Four Eyes Skin Assessment

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BACKGROUND

- Stage IV pressure injury found on patient
- Patient was a transfer and on unit for a few days
- Was undocumented but found on our unit
- Pressure injury counted against unit

P I C O

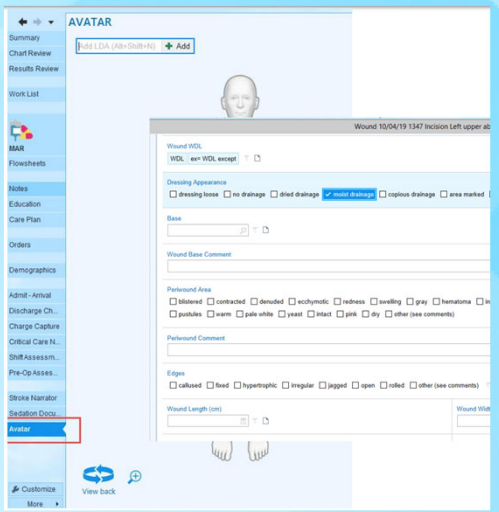
- P – RNs working on PCU
- I – two-nurse skin assessment at admission/transfers
- C – single nurse assessment at admission/transfers
- O – identification, documentation, and interventions of PIs

EVIDENCE

- 320 wounds found on 184 patients with four-eyes assessment (Woodhouse, 2019)
- Increase in present on arrival pressure injuries (Salicki & Dion, 2015)
- Decrease of pressure injuries in 242 patients (Martin et al., 2017)
- Conclusion: four-eyes assessment increased identification of PIs and permitted treatment and prevented them from further deterioration

IMPLEMENTATON

- Education for dual skin assessment
  - Can be provided during morning huddle
- 30 day data collection on admissions and transfers
  - Charted in EPIC using the LDA and paper for this project's purpose
- Secondary nurse will verify skin assessment on patient's chart
- Order for wound consult will be put in if a pressure injury is found
- Pre and post intervention numbers for injuries identified will be compared
- Expectation: increase in pressure injuries documented on admission, decrease in HAPIs, and earlier treatment



OUTCOMES

- Nurse Residency group was unable to carry out the project due to the pandemic and various changes to the unit
- Home unit was closed for one month
- Group members were floated to different units
- Staffing issues related to illness and resignations
- Float RNs were unfamiliar with the project

NEXT STEPS

- Will create an education pamphlet for nurses and new interim manager
- Visual reminders throughout unit to complete skin assessment with secondary nurse

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