OASIS-C Integument Assessment: Not for Wimps! Part I: Pressure Ulcers

Presented by:
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OASIS-C Integument Assessment: Not for Wimps!
Part I - Pressure Ulcers

May 1, 2012
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Purpose

- To master wound healing principles and terminology of pressure ulcers.
- To utilize these definitions when documenting pressure ulcers in comprehensive assessments and OASIS data items.

Objectives

- Define the principles of wound healing applied to pressure ulcers;
- Define healing status of pressure ulcers; and
- Identify and document the correct stage and any increase in pressure ulcers during the episode of home care
Skin Assessment

- Observe the skin at every assessment time point:
  - Temperature
  - Color
  - Moisture
  - Turgor
  - Integrity

- Determine wound type and etiology.

- Who gets “credit” for this wound?

Wound Assessments

A anatomic location
S size, shape, stage
S sinus tract, tunneling, fistulas, undermining
E exudate
S sepsis
S surrounding skin
M maceration
E edges, epithelialization
N necrotic tissue
T tissue bed
S status

Baranoski, S., and Ayello, E.A., Wound Care Essentials: Practice Principles

OASIS Alerts!

Integument items are:

- Based on what you see (tissue, structure, condition, etc.)

- Matched to the NPUAP Pressure Ulcer Stages and WOCN OASIS-C Wound Guidance Document

- Modified by CMS guidance to report findings in OASIS data items

- Q87.1
Pressure Ulcer Definition

- Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction.

- 4 Stages + Suspected Deep Tissue Injury + Unstageable
  (NPUAP 2007)

Unavoidable Pressure Ulcer
NPUAP March 2010

Unavoidable - means that the individual developed a pressure ulcer even though the provider had:

- Evaluated the individual’s clinical condition and pressure ulcer risk factors;
- Defined and implemented interventions that are consistent with individual needs goals and recognized standards of practice;
- Monitored and evaluated the impact of the interventions; and
- Revised the approaches as appropriate.
Stage I

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Further description:
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons (a heralding sign of risk).

Stage II

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury

Stage III

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further description:
The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.
Stage IV

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Further description:
The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

OASIS Alert!

- CMS modifies the NPUAP reference to “directly palpable” in a stage IV pressure description. For OASIS purposes, to classify a pressure ulcer as a stage IV, exposed bone/tendon must be “visible” and not “directly palpable”.
  - Q89.3

Suspected Deep Tissue Injury (SDTI)

- Purple or maroon localized area of discolored intact skin OR a blood filled blister due to damage of underlying soft tissue from pressure and/or shear.

- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

(NPUAP 2007)
Suspected Deep Tissue Injury (SDTI)

Further description:
Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapidly exposing additional layers of tissue even with optimal treatment.

Unstageable

- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further description:
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.

OASIS Alert!

- Unstageable pressure ulcers:
  - Full thickness tissue loss in which the true wound depth is obscured by slough and/or eschar in the wound bed;
  - Suspected deep tissue injury in evolution; and
  - Pressure ulcer under a dressing or device that cannot be removed.
OASIS Alert!

- A previously stageable pressure ulcer now covered by eschar is considered “unstageable.”
  - Q98.1
- Do not reverse stage pressure ulcers.
  - OASIS-C Guidance Manual

Pressure Ulcers

- Partial thickness tissue loss:
  - Involves epidermis and into but not through the dermis
  - Superficial; presents as shallow crater, abrasion or blister
  - Heals by epithelialization
    - Regeneration of epidermis across a wound surface
    - Includes stage I and II pressure ulcers

Pressure Ulcers

- Full thickness tissue loss:
  - Penetrates through the fat (subcutaneous tissue) and may involve muscle, tendon, or bone
  - Deep crater; may tunnel
  - Heals by granulation, contraction and epithelialization
  - Never considered fully healed
  - Closed when fully granulated and covered with new epithelial tissue
  - Includes stage III and IV pressure ulcers
Degree/Status of Healing
Pressure Ulcer

- Wound Status:
  - Not healing
  - Early/partial granulation
  - Fully granulating
  - Newly epithelialized
    - When epithelial tissue has completely covered the wound surface, regardless of how long the pressure ulcer has been re-epithelialized.

- www.wocn.org  Wound Guidance Document

OASIS Alerts!

