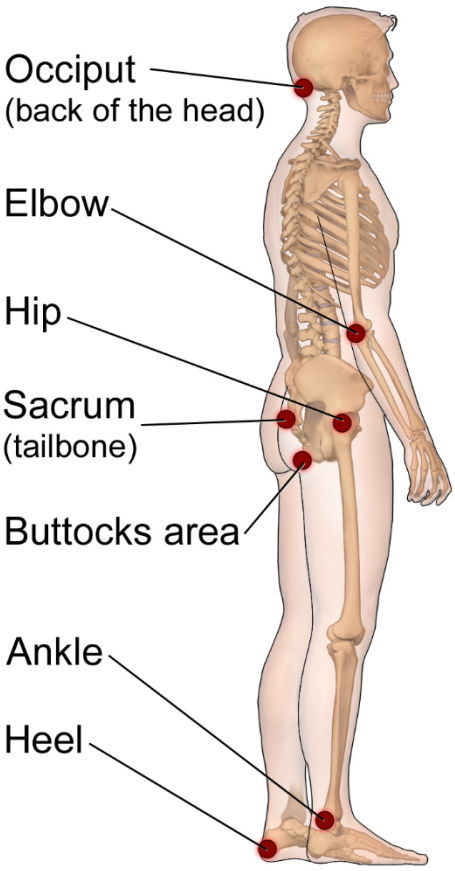
MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Four-Eyes Skin Assessment:
What is it and How Does It Affect Me?

What are pressure injuries?

Pressure injuries (formerly known as "bed sores" or "pressure ulcers") are injuries to the skin or underlying tissue usually over a bony area of the body. They are a result of persistent pressure between the bone, skin and a surface, or pressure in combination with rubbing or friction. Locations where pressure injuries commonly form are indicated with dots in the diagram to the right.



Common Pressure Ulcer Sites

What is the impact of pressure injuries?

- Affects as many as 2.5 million patients every year.
- May reduce quality of life and cause illness and death.
- Increases length of hospital stays by 7-10 days
- People with pressure injuries are 3 times more likely to be discharged to Long-Term Care Facilities (rather than being discharged to home)
- Cost of care for one pressure injury is between $500 and $70,000 depending on the severity
- Pressure injuries vary in severity, there are four stages. See page 3 for details.

What is a "four-eyes skin assessment"?

On our unit we identify your risks for skin breakdown. We do this by performing a "**four-eyes skin assessment**". This is a process where two unit nurses (four eyes) examine the entire skin of every individual for any

abnormalities. It requires looking at and touching the skin from head-to-toe, with a particular emphasis over bony areas of the body.

This assessment only takes a couple of minutes and helps protect you from skin breakdown and pressure injuries during your hospital stay. The first four-eyes skin assessment will happen when arriving to our unit. This may be from another unit, from home, or from the emergency department.

Since protecting your skin is so important, you can also expect that your nurses will do recurrent skin assessments daily to ensure that there are no developing problems.

What is a "house-wide" skin survey?

At Michigan Medicine we do a monthly house (hospital)-wide skin survey to ensure that our patients are not developing any pressure injuries while under our care. This house-wide skin survey occurs on the 3rd Tuesday of every month and includes two staff members from our units performing quick, comprehensive skin assessments. If you have any questions or concerns, be sure to speak with your bedside nurse!

What other actions are taken to keep my skin healthy?

Nurses and supporting staff also ensure that our patients are not developing pressure injuries by making sure that you are not laying or sitting in one position for too long. Every 2 hours (at least) we will encourage mobility or help you change position if you are unable to.

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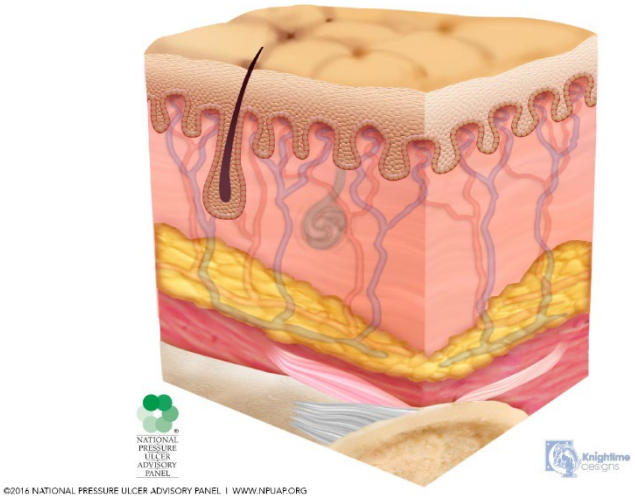
Pressure injury stages

