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

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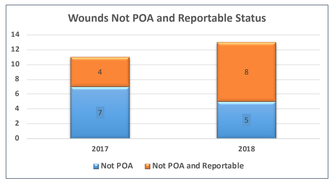
OBJECTIVES

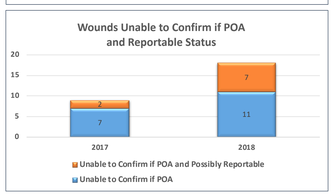
- To improve nursing accountability in performing admission skin assessments on all patients within 24 hours of admission
- To improve the presence of and accuracy of documentation of wounds present on admission (POA)
- To indirectly decrease rates of hospital acquired pressure injuries (HAPIs)
- To improve the standard of care by implementing plans-of-care related to wounds earlier in the patients hospitalization

GENERAL BACKGROUND

- Patient head-to-toe skin assessment on admission to the acute care setting is an important aspect of plan-of-care building and nursing assessment.
- When admitted to the acute care setting, inpatient facilities should identify all concerns related to patient skin integrity within the first 24-hours of admission, weekly for continuous monitoring, and with any notation of change to the wound (positive or negative).
- Wounds documented within the first 24-hours of admission are considered POA to the acute care setting.
- Any skin integrity concern directly related to pressure that develops after the initial 24-hour admission period is defined as a HAPI and is considered not POA.
- HAPIs lead to poor patient outcomes, increased mortality rates, increased healthcare spending, a reduction in hospital reimbursement, inability to comply with hospital standards, and increased risk for litigation.
- It is within the scope of practice of registered nurses (RNs) to perform the assessment of and document on skin integrity.
- Patient care technicians (PCTs) are not licensed to clinically perform head-to-toe skin assessments but may assist with patient care during the assessment.

BACKGROUND DATA SPECIFIC TO UNIVERSITY OF MARYLAND UPPER CHESAPEAKE MEDICAL CENTER (UM UCMC)





*data from 2018 spans from January to October

- In 2017, there were 11 wounds identified as not POA, four of which were reportable to the state. There were an additional 9 wounds that were unable to be confirmed as POA, two of which could have been reportable.
  - There were *20 missed opportunities* to identify wounds on admission in 2017.
  - Six of these wounds may have been reported to the state, potentially negatively impacting hospital reimbursement and funding.
- In 2018, there were 13 wounds identified as not POA, eight of which were reportable to the state. There were an additional 18 wounds that were unable to be confirmed as POA, seven of which could have been reportable.
  - There were *31 missed opportunities* to identify wounds on admission in 2018.
  - Fifteen of these wounds may have been reported to the state, potentially negatively impacting hospital reimbursement and funding.

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 UCMC between March 19, 2019 and April 25, 2019.
- Participants 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 and ICU.
- 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.
- RNs documented within the Electronic Medical Record (EMR) all skin integrity concerns listed on the assessment tool as well as coordinating wound photography.
- A pre and post survey was completed by RNs during the study period.

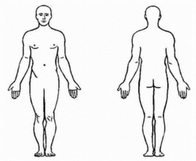
Patient Label

Four Eyes Admission/Transfer Skin Assessment Tool

(to be completed within 24 hours of admission)

Option A:
☐ I have assessed the patient's skin from head to toe on admission/transfer. There are no skin integrity concerns at this time.

Option B:
☐ I have assessed the patient's skin from head to toe on admission/transfer and the below concerns were identified.



Mark the anatomical figure with a wound number corresponding to the information listed below.

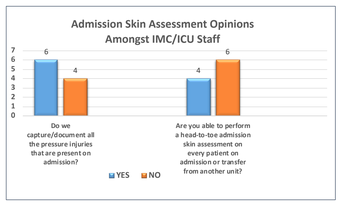
Wound Number	Location Description	Wound Type (pressure injury, surgical, traumatic, ulcer, incontinence, burn, etc.)	Wound Stage (only if a pressure injury)	Wound Measurement
Example	Left knee	Pressure	3	2x4x0.1cm
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

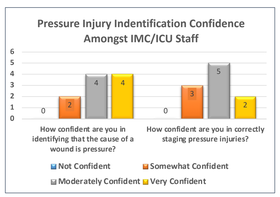
By signing this document, I agree that the information above is accurate.

