Four Eyes Skin Assessment Initiative

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Wisconsin Association of Clinical Nurse Specialists
CNO/CNS/Shared Governance Breakfast

September 11, 2015
Background and Significance

~To Nursing and Shared Governance~

Focus on Prevention of Pressure Ulcers

- **2009:** CMS classified stage III and IV pressure ulcers as “never events”
  - Hospitals no longer eligible for reimbursement of associated healthcare costs
- **2013:** Froedtert goal to keep stage II pressure ulcers below NDNQI mean
  - Stage II pressure ulcers soon to be classified as “never events”
Background and Significance

~To Nursing and Shared Governance~

Focus on Prevention of Pressure Ulcers

_AVERAGE COST OF STAGE III AND STAGE IV HAPUS:_

$4,779.53 - $6,466.43 per day

*Average of $127,185 per hospital stay
Background and Significance

**Statistics:**

Individuals who developed HAPUs were:

- Had longer length of stay (4.8 vs. 11.2)
- More likely to die during their hospital stay (3.3% vs. 11.2%)
- More likely to die within 30 days of discharge (4.4% vs. 15.3%)
- More likely to be readmitted within 30 days (17.6% vs. 22.6%)

*all statistically significant at p = < .001*
## Background and Significance

### Estimated Daily Costs

#### Prevention of HAPUs

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment*</td>
<td>2.50</td>
</tr>
<tr>
<td>Support surfaces</td>
<td>0.69</td>
</tr>
<tr>
<td>Chair cushion</td>
<td>0.17</td>
</tr>
<tr>
<td>Nutrition</td>
<td>1.10</td>
</tr>
<tr>
<td>Reposition*</td>
<td>12.02</td>
</tr>
<tr>
<td>Moisture/incontinence*</td>
<td>27.10</td>
</tr>
<tr>
<td>Unforeseen cost</td>
<td>11.09</td>
</tr>
<tr>
<td><strong>Total costs</strong></td>
<td><strong>54.66</strong></td>
</tr>
</tbody>
</table>

#### Treatment of HAPUs

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support surface</td>
<td>148.56</td>
</tr>
<tr>
<td>Moisture/incontinence*</td>
<td>114.34</td>
</tr>
<tr>
<td>Repositioning*</td>
<td>12.27</td>
</tr>
<tr>
<td>Chair cushion</td>
<td>0.17</td>
</tr>
<tr>
<td>Nutrition</td>
<td>1.10</td>
</tr>
<tr>
<td>Risk Assessment*</td>
<td>2.55</td>
</tr>
<tr>
<td>Topical antibiotics</td>
<td>15.40</td>
</tr>
<tr>
<td>Inpatient costs</td>
<td>1922.04</td>
</tr>
<tr>
<td>Unforeseen costs</td>
<td>544.11</td>
</tr>
<tr>
<td><strong>Total costs</strong></td>
<td><strong>2770.54</strong></td>
</tr>
</tbody>
</table>
Project Background

► Purpose:
  o Prevent pressure ulcers
  o Detect new and existing patient wounds
    ■ Early intervention and treatment

► Background:
  o Quarterly skin prevalence studies
  o April 2014: 7 unrecognized and undocumented deep tissue injuries were discovered on a single patient on 3NW
  o Root cause analysis:
    ■ Standard of care for skin prevention not enough
    ■ High risk patient population
    ■ **NEED:** Added element to skin breakdown prevention plan of care
Risk Factors

- Diabetes
- Cardiovascular diseases
- Peripheral vascular disease
- Recent fall
- Lengthy procedures or surgeries
- Unable to reposition themselves independently
- Compromised blood flow
- Medications
  - Steroids
  - Immunosuppressant therapy
  - Anti-embolic agents
- Active smokers or recent smoking history
- History of substance abuse
Project Overview