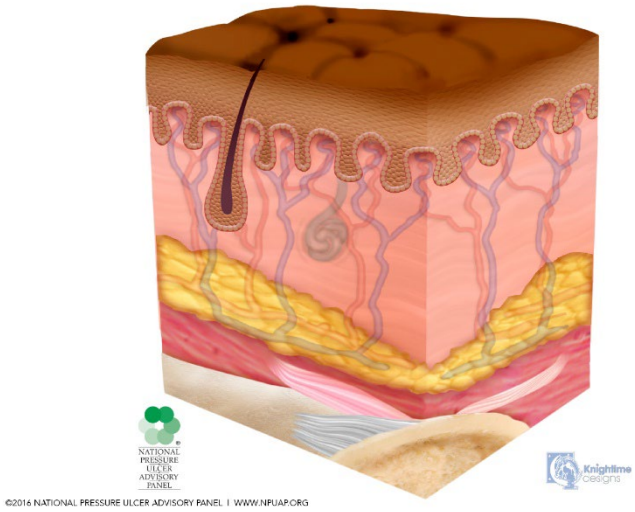
Healthy Skin

The skin is not red or discolored.

Healthy Skin – Lightly Pigmented



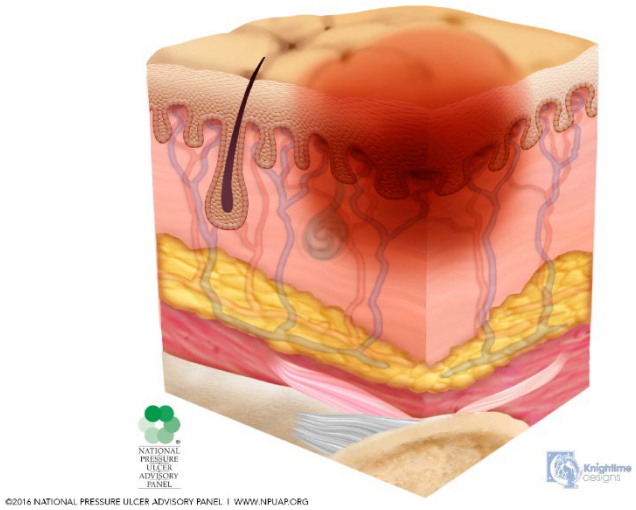
Healthy Skin – Darkly Pigmented



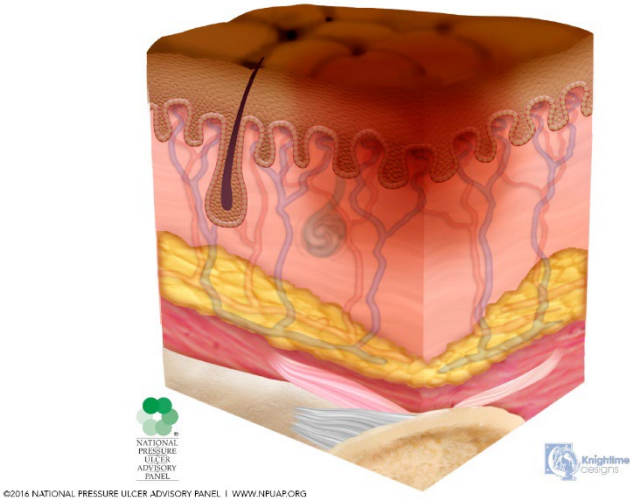
Stage 1 Pressure Injury:

The skin is intact but has a specific area of non-blanchable redness. This means when you press on it it stays red and does not lighten or turn white (blanch).