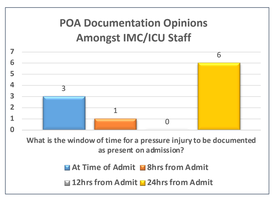
Nurse #1
Name: _____
Signature: _____
Date/Time: _____

Nurse #2
Name: _____
Signature: _____
Date/Time: _____

PRE-ASSESSMENT STAFF SURVEY DATA







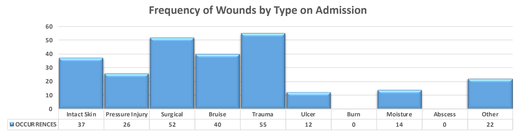
RESULTS

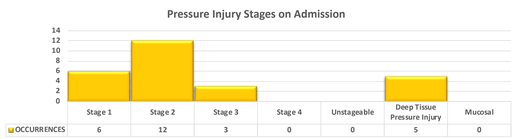
IMC Results

130 total patients evaluated

221 wounds total identified on admission to the IMC

IMC Patients with Wounds	Percentage
1 Wound = 37 patients	39.80%
2 Wounds = 24 patients	25.80%
3 Wounds = 11 patients	11.80%
4 Wounds = 10 patients	10.80%
5 Wounds = 5 patients	5.40%
6+ Wounds = 6 patients	6.50%
Total Patients with Wounds = 93 patients	**71.50%**



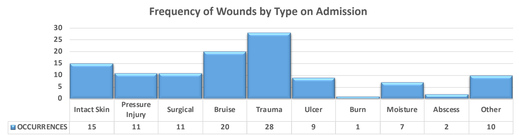


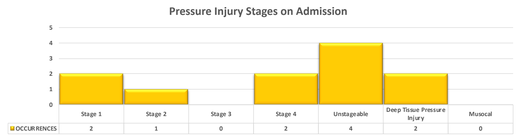
ICU Results

54 total patients evaluated

99 wounds total identified on admission to the ICU

ICU Patients with Wounds	Percentage
1 Wound = 17 patients	43.60%
2 Wounds = 8 patients	20.50%
3 Wounds = 5 patients	12.80%
4 Wounds = 3 patients	7.70%
5 Wounds = 2 patients	5.10%
6+ Wounds = 4 patients	10.30%
Total Patients with Wounds = 39 patients	**72.20%**





HAPI Results

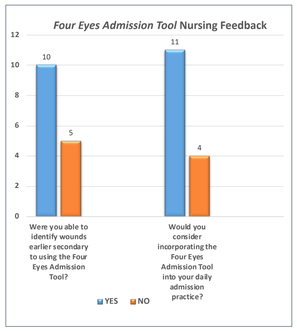
In the month prior to implementing the *Four Eyes Assessment Tool*, two HAPIs were identified.

- IMC: one deep tissue pressure injury
- ICU: one deep tissue pressure injury
- Neither were reportable to the state
- Neither were found during prevalence.

In the month during the *Four Eyes Assessment Tool* implementation, seven HAPIs were identified.

- IMC: two deep tissue pressure injuries
- ICU: two stage 2 pressure injuries, one deep tissue pressure injury, one mucosal pressure injury (device related), one unstageable pressure injury (device related)
- One was reportable to the state
- Three were found during prevalence.

POST-ASSESSMENT STAFF SURVEY DATA



Positive Feedback:

- Decreases missed amount of skin breakdown on admission (n=7)
- Guarantees nursing is performing admission skin assessment (n=1)
- Provides second opinion for questionable areas of skin breakdown (n=4)
- Provides assistance when doing turns and dressing changes (n=1)
- Early application of prevention measures (n=1)

Negative Feedback:

- Extra paperwork during already chart-heavy admission process (n=1)
- Difficulty finding another nurse to perform two-RN assessment process (n=5)
- Younger or alert and oriented patients feel uncomfortable with the head-to-toe assessment (n=4)

Cited Reason for Why Nurses Would Not Use *Four Eyes* in the future:

- Time (n=4)

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, contradictory 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 320 wounds present on admission (POA).
- The majority of patients were admitted with between one to three wounds POA.
- The ICU 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 most common wound type 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 breakdown 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 (UM UCH) 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 analyzation of the data to determine accuracy in wound etiology and pressure injury staging by nurses
  - Further analyzation of the data to assess for presence of wound photography correlated with wounds documented on the *Four Eyes Assessment Tool*

REFERENCES

1) National Pressure Ulcer Advisory Panel (2016). Pressure Injury Prevention Points.
2) Wound, Ostomy and Continence Nurses Society. (2010). *Guideline for prevention and management of patients with pressure ulcers*. WOCN clinical practice guideline series 2. Mt. Laurel, NJ.
3)Wound, Ostomy and Continence Nurses Society. (2016). *Pressure Ulcer Evaluation: Clinical Resource Guide.* Mt. Laurel: NJ.