- An ulcer diagnosed by a physician as a diabetic ulcer is not a pressure ulcer or stasis ulcer.
  - Q89

- A pressure ulcer covered with a skin graft or debrided remains a pressure ulcer.
  - Q89.1 and 95

- A pressure ulcer closed with a muscle flap becomes a surgical wound.
  - Q94

OASIS Alerts!

- A previously closed stage III or IV pressure ulcer that is currently open again is reported at its worst stage.
  - OASIS-C Guidance Manual

- A pressure ulcer closed with a muscle flap that heals and then breaks down due to pressure becomes a new pressure ulcer.
  - Q94
OASIS Alerts!

- A single pressure ulcer partially granulated to the surface, leaving the ulcer open in more than one area is only one pressure ulcer.
  - Q96

- Two pressure ulcers that are separated by intact skin but have a tunnel which connects the two remain two pressure ulcers.
  - Q88.5

M1306 Unhealed Pressure Ulcer Stage II or Higher

<table>
<thead>
<tr>
<th>Column 1: Complete at SOC/ROC/FU &amp; D/C</th>
<th>Column 2: Complete at PU &amp; D/C</th>
<th>Number of Times Listed in Column 1, that were present on admission, most recent SOC/ROC/FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage III: Partial thickness loss of skin, presenting as a shallow open ulcer with red, pink, or yellow bed, without slough. May also present as an intact or open/punctured serous-filled blister.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IV: Full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage V: Full-thickness tissue loss with viable bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstageable: Known or likely, but unstageable due to non-removable dressing or device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstageable: Suspected deep tissue injury, new in evolution</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Number of Ulcers In the Most Recent SOC/ROC/FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II</td>
<td>0</td>
</tr>
<tr>
<td>Stage III</td>
<td>1</td>
</tr>
<tr>
<td>Stage IV</td>
<td>2</td>
</tr>
<tr>
<td>Stage V</td>
<td>3</td>
</tr>
<tr>
<td>Unstageable</td>
<td>4</td>
</tr>
</tbody>
</table>

Q96 Q88.5
## Patient 1 at SOC does not have an unhealed stage II pressure ulcer. There are no pressure ulcers.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed pressure ulcers</th>
<th>Complete at TV &amp; DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II: Full thickness loss of tissue</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Stage III: Full thickness loss of tissue with exposed bone, tendon, or muscle</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Stage IV: Full thickness loss of tissue with exposed bone, tendon, or muscle in addition to &quot;b&quot;</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

## Patient 1 at Follow Up has 1 unhealed stage II pressure ulcer.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed pressure ulcers</th>
<th>Complete at TV &amp; DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II: Full thickness loss of tissue</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>b. Stage III: Full thickness loss of tissue with exposed bone, tendon, or muscle</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Stage IV: Full thickness loss of tissue with exposed bone, tendon, or muscle in addition to &quot;b&quot;</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

## Patient 2 at SOC has 1 unhealed stage III pressure ulcer.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed pressure ulcers</th>
<th>Complete at TV &amp; DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II: Full thickness loss of tissue</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Stage III: Full thickness loss of tissue with exposed bone, tendon, or muscle</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>c. Stage IV: Full thickness loss of tissue with exposed bone, tendon, or muscle in addition to &quot;b&quot;</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: M1306 would be skipped.

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**Time Points:** WOCN Guidelines NPUAP Staging

**Patient 1 at SOC does not have an unhealed stage II pressure ulcer. There are no pressure ulcers.**

**Patient 1 at Follow Up has 1 unhealed stage II pressure ulcer.**

**Patient 2 at SOC has 1 unhealed stage III pressure ulcer.**

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**Fuzzi**

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Patient 2 at Follow up. The stage III pressure ulcer has progressed to a stage IV pressure ulcer.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed Pressure Ulcers</th>
<th>Complete AT V &amp; DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stage III</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stage IV</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- 01 Unhealed: Known or likely to unhealable due to non-namplacable or resistant or non-reparable or non-replaceable or non-repairable or non-reconstructible.
- 02 Unhealed: Known or likely to unhealable due to non-repairable or non-reconstructible.
- 03 Unhealed: Suspected deep tissue injury in evolution.

Time Points: NPUAP Staging

Patient 3 at SOC has 1 unhealed (open) stage II pressure ulcer, 1 open stage III pressure ulcer and one closed stage III pressure ulcer.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed Pressure Ulcers</th>
<th>Complete AT V &amp; DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II (open)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stage III (open)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Stage III (closed)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- 01 Unhealed: Known or likely to unhealable due to non-namplacable or resistant or non-reparable or non-replaceable or non-repairable or non-reconstructible.
- 02 Unhealed: Known or likely to unhealable due to non-repairable or non-reconstructible.
- 03 Unhealed: Suspected deep tissue injury in evolution.