Stage 1 Pressure Injury – Lightly Pigmented

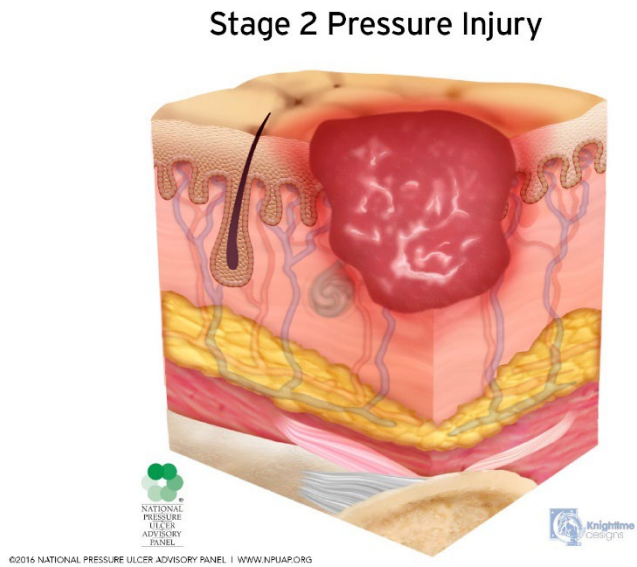


Stage 1 Pressure Injury – Darkly Pigmented



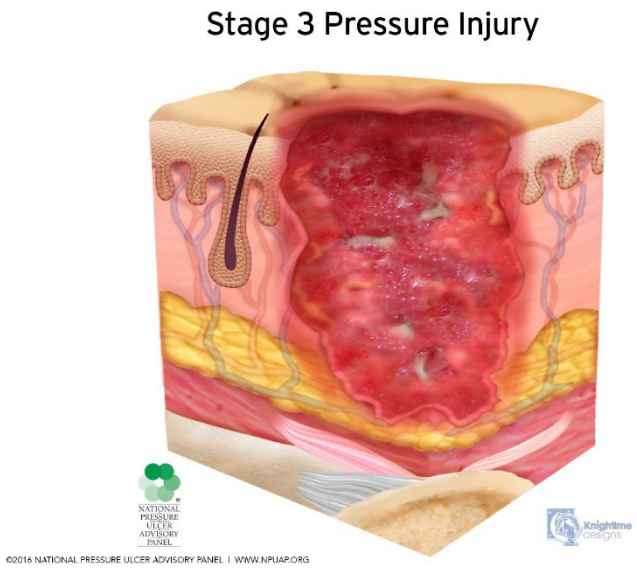
Stage 2 Pressure Injury:

The top layer of skin is broken and there is a shallow open sore. The second layer of skin may also be broken. There may or may not be drainage.



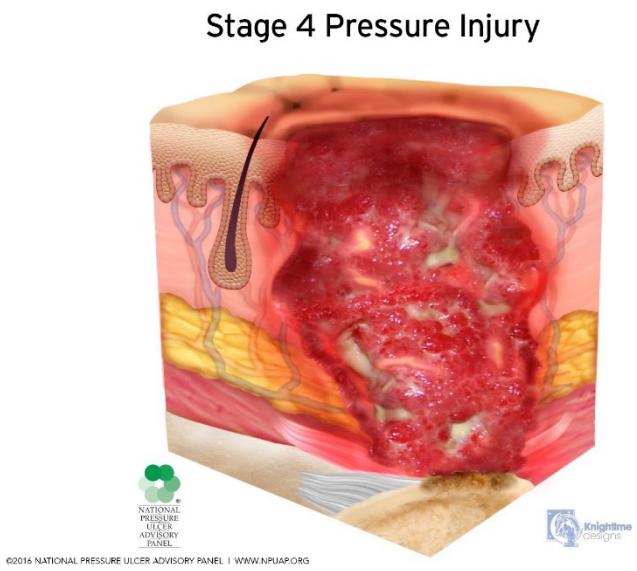
Stage 3 Pressure Injury:

The wound extends through the second layer of skin into the fat tissue. The depth of tissue damage varies by location on the body. Bone, tendon, and muscle are not visible.



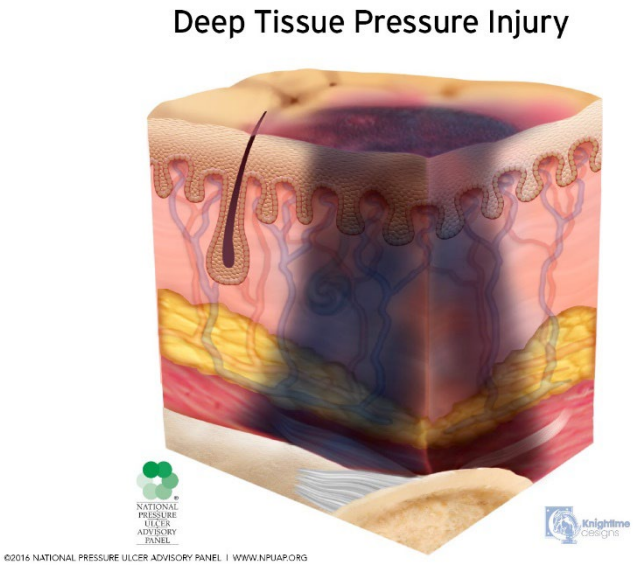
Stage 4 Pressure Injury:

The wound has full skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone. Depth varies by location on the body.



Deep Tissue Pressure Injury

The skin may or may not be broken. There is deep red or purple discoloration that may or may not have separation in the skin layers. A blister near the surface of the wound may also be present.



Unstageable Pressure Injury- Dark Eschar or Slough

Dark Eschar is tan, brown or black skin that sheds or falls off. **Slough** is wet dead tissue. This type of wound is unstageable because the wound is completely covered. If the slough and eschar are removed the wound may be a stage 3 or 4.

Unstageable Pressure Injury – Slough and Eschar