► Framework:
  - Plan, Do, Study, Act (PDSA) Model

► Outcome measures
  1. Monthly staff compliance through Quality Council audits
  2. Incidence of pressure ulcers on 3NW
  3. Number of pressure ulcers newly acquired on 3NW
  4. Identify wounds and intervene with appropriate wound care
CNS Involvement

- Assisted with Literature Review
- Facilitated completion of audits
  - Identified new patients to 3NW
  - Developed auditing tool to complete audits
- Staff support and resource
  - Thorough communication with staff
  - Development of monthly compliance charts and all-star lists
  - Random mini prevalence studies on 3NW
  - “Naughty” emails to staff with accountability piece
  - Recognition emails for early identification of wounds or completion of Four Eyes skin assessment
Hi _(name)_,

In order to provide each patient with excellent care, it is the expectation that each patient receives a “four eyes skin assessment” upon admission to 3NW.

During randomized audits of a patient that you admitted to 3NW we found no supporting documentation for a “four eyes skin assessment” on _(date)_.

Pressure ulcers are considered “never events.” Our organization does not receive reimbursement for hospital acquired stage 3 and stage 4 pressure ulcers. In the future, it is highly likely that this no reimbursement rule will also apply to stage 2 hospital acquired pressure ulcers.

Pressure ulcers represent 7.5% of your quality goal on your performance evaluation.

Our goal on 3NW is to achieve 100% compliance for four eyes skin assessments and reduce our hospital acquired pressure ulcer rate to zero.

Currently in the month of __________, our randomized audits revealed _(%)_ compliance with four eyes skin assessments.

Please make sure that you are completing and documenting accurate four eyes skin assessments on every patient upon admission to 3NW.

Please see Cristin, Chris, Kristy, or Megan with questions and concerns.

Thank you!
Literature Review

- “Routine inspection of skin”
  - Clearly defined assessment of patient’s skin?
- Pressure ulcer risk assessments
- Patient’s skin inspected on every shift
- Four eyes skin assessments on admission, transfer, return from surgery
  - “comprehensive head to toe skin assessment should be carried out with all clients at admission and daily thereafter…particular attention should be paid to vulnerable areas, especially over bony prominences and skin adjacent to external devices”
Project Description

- Plan, Do, Study, Act (PDSA) Methodology

Initiative began February 2014
- Staff notified via email
- Follow-up at staff meetings

Expectations:
- Complete Four Eyes with another staff RN for every admission or transfer to 3NW
- Assessments completed and documented within 24 hours

Standardized documentation in EPIC
1) Existing Wound/Present on admission: describes location of wound, wound bed, interventions to prevent skin breakdown, etc. This is used for pressure ulcers found upon admission or transfer. This also outlines that a wound consult has been ordered (or that the MD has been notified of the need for a wound consult).

2) No wounds: outlines that no wounds or notable skin abnormalities have been notified at this time.

3) Acquired Wound: describes location of wound, wound bed, and interventions to prevent skin breakdown. This may be used for non-pressure related wounds found later on during the patient’s stay.
Monthly Audits

- Used to measure staff compliance with initiative
  - 3NW Quality council members
  - CNS printed list of new patient medical record numbers (MRNs) that were new to the unit each day
  - Quality council members audited patient charts
Project Results

Compliance Percentage

- March '14: 79
- April '14: 80
- May '14: 91
- June '14: 91
- July '14: 90
- August '14: 90
- September '14: 95
- October '14: 99
- November '14: 98
- December '14: 98
- January '15: 96
- February '15: 97
- March '15: 97
- April '15: 99
- May '15: 99
- June '15: 100
- July '15: 100
Project Results

2) Prevalence of Pressure Ulcers:
   a. No further pressure ulcers were identified during subsequent prevalence studies

3) Pressure Ulcers Newly Acquired on 3NW
   a. 4 HAPUs: one unstageable, 2 DTIs, 2 stage II pressure ulcers

4) Identification of patient wounds and early intervention
   a. 59 total new wounds were recognized
Project Results

