- The majority of patients were admitted with between one to three wounds POA.
- The IMC had a higher percentage of patients admitted with six or more wounds and considerably higher rates of patients admitted with stage IV, unstageable, and deep tissue pressure injuries.
- Approximately 72% of all patients admitted or transferred to either unit had wounds POA, with the results common wound types being traumatic. Only 28% of patients were admitted with intact skin, highlighting the importance of head-to-toe skin assessments for every patient on admission or transfer.
- HAPIs across the two units did not decrease during the study window. This finding may be due to the occurrence of two prevalence studies during implementation of the Four Eyes Assessment Tool and increased vigilance on the part of nursing during the study. Two of the pressure injuries were device related and therefore would never have been associated as POA.
- Post-survey data indicated that the 73% of nurses would continue to utilize the two-RN process during their admission process for skin assessment.
- Post-survey data also indicated that the majority of nurses felt the Four Eyes Assessment Tool was useful in early identification of wounds and decreased the odds of missing skin breakdowns that was POA. Nurses cited time and inability to locate another RN as the major reasons for not continuing to implement the Four Eyes Assessment Tool.

IMPLICATIONS

- Future implications of the Four Eyes Assessment Tool and overall study include:
  - Utilization of the tool throughout all units within the University of Maryland Upper Chesapeake Health (UMUCH) system in order to improve nursing accountability in performing admission head-to-toe skin assessments.
  - Development of a team-based admission protocol process that extends beyond the needs related to wound care to encourage timeliness of admission requirements and documentation as well as improve the patient experience.
  - Further analysis of the data to determine accuracy in wound etiology and pressure injury staging by nurses.
  - Further analysis of the data to assess for presence of wound photography correlated with wounds documented on the Four Eyes Assessment Tool.

REFERENCES