Time Points: NPUAP Staging

Patient 3 at Discharge. The stage II pressure ulcer that was open at SOC has healed. There is a different stage II pressure ulcer open in another location. The stage III pressure ulcer remains open and the other stage III pressure ulcer remains closed.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed Pressure Ulcers</th>
<th>Complete AT V &amp; DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II (open)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stage III (open)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Stage III (closed)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- 01 Unhealed: Known or likely to unhealable due to non-namplacable or resistant or non-reparable or non-replaceable or non-repairable or non-reconstructible.
- 02 Unhealed: Known or likely to unhealable due to non-repairable or non-reconstructible.
- 03 Unhealed: Suspected deep tissue injury in evolution.
**Patient 4**

At SOC there is 1 unhealed stage II pressure ulcer, 1 unhealed stage III pressure ulcer and 1 closed stage III pressure ulcer.

- **Stage II** Pressure ulcer:
  - Patient at SOC has 1 unhealed stage II pressure ulcer, with red glistening base with etched edges and undermining.
  - Stage II ulcer is open.

- **Stage III** Pressure ulcer:
  - Patient at SOC has 1 unhealed stage III pressure ulcer, with slough or eschar base, bone exposed, undermining.
  - Stage III ulcer is closed.

**At Recertification**

-**Stage II** Pressure ulcer:
  - The stage II pressure ulcer that was open at SOC has fully re-epithelialized. Another stage II pressure ulcer is open in a different location.

-**Stage III** Pressure ulcer:
  - The stage III pressure ulcer now has bone exposed and the other stage III pressure ulcer remains closed.

- **Stage IV** Pressure ulcer:
  - No stage IV pressure ulcer is present.

**Patient 5**

At SOC, there is 1 pressure ulcer on the left heel covered with eschar and 1 blood filled blister on the right heel from pressure after many days of bed rest. There is a stage III pressure ulcer which closed in the hospital and remains closed.

- **Stage II** Pressure ulcer:
  - Patient at SOC has 1 pressure ulcer on the left heel covered with eschar, with red glistening base with etched edges and undermining.
  - Stage II ulcer is closed.

- **Stage III** Pressure ulcer:
  - Patient at SOC has 1 blood filled blister on the right heel from pressure, with slough or eschar base, bone exposed, undermining.
  - Stage III ulcer is closed.

- **Stage IV** Pressure ulcer:
  - No stage IV pressure ulcer is present.
**Patient 5** At Recertification, the pressure ulcer on the left heel remains covered with eschar. The blood-filled blister on the right heel has broken open and is now a stage III. The stage III pressure ulcer which closed in the hospital remains closed.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unchanged</th>
<th>Improved</th>
<th>Poor</th>
<th>Column 2</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
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</thead>
<tbody>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blood-filled blister</td>
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<td>2</td>
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<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

**Patient 6** is bedbound. At SOC there is a skin graft on a stage III pressure ulcer with orders not to remove the pressure dressing until the physician's visit. There is a deep red, warm and boggy area noted on the right heel.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unchanged</th>
<th>Improved</th>
<th>Poor</th>
<th>Column 2</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
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<td>0</td>
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<tr>
<td>Blood-filled blister</td>
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</tr>
</tbody>
</table>

**Patient 6** At Discharge, the skin graft on the stage III pressure ulcer has healed with some contracture and discoloration of the graft site and the deep red, warm and boggy area noted on the right heel is resolved.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unchanged</th>
<th>Improved</th>
<th>Poor</th>
<th>Column 2</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blood-filled blister</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unchanged</td>
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<td>0</td>
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<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>
Patient 7 at SOC has a stage I pressure ulcer on each heel.

Patient 7 at Recertification, there is no evidence of a stage I pressure ulcer on the right heel. The stage I pressure ulcer on the left heel is now a stage II.

Patient 8 at SOC has a stage III pressure ulcer.
Patient 8 At Recertification, the stage III pressure ulcer from SOC is now covered with eschar.