Percentage of New Patient Wounds

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug</td>
<td>2.7</td>
</tr>
<tr>
<td>Sept</td>
<td>2.7</td>
</tr>
<tr>
<td>Oct</td>
<td>7.9</td>
</tr>
<tr>
<td>Nov</td>
<td>8.3</td>
</tr>
<tr>
<td>Dec</td>
<td>6.5</td>
</tr>
<tr>
<td>Jan</td>
<td>5.8</td>
</tr>
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</table>
Project Results

- **Barriers:**
  - Staff buy-in and support
  - Accountability

- **Areas for improvement:**
  - Admission or transfer at or around shift change
  - Admission or transfer by float RN or resource pool RN

- **New Interventions:**
  - New expectations with accountabilities
  - Random 3NW prevalence studies (2-3 patients)
  - Monthly compliance percentage and “All-star” lists
  - Pizza party for reaching our goal
  - Frequency of audits
Project Results

- New accountabilities
  1) The first RN to document the first head to toe assessment would ultimately be responsible for documentation of the four eyes skin assessment.
  2) The first four eyes skin assessment was to be documented within 8 hours of arrival to 3NW.
  3) The shift coordinator would serve as a resource to educate float RNs on our four eyes initiative and help them complete their assessment prior to their end of shift. Ultimately, the RN following the float RN would be responsible for follow-up during bedside shift report and documentation of four eyes if it was not previously completed by the float RN.
Project Results

New accountabilities (continued)

4) If four eyes was not clinically indicated or appropriate during a RNs shift, they were to document the need for four eyes and their communication to the oncoming RN during bedside shift report in a progress note. If the patient was to refuse four eyes, a progress note should document the patient’s refusal, as well as the RNs attempt to educate the patient on the importance of the four eyes initiative.

5) A RN that missed completion or documentation of four eyes would receive an email on behalf of the CNS and Quality Council chairs regarding the date and MRN of the patient with the missed four eyes. If the RN missed documentation three times, a “warning” email would be sent on behalf of the nurse manager. Any further missed documentation would result in corrective action.
Implications for Nursing Practice

► Initiative presented to House wide Quality Council
  o Sharing of 3NW dot phrases: led to development of WOCN dot phrases
  o Goal: hospital-wide initiative

► Promotes patient wellness
  o Pressure ulcers are prevented
  o Current wounds are detected and receive expert wound care

► Nurses function at the top of their license

► Four Eyes saves the hospital thousands of dollars with each patient
Implications for Nursing Practice

WOCN Dot Phrases

 Skin assessment completed by *** RN and *** RN. No pressure ulcers found upon admission/transfer. Using Braden scale daily and performing skin assessment during bedside shift report.

 Skin assessment completed by ***, RN and ***, RN. Wound located on {IP WOUND LOCATION:24008}, noted. Description of the wound bed is documented in the Adult Patient Care Summary-Skin, under new LDA for {WOUND/PRESSURE ULCER:24009}.

 To prevent further skin breakdown; prevention and wound treatment initiated utilizing the First-Steps Skin/Wound Algorithms. **RN called Dr. ***, to notify on new skin breakdown.** Wound consult obtained for stage III or IV pressure ulcers. Will continue to monitor skin for risk of breakdown using Braden Scale and visual skin assessments. Wound treatment(s) applied as ordered and will monitor wound healing.

 Skin assessment completed by ***, RN and ***, RN. Wound located on {IP WOUND LOCATION:24008}, noted upon admission/transfer. Description of the wound bed is documented in the Adult Patient Care Summary-Skin, under new LDA for {WOUND/PRESSURE ULCER:24009}.

 To prevent further skin breakdown; prevention and wound treatment initiated utilizing the First-Steps Skin/Wound Algorithms. **RN called Dr. ***, to notify of community acquired wound.** Will continue to monitor skin for risk of breakdown using Braden Scale and visual skin assessments. Wound treatment(s) applied as ordered and will monitor wound healing.
References


Contact Information

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