So You Think You Know OASIS?

Mastering the Skin Assessment

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M1300 – M1399
Integumentary Status

Skin Assessment
Pressure Ulcers

• 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

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, epithelialization
• Never considered fully healed
• Closed when fully granulated and covered with new epithelial tissue
• Includes Stage III and IV Pressure Ulcers
OASIS Alert!

Unstageable pressure ulcers
• Pressure ulcer under a dressing or device that cannot be removed
• 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

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

Degree/Status of Healing

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
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

M1306 Unhealed Pressure Ulcer Stage II or Higher

[ ] 0 - No [ Go to M1302 ]
[ ] 1 - Yes

What did the skin inspection reveal?
### SOC - Patient A has one unhealed Stage III Pressure Ulcer.

<table>
<thead>
<tr>
<th>Column 1 Complete at SOC/ROC</th>
<th>Column 2 Complete at PU &amp; AO/DCC</th>
<th>Number of Ulcers present on the day of assessment</th>
<th>Number of Ulcers in column 1 that were present on admission (could not be recertified)</th>
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<tbody>
<tr>
<td>Stage III: Partial thickness loss of skin presenting as a shallow open ulcer with red granulation tissue, without slough. May also present as an intact or superficially ulcerated lesion.</td>
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<td><em>Unstaged:</em> Suspected deep tissue injury or infection.</td>
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**Patient A** has one unhealed Stage III Pressure Ulcer.

- **0** Stage III Ulcers present on the day of assessment.
- **0** Ulcers in Column 1 that were present on admission (could not be recertified).

### Recert - The Stage III PU has progressed to a Stage IV PU.

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**Patient A** has one unhealed Stage III Pressure Ulcer.

- **0** Stage III Ulcers present on the day of assessment.
- **0** Ulcers in Column 1 that were present on admission (could not be recertified).
SOC - Patient B has one unhealed Stage II PU, one unhealed open Stage III PU and one unhealed closed Stage III PU.

DC - the Stage II PU that was open at SOC has healed. A new Stage II PU is open in another location. The Stage III PU remains open and the other Stage III PU remains closed.

OASIS Alert!

• **Stage II Pressure Ulcers** that close/heal/fully epithelialize are not reportable in OASIS items.

• Reportable Stage II Pressure Ulcers cannot be “newly epithelialized” for data collection.

• **Stage II Pressure Ulcers** do not granulate - can only be “not healing” for data collection.

• Only closed Stage III and IV Pressure Ulcers can be “newly epithelialized.”
M1324 Stage Most Problematic (Observable) Pressure Ulcer

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

M1330 Does This Patient Have a Stasis Ulcer?

Does this patient have a Stasis Ulcer?
- 0 - No (Go to M1324)
- 1 - Yes, patient has BOTH observable and unobservable ulcers
- 2 - Yes, patient has observable ulcers ONLY
- 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) (Go to M1332)

M1332 Current Number of (Observable) Stasis Ulcers

Current Number of (Observable) Stasis Ulcer(s):
- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more

Report the presence of ulcers caused by inadequate venous circulation.
OASIS Alert!

- *Stasis ulcers* that close/heal/fully epithelialize are not reportable in OASIS items.
- Reportable stasis ulcers cannot be “newly epithelialized” for data collection.

M1334 Status Most Problematic (Observable) Stasis Ulcer

(M1334) Status of Most Problematic (Observable) Stasis Ulcer:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/Partial granulation
- 3 - Not healing

Surgical Wounds

- Frequently heal by Primary Intention
  - Wound edges are directly next to one another
  - Little tissue loss, no granulation occurs
  - Wound closure is performed with sutures, staples, or adhesive, etc.
- May heal by Secondary Intention
  - Wound is allowed to granulate

OASIS Alert! If there is any separation of the incision, then healing will be by secondary intention for data collection purposes.
Surgical Wound

**Scar:** Surgical wound that has been re-epithelialized (epidermal wound surfacing across the entire wound surface) for approximately 30 days or more without dehiscence or signs of infection.

How will you know when 30 days begins?

**OASIS Alert!** A scar is not reported in OASIS data items.

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M1340 Have a Surgical Wound?

(M1340) Does this patient have a Surgical Wound?

- 0 - no [Go to M1380]
- 1 - yes, patient has at least one (observable) surgical wound
- 2 - Surgical wound known but not observable due to non-removable dressing [Go to M1380]

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**OASIS Alert!**

- Surgical wounds healing by primary intention do not granulate and can only be “not healing” or “newly epithelialized” for data collection.
- Surgical wounds healing by secondary intention can be “not healing,” “early/partial granulation,” “fully granulating,” or “newly epithelialized.”
M1342 Status of Most Problematic (Observable) Surgical Wound

(M1342) Status of Most Problematic (Observable) Surgical Wound:
- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing

Report what you see.

M1350 Have a Skin Lesion or Open Wound Receiving Intervention

(M1350) Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency? 
- 0 - No
- 1 - Yes

Report other wounds with interventions on the POC.

“YES” refers to:
- Other wound types (burns, diabetic ulcers, cellulitis, abscesses, wounds caused by trauma, etc.)
- Non-bowel ostomies receiving clinical intervention per the POC/485 (e.g., cleansing, dressing changes, etc.) from the home health agency.

OASIS Alerts!
Status of Healing Possibilities

*For purpose of handouts, please see chart at end of presentation.
CMS Guidance

- OASIS-C Implementation Manual
  Revised annually 12/2010
- CMS Q and A
  Core group revised and posted 12/2010
  https://www.qtsi.com/hhadownload.html
- Q and A updated quarterly
  www.fazzi.com
- WOCN OASIS Wound Guidance Document
  www.wocn.org
- Alert! Follow the most recent guidance from CMS when conflicts found.

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## Status of Healing Possibilities

<table>
<thead>
<tr>
<th>Condition</th>
<th>Not healing</th>
<th>Early/partial granulation</th>
<th>Fully granulating</th>
<th>Newly epithelialized</th>
<th>Scar/healed and not reported on OASIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 PU</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Stage 2 PU</td>
<td>X</td>
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<tr>
<td>Stage 3 PU</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Stage 4 PU</td>
<td>X</td>
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<td>Closed Stage 3 or 4 PU</td>
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<tr>
<td>Stasis ulcer</td>
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<td>Surgical Wound Primary Intention</td>
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<tr>
<td>Surgical Wound Secondary Intention</td>
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</table>