<table>
<thead>
<tr>
<th>M1308</th>
<th>Current Number of Unhealed (Non-Healed) Pressure Ulcers at Each Stage:</th>
<th>SOC/ROC/DC</th>
<th>Staging</th>
<th>Staging</th>
<th>NPUAP Staging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Partial thickness loss of tissue without slough or eschar present on full thickness ulcer.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stage II</td>
<td>Full thickness loss of tissue with or without slough present on full thickness ulcer.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stage III</td>
<td>Full thickness loss of tissue with or without slough present on full thickness ulcer.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stage IV</td>
<td>Full thickness loss of tissue with or without slough present on full thickness ulcer.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stage V</td>
<td>Full thickness loss of tissue with or without slough present on full thickness ulcer.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Consider all stage III and IV pressure ulcers from M1308 Col.1 row b (stage III), row c (stage IV), and row d2 (unstageable covered w/ slough or eschar).

Depth does not include the depth of any tunneling.

OASIS Alert!

- Status of the pressure ulcer needs to correspond to the visual assessment of the clinician on the day of the assessment.
  - Q98
WOCN Definitions

Degree of Healing

- Not healing
  - Wound with ≥ 25% avascular tissue (eschar and/or slough) OR
  - Signs/symptoms of infection OR
  - Clean but non-granulating wound bed OR
  - Closed/hyperkeratotic wound edges OR
  - Persistent failure to improve despite appropriate comprehensive wound management

- Early/partial granulation
  - ≥ 25% of the wound bed is covered with granulation tissue
  - < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges open

- Fully granulating
  - Wound bed filled with granulation tissue to the level of the surrounding skin
  - No dead space
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges are open

- Newly epithelialized
  - Wound bed completely covered with new epithelium
  - No exudate
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection

OASIS Alerts!

- Stage II pressure ulcers that close/heal/fully epithelialize are not reportable on OASIS and therefore will not be “newly epithelialized” for data collection.

- Stage II pressure ulcers do not granulate.

- Stage II pressure ulcers (includes serum filled blister) can only be “not healing” for data collection.
M1320 Status Most Problematic (Observable) Pressure Ulcer \textit{SOC/ROC/DC}

(M1320) Status of Most Problematic (Observable) Pressure Ulcer:
- 0 - Newly epithelialized \textup{Applies only to stage III and IV}
- 1 - Fully granulating
- 2 - Early partial granulation
- 3 - Not healing \textup{Only status for a stage II}
- NA - No observable pressure ulcer \textup{Non-removable dressing/device}

Excludes stage I pressure ulcer

M1322 Current Number of Stage I Pressure Ulcers

(M1322) Current Number of Stage I Pressure Ulcers: \textit{Inked area with non-removable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warm or colder as compared to adjacent area.}
- 0
- 1
- 2
- 3
- 4 or more

Upon inspection, the patient has 1 pressure ulcer on the left heel that is covered with eschar. There is 1 stage III pressure ulcer on his sacrum. Granulation tissue is present in the wound bed with areas of slough scattered over 10\% of the wound bed.

M1324 Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:
- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - No observable pressure ulcer or unhealed pressure ulcer

- Staging an ulcer requires seeing the wound base.
- In a multi pressure ulcer situation, consider an ulcer that is observable over one that is not.
Unusual Situation

- Pressure ulcer sutured closed without a flap procedure is a pressure ulcer
  - M1306 Yes
  - M1308 d1. Unstageable D/T non-removable dressing or device
  - M1310/1312/1314 Leave blank
  - M1320 NA-not observable ("has a dressing")
  - M1324 NA-not observable (cannot be staged when "has a dressing")

M1307 Oldest Non-epithelialized Stage II Pressure Ulcer - DC

(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge:

☐ 1. Was present at the most recent DO/ROC assessment
☐ 2. Developed since the most recent DO/ROC assessment: record date pressure ulcer first identified: ___ month/day/year
☐ NA - No non-epithelialized Stage II pressure ulcers are present at discharge

- Need to know wound history
- Identifies:
  - Length of time a stage II pressure ulcer remained unhealed.
  - Who developed stage II pressure ulcer while receiving care from the HHA.

Session Survey

Please take a moment to complete a brief survey on today’s session:

https://www.surveymonkey.com/s/TN7JFTV

Following completion of the survey you will be able to download a Certificate of Attendance.

Thank you for attending the presentation.
Resources

- National Pressure Ulcer Advisory Panel
  - www.npuap.org
- Wound Ostomy Continence Nurses
  - www.wocn.org
- WOCN Position Paper: “Avoidable versus Unavoidable Pressure Ulcers”
- OASIS C Guidance Manual
- CMS OASIS Q